



Essex Autonomy Project

The Deprivation of Liberty Safeguards

Essex Autonomy Project Briefing (Updated February 2011)

Authors: Antal Szerletics and Tom O'Shea

Introduction	1
Deprivation of liberty in the jurisprudence of the ECHR	2
Deprivation of liberty in selected domestic law	10
The deprivation of liberty safeguards	15
Problems with DoLS	20
Alternatives to DoLS	25
Appendix 1: Guardianship regulations in Russia	32
Appendix 2: Custodianship in Germany	33
Appendix 3: Additional Article 5 ECHR cases	38
Appendix 4: Deprivation of liberty case law (England and Wales)	41

Introduction

It is a foundational commitment of modern liberal states that detention of citizens is only undertaken in accordance with a due process of law and is subject both to periodic review and lawful challenge. This principle governs not only criminal imprisonment but all other legally permissible deprivations of liberty imputable to the state, ranging from extradition to the control of infectious diseases. The deprivation of liberty safeguards (DoLS) are a legal framework – intended to secure a lawful basis for depriving people of their liberty – implemented in England and Wales in April 2009. The safeguards cover mentally disordered adults who are deprived of their liberty in their best interests in a registered care home or hospital for the purpose of care or treatment for which they lack capacity to consent, yet who are not detainable under the Mental Health Act (MHA).

The immediate aim of DoLS was to provide a mechanism for closing the so-called ‘Bournewood gap’ which the European Court of Human Rights (ECtHR) identified in 2004 in *HL v the United Kingdom*.¹ In this case, the Court found breaches of Article 5(1) and (4) of the European Convention on Human Rights (ECHR) which require that deprivations of liberty are undertaken in accordance with ‘a procedure prescribed by law’ and that detained persons can initiate a speedy process of review of the lawfulness of detention. HL was an informally admitted psychiatric patient in a hospital, but legislators believed a similar lack of procedural safeguards also covered a sizeable population – mostly of persons with dementia and learning disabilities – who were deprived of their liberty in care homes. DoLS are meant to ensure Convention compliance without the need to refer each relevant case to the Court of Protection or High Court. Whether DoLS should have a wider function than this – namely, to be a tool for enforcing the rights of vulnerable adults and shining a light on dubious care practices more generally – remains a source of disagreement between professionals.

Critics of DoLS have identified numerous difficulties with the regulations and their implementation. These include:

- (i) overly intricate assessments required to determine whether DoLS are to be engaged, especially concerning the interface with the MHA outlined in Schedule 1A (whose Byzantine complexity presents a challenge even to many lawyers);
- (ii) lack of clarity concerning the meaning of ‘deprivation of liberty’;
- (iii) poor training, outdated guidance (particularly in the Code of Practice) and failures to effectively disseminate important legal developments;
- (iv) administrative burden stemming from highly bureaucratic procedures for obtaining authorisations, and higher than expected costs;
- (v) delays and expense when there are referrals to the Court of Protection, alongside difficulties in finding legal counsel, which threaten an effective exercise of people’s rights;

¹ *HL v United Kingdom* [2004] ECHR 471 (app. no. 45508/99).

- (vi) insufficient independence of supervisory bodies from managing authorities, leading to potential conflicts of interest and lack of robust procedures for review;
- (vii) concerns that recent case law (such as the Cheshire judgement discussed below) has narrowed the interpretation of deprivation of liberty too much, thereby impeding proper scrutiny of care practices;
- (viii) lack of effective and speedy safeguards for populations potentially deprived of their liberty but ineligible for DoLS, such as persons with mental disorders residing in supported living or a family home rather than a hospital or registered care home.

In light of these concerns, this report surveys the deprivation of liberty safeguards, examining their origins, the nature of the current legal regime, developments in the case law, criticisms of both legislation and current practice, and possible alternative systems.

The notion of deprivation of liberty in the jurisprudence of the European Court of Human Rights

After the implementation of the Human Rights Act (and especially in the light of section 64 (5) of the MCA),² English courts have had to consider the notion of deprivation of liberty as understood in the European Convention and the European Court's case law. While there remains some overlap between the notions of deprivation of liberty and imprisonment in the context of the common law tort of 'false imprisonment', the two notions are distinct in various ways.

Article 5 (1) of the European Convention sets out the right to liberty and security and formulates an exhaustive list of exceptions in which cases someone can be lawfully deprived of his or her liberty.³ For our purposes, Articles 5 (1) e (the detention of persons of unsound mind, in particular) and 5 (4) (the speedy review of detention) are of particular importance.⁴

² 'In this Act, references to deprivation of a person's liberty have the same meaning as in Article 5(1) of the Human Rights Convention.' Section 64(5) MCA, inserted by MHA 2007.

³ While the notion of 'deprivation of liberty' is extensively discussed in European case law, the meaning of 'security' remains unclear. The Court made some use of the concept of 'security' in cases involving the disappearances of prisoners when it was uncertain if the prisoner was detained at all after a certain period of time (*Timurtas v Turkey* [2000] ECHR 221, app. no. 23531/94). In this respect, security seems to imply protection from arbitrary state intervention and require an effective judicial review/effective investigation into the circumstances of disappearance. See also *Austin v Commissioner of Police of the Metropolis* [2009] UKHL 5 para. 41 and references there.

⁴ However, it has been argued that Article 5 as a whole and specifically the full list of exceptions in Art. 5 (1) have to be kept in view when establishing the general rationale in relation to what is counted as a deprivation of liberty, rather than a mere restriction of movement. See *Cheshire West and Chester Council v P* [2011] EWCA Civ 1257 paras. 24-28.

Article 5 ECHR – Right to liberty and security

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;
...
4. 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.

Deprivation of liberty is often contrasted with restriction on freedom of movement. The scope of Article 5 extends only to deprivation of liberty; freedom of movement is protected by Article 2 of Protocol 4 ECHR which was, however, not ratified by the UK.⁵ The dividing line between the two concepts is not clear-cut; however, a proper differentiation seems crucially important, especially because there are significant differences between deprivation of liberty and restriction of movement in terms of their justification.

The right to liberty and security is an *absolute* or *unqualified* right and it admits only a few exceptions which are listed exhaustively in Article 5 (1) a-f.⁶ The protection from unjustified or arbitrary deprivation of liberty is of ‘paramount importance’ in democratic societies and the listed exceptions are to be narrowly interpreted.⁷ Article 2 Protocol 4 is a *qualified* right, comparable to those rights enshrined in Articles 8 - 11 of the Convention (e.g. right to respect for private and family life, freedom of religion, freedom of expression). This means that the right to freedom of movement may be balanced against other rights and interests and can be restricted for reasons set out in paras. 3 and 4 of Article 2 Protocol 4.⁸ Thus, where the line is drawn between deprivation of liberty and restriction of movement is particularly important. Arguably, this is even more so in the case of the United Kingdom, which did not ratify Protocol 4, so from the perspective of the Convention, UK authorities have no legal obligation to justify limitations of liberty that amount ‘merely’ to restrictions on freedom of movement.

⁵ Article 2 (1) of Protocol IV states: ‘Everyone lawfully within the territory of a State shall, within that territory, have the right to liberty of movement and freedom to choose his residence.’

⁶ See, e.g. *Austin v Commissioner of Police of the Metropolis* [2009] UKHL 5, paras. 12-16. See also *Secretary of State for the Home Department v JJ and Others* [2007] UKHL 45 (Lord Hoffmann) paras. 34-35.

⁷ *Engel and Others v The Netherlands* (1976) I EHRR 647 (app. no. 5100/71) para. 57.

⁸ Article 2 (3) of Protocol 4 states: ‘No restrictions shall be placed on the exercise of these rights other than such as are in accordance with law and are necessary in a democratic society in the interests of national security or public safety, for the maintenance of *ordre public*, for the prevention of crime, for the protection of health or morals, or for the protection of rights and freedoms of others.’ Article 2 (4) states: ‘The rights set forth in paragraph 1 may also be subject, in particular areas, to restrictions imposed in accordance with law and justified by the public interest in a democratic society.’

When considering the distinction between deprivation of liberty and restriction of movement, it might be helpful to recall those cases that are *not* included in the list of exceptions in Article 5 (1). Munby LJ claims that if the framers of the convention would have considered practices such as 'kettling' or the 'close and pervasive supervision' of children by their parents to be deprivations of liberty, then they would have included them in the list of exceptions, since these practices are often taken to be justifiable forms of limitations on liberty.⁹ In the context of kettling, he goes on to say that 'the framers of the Convention can hardly have forgotten the problem of public disorder or intended to deny the authorities the conventional means of coping with it'.¹⁰

Restriction on freedom of movement might manifest itself in the form of a physical restraint or in a restriction on the freedom to choose one's residence (e.g. being required to live at a particular address or to keep within a particular geographical location). In serious cases, both physical restraint and limitation of residence might add up to deprivation of liberty. As Baroness Hale pointed out in the context of control orders, 'merely being required to live at a particular address [...] does not, without more, amount to a deprivation of liberty. There must be a greater degree of control over one's physical liberty than that.'¹¹ The exact amount of this control remains, however, unclear in Strasbourg jurisprudence; 24-hour house arrest, seven days per week was found to be deprivation of liberty¹² but a house arrest (curfew) of up to 12 hours per day on weekdays and for the whole of the weekend counted as restriction on movement.¹³

The *Engel and Others v The Netherlands* and the *Guzzardi v Italy* cases provide important guidance on how to distinguish deprivation of liberty and restriction of movement.¹⁴ In the *Engel* case, the European Court of Human Rights had to consider whether disciplinary measures imposed on conscript soldiers constituted deprivation of liberty. It was said that when assessing if a restriction amounts to a deprivation of liberty, 'the starting point must be the specific situation of the individual concerned and account must be taken of a whole range of factors [...] such as the type, duration, effects and manner of implementation of the measure in question'.¹⁵ The distinction between the two concepts is 'merely one of a degree or intensity and not one of nature or substance'.¹⁶ It has also been stated that 'paragraph 1 of Article 5 is contemplating individual liberty in its classic sense, that is to say the physical liberty of the person. Its aim is to ensure that no one should be dispossessed of this liberty in an arbitrary fashion'.¹⁷ As Munby LJ points out,¹⁸ the idea of 'relative normality' also appears in *Engel* when the Court argues that 'a disciplinary penalty or measure which on analysis would unquestionably be deemed a deprivation of liberty were it to be applied to a

⁹ *Cheshire West and Chester Council v P* [2011] EWCA Civ 1257 para. 27.

¹⁰ *Ibid.* para 26.

¹¹ *Secretary of State for the Home Department v JJ and Others* [2007] UKHL 45 (Baroness Hale of Richmond) para. 57.

¹² *Secretary of State for the Home Department v JJ and Others* [2006] EWHC 1623 (Admin) (Sullivan J) paras. 26-33 with reference to a collection of European cases. House arrest was found to be a deprivation of liberty in the following cases: *Mancini v Italy* (2nd August 2001), *Vachev v Bulgaria* (8th July 2004), *Nikolova v Bulgaria* (30th September 2004) and *Pekov v Bulgaria* (30th March 2006).

¹³ This was the situation in *Trijonis v Lithuania* (app. no. 2333/02), judgment of 17th March 2005.

¹⁴ *Engel and Others v The Netherlands* (1976) I EHRR 647 (app. no. 5100/71) and *Guzzardi v Italy* (1981) 3 EHRR 333 (app. no. 7367/76)

¹⁵ *Ibid.* paras. 58-59.

¹⁶ *Ibid.* paras. 58-59.

¹⁷ *Ibid.* para. 58.

¹⁸ *Cheshire West and Chester Council v P* [2011] EWCA Civ 1257 paras. 79-81.

civilian may not possess this characteristic when imposed upon a serviceman'.¹⁹ In the light of these principles, the Court found that the sanction of 'light arrest' (i.e. confinement to one's own barrack or tent) did not, while 'strict arrest' (confinement in a cell) and 'committal to a disciplinary unit' (the most severe disciplinary penalty) did constitute a deprivation of liberty.²⁰

The principles laid out in *Engel* were reiterated in *Guzzardi v Italy*. In this case, a suspected mafioso was put under special police supervision and was sent to the island of Asinara where he was subjected to a series of restrictions (to report to the authorities twice a day, to return to his residence by 10 PM, not to frequent certain places, etc.). The majority Court found that there was a deprivation of liberty in the case. In his dissenting opinion, Judge Fitzmaurice argues that the measures imposed on Mr. Guzzardi were mere restrictions on freedom of movement which do not engage Article 5.²¹

Cases related to deprivation of liberty in mental health care settings

Besides the general guidance provided by the *Engel* and the *Guzzardi* cases with respect to the differentiation between deprivation of liberty and restriction on movement, the Strasbourg Court also examined issues related to Article 5 specifically in the context of mental health care. The *Ashingdane v UK* case, dealing with the detention of a mental health patient in Broadmoor and Oakwood hospitals, was one of the first major cases in this respect,²² in which the Court reaffirmed the basic principles laid out in *Engel* and *Guzzardi*.²³ The ruling in *Nielsen v Denmark* was contentious: it was passed with only a small majority of the Court, and the judgment can be criticized for overemphasising parental authority in determining deprivation of liberty. One significant implication of the *HL v UK* decision (besides the identification of the Bournemouth-gap) is that it appears to depart from the problematic heritage of *Nielsen v Denmark* and *HM v Switzerland* regarding deprivation of liberty.²⁴ As the Court pointed out, the key determinant of deprivation of liberty is whether health care professionals exercise 'complete and effective control' over the person's care and movements.²⁵ In *Storck v Germany* – its most recent judgment – the Court offers a systematic, three-pronged test for identifying cases that involve a deprivation of liberty. We discuss the *Nielsen*, *HM* and *Storck* cases in more details at this point; the analysis of the *Ashingdane* and the *HL v UK* judgments can be found in the Appendix of this document.

Nielsen v Denmark [1988] 11 EHRR 175

Nielsen v Denmark was about the detention of a 12 year old boy in a child psychiatric ward. The detention was initiated by the mother of the child and was supported by the family doctor and the chief physician of the ward. The aim of the detention was curative; the applicant was in need of

¹⁹ *Engel and Others v The Netherlands* (1976) I EHRR 647 (app. no. 5100/71) para. 59.

²⁰ *Ibid.* paras. 60-66.

²¹ He writes in para. 7 of his dissenting opinion: 'It is of course obvious that all deprivation of liberty, especially if it takes the form of actual imprisonment or other close confinement, must imply restricting freedom of movement and choice of residence. It is inherently in its character to do so. But the reverse is not true. Mere exile or banishment, for instance, does not in itself involve deprivation of liberty.'

²² *Ashingdane v United Kingdom*, Series A no. 93, judgment of 28 May 1985.

²³ *Ibid.* para. 41.

²⁴ Munby LJ in para. 49 of *JE v DE* [2006] EWHC 3459 (Fam)

²⁵ *HL v United Kingdom* [2004] ECHR 471 (app. no. 45508/99), para 91.

medical treatment for his nervous condition. The treatment did not involve medication, but consisted of regular talks and environmental therapy.²⁶

The restrictions on the applicant's freedom of movement and contacts with the outside world were similar to restrictions imposed on a child in most ordinary hospitals: the door of the ward was locked (like in all children's wards in the hospital) to prevent the children exposing themselves to danger or running around and disturbing others. The applicant was allowed to leave the ward with permission and he was also able to visit his mother and father regularly.

A narrow majority of the Court found that 'the hospitalisation of the applicant did not amount to a deprivation of liberty within the meaning of Article 5, but was a responsible exercise by his mother of her custodial rights in the interest of the child'.²⁷ The minority contested both that the objective conditions of detention amounted merely to a restriction of liberty and that parental authority would be sufficient to make a deprivation of liberty lawful. They 'attach great importance to the fact that the committal lasted over a period of several months' which, in their opinion, constituted a deprivation of liberty.²⁸ One of the dissenting judges even contends that 'the fact that a parent may legally, and without being subject to any judicial review, place a child who is in his custody in a psychiatric ward constitutes a violation of [...] Article 5 (1)'.²⁹ The Court of Appeal (England & Wales) in its recent *RK* judgment clarifies the role of parental consent the following way: '[...] an adult in the exercise of parental responsibility may impose, or may authorise others to impose, restrictions of liberty of the child. However restrictions so imposed must not in their totality amount to deprivation of liberty'.³⁰

HM v Switzerland [2002] ECHR 157

A Swiss state authority ordered the placement of an 84-year-old woman in a nursing home in order to provide appropriate medical treatment and care for her. The intervention was due to self neglect: HM allegedly no longer received care from a doctor; it was not certain that she had enough to eat; and the conditions of hygiene in her flat were 'intolerable'. She was free to move within the nursing home, which was an open institution, and she could maintain social contacts with the outside world. Although initially undecided, after moving into the home, she did not object to staying there and she was not found to lack capacity (as opposed to HL in the *Bournewood* case).

The Court found that the applicant was not deprived of her liberty:

'Bearing these elements in mind, in particular the fact that the [authorities] had ordered the applicant's placement in the nursing home in her own interests in order to provide her with the necessary medical care and satisfactory living conditions and standards of hygiene, and also taking into consideration the comparable circumstances in *Nielsen*, the Court concludes that in the

²⁶ *Nielsen v Denmark* [1988] 11 EHRR 175 (app. no. 10929/84) para. 70.

²⁷ *Ibid.* para. 73.

²⁸ Joint Dissenting Opinion of Judges Thór Vilhjálmsson, Pettiti, Russo, Spielmann, De Meyer, Carrillo Salcedo and Valticos

²⁹ Dissenting Opinion of Judge Carrillo Salcedo.

³⁰ *Re RK; RK v BCC* [2011] EWCA Civ 1305 para. 14.

circumstances of the present case the applicant's placement in the nursing home did not amount to a deprivation of liberty [...], but was a responsible measure taken by the competent authorities in the applicant's interests.'³¹

The separate opinions³² of Judge Jörundsson and Judge Loucaides are of particular importance here. The judges rejected the view that the circumstances in *Nielsen v Denmark* were comparable to the circumstances of the present case. *Nielsen v Denmark*, since it involved a child placed in hospital by his mother, is comparable to the circumstances of an adult placed under curatorship and not the circumstances of HM.³³ In addition to this, Judge Loucaides pointed out that there is an important distinction to be made between the existence of deprivation of liberty and the justification for it. In his opinion, these categories had been confused by the majority when they claimed that the applicant's placement did not amount to a deprivation of liberty *because* the placement was in her own best interests. The question whether a particular action is intended to serve (or actually serves) the interests of the person concerned should not have determine whether there is a deprivation of liberty – it figures in its justification. As Munby LJ observes: 'The argument, if taken to its logical conclusion, would seem to lead to the absurd conclusion that a lunatic locked up indefinitely for his own good is not being deprived of his liberty.'³⁴

Storck v Germany [2005] 43 EHRR 96

The *Storck* case contains important guidance on how to determine whether there has been a deprivation of liberty in a specific situation.³⁵ The applicant — a young woman aged 18 — was placed in a private psychiatric institution by her father and was kept in a locked ward. She was under continuous supervision and control and was not free to leave the clinic during her entire stay of 20 months. Strong medication was administered to her and when she attempted to flee from the clinic, she was shackled. When she succeeded once in escaping, she was brought back by the police. She was unable to maintain regular contact with the outside world.

The Court identified three necessary elements for deprivation of liberty:

1. The **objective element** of a person's confinement to a certain limited place for a not negligible length of time.³⁶ Based on the facts, this condition was satisfied in the present case.
2. The **subjective element** that the person has not validly consented to the confinement (para. 74). A person may give a valid consent only if he or she has the capacity to do so. This element was a matter of dispute in the case. It is true that the applicant came to the clinic herself (accompanied by her father) and it was generally accepted that she had the capacity to consent or object to her detention since she was an adult and was not placed under guardianship. However, based on the 'vagrancy case', the Court put forward that 'the

³¹ *HM v Switzerland* [2002] ECHR 157 (app. no. 39187/98) para. 48.

³² Judge Jörundsson concurred in his opinion with the majority decision. He found the existence of deprivation of liberty but claimed that it was justifiable under Art. 5 (1) e. Judge Loucaides dissented.

³³ Munby LJ in para. 31 of *JE v DE* [2006] EWHC 3459 (Fam)

³⁴ *Ibid.* para. 47. *Cf.* the summary of this report on the *Cheshire* judgment and the role of purpose, motive and intention in the determination of deprivation of liberty.

³⁵ *Storck v Germany* [2005] 43 EHRR 96 (app. no. 61603/00)

³⁶ *Ibid.* para. 74.

right to liberty is too important in a democratic society for a person to lose the benefit of the Convention protection for the single reason that he may have given himself up to be taken into detention.³⁷ The Court considered it a key factor that the applicant tried on several occasions to flee from the clinic during her detention which implies an objection to the detention.

The Court made reference to the *HL v UK* case arguing that if in the HL case there was a deprivation of liberty, then in this case, *a fortiori*, there shall also be a deprivation of liberty, since HL never attempted to leave the ward.³⁸ In the *HM v Switzerland* case, on the other hand, consent could be inferred from the fact that HM had capacity and (although she was somewhat undecided) she did not attempt to leave the care home.

3. The confinement must be **imputable** to the State.³⁹ This condition was also met in the case because the applicant was brought back by the police to the clinic after she had escaped, thus the state authorities became actively involved in her detention. Alternatively, it can also be argued that the State's positive obligation to protect the applicant against interferences with her liberty by private persons also establishes a link between the State and the detention.⁴⁰

For an application of the Storck conditions in relation to deprivation of liberty concerning people suffering from *Smith Magenis Syndrome* (and especially for a detailed analysis of the third Storck condition), see *A Local Authority v A and B* [2010] EWHC 978 (Fam) (Munby LJ). A summary of the case is available in the Appendix of this document.

The justification of deprivation of liberty under Article 5 (1) e

Once it is established that a deprivation of liberty has occurred, the European Court, has to look into the question whether the detention was 'in accordance with a procedure prescribed by law' for the purpose of 'lawful detention of persons of unsound mind' under Article 5 (1) e. The Court gave detailed analysis of this issue in *Winterwerp v The Netherlands*.⁴¹

The case concerned a Dutch national who was confined in a psychiatric hospital on his wife's application under an order made by the District Court. Subsequently, the order was renewed from year to year by the Regional Court on the basis of medical reports from the doctor treating the applicant. Mr. Winterwerp complained about the violation of his rights under Articles 5 (1), 5 (4) and 6. In particular, he complained about the facts that he was never heard by the courts or notified of the orders, that he did not receive any legal assistance and that he had no opportunity of challenging the medical reports. While the Court found violations of Articles 5 (4) and 6 (mainly procedural shortcomings), it established that the applicant's detention was justified under Article 5 (1).

³⁷ Ibid. para. 75, referring to para. 65 of *De Wilde, Ooms and Versyp v. Belgium* [1971] 1 EHRR 373.

³⁸ Ibid. para. 77.

³⁹ Ibid. paras. 89 ff.

⁴⁰ Ibid. para. 77.

⁴¹ *Winterwerp v The Netherlands* (1979) ECHR 4 (app. no. 6301/73)

The Convention does not state what is to be understood by the words ‘persons of unsound mind’.⁴² It is a term whose meaning is ‘continually evolving as research in psychiatry progresses’, though in the present case it was accepted uncontentiously that the applicant fell within this category of people. The requirement of ‘lawfulness’ encompasses both procedural and substantial safeguards — its main aim being to protect from arbitrary detention. With respect to procedural safeguards, it overlaps to a certain extent with the requirement to act ‘in accordance with a procedure prescribed by law’ of Article 5 (1). With regard to its more substantive elements, lawfulness has been thought to imply three minimum conditions:⁴³

1. The person must be reliably shown to be of unsound mind on the basis of ‘objective medical expertise’.
2. The mental disorder must be of a kind or degree warranting compulsory confinement.
3. Continued confinement must be for a proportionate length of time and is valid only as long as the disorder persists.⁴⁴

In the present case, the Court found that all three criteria were satisfied and the deprivation of liberty of Mr. Winterwerp was justified under Article 5 (1) e.

In *G v E*,⁴⁵ the Court of Appeal of England and Wales had to consider whether the Winterwerp conditions are applicable when deciding about the lawfulness of detention under the Deprivation of Liberty Safeguards. DoLS normally require that the detention be in the best interests of the detained person; the question was whether the Winterwerp conditions impose additional requirements when it comes to the justification of deprivation of liberty.

The original application concerned E: a 19 year old man with severe learning disabilities.⁴⁶ Due to concerns over his care, the local authority moved E to a residential unit in April 2009, and subsequently to another one in June. E’s sister (G) asked the Court of Protection to assess (1) whether her brother has been unlawfully deprived of his liberty at the care home and (2) whether it is in E’s best interests to return to live with his foster carer (F) or whether he should be cared for in a residential care home.

It was established in the judgment of the High Court that E lacked capacity to consent to his care arrangements and that his detention in the care home amounted to deprivation of liberty.⁴⁷ Since there was no attempt to secure any kind of DoLS authorisation by the local authority (DoLS having come into force only a few days earlier), there was a violation of E’s right to liberty.

Both the High Court and the Court of Appeal, however, rejected G’s proposition that Article 5 ECHR, as interpreted in Winterwerp, ‘established a threshold condition or conditions which had to be

⁴² Ibid. para. 37.

⁴³ Ibid. para. 39.

⁴⁴ This condition was further interpreted in *Johnson v UK* (see Appendix).

⁴⁵ *G v E* [2010] EWCA Civ 822 (Sir Nicholas Wall, Thorpe LJ, Hedley J)

⁴⁶ See Thirty Nine Essex Street - Court of Protection Newsletter: April 2010 (eds. Alex Ruck Keene and Victoria Butler-Cole) pp. 5-6. See also: [www.mentalhealthlaw.co.uk/G v E \(2010\) EWHC 621 \(Fam\)](http://www.mentalhealthlaw.co.uk/G_v_E_(2010)_EWHC_621_(Fam)) (22.02.2011).

⁴⁷ *G v E & Others* [2010] EWHC 621 (COP) (Baker J)

satisfied in deprivation of liberty cases before it was open to the court to go on to consider what order was in E's best interests'.⁴⁸ The appellant (G) argued that if the first and second Winterwerp conditions had been sufficiently taken into account in the case, then the continued detention of E (even in the presence of a proper DoLS authorisation) would have been unjustified since there was no objective (i.e. psychiatric) medical evidence of unsoundness of mind and E's mental disorder was not of a kind or degree warranting compulsory confinement under the Convention. In other words, there is a minimum threshold of mental illness that is necessary for deprivation of liberty which was not met in E's case, since E has learning disability and does not suffer from mental illness in the narrower sense of the term. Counsel for G argued that 'any balancing of the second *Winterwerp* condition with other circumstances would water down its degree of substantive protection'⁴⁹ and the demands of this second condition 'could not be satisfied by the traditional balance sheet approach of a best interests analysis in this regard.'⁵⁰

The Court did not share the view that 'Article 5 imposes any threshold conditions which have to be satisfied before a best interests assessment under DOLS can be carried out'.⁵¹ The MCA is mostly addressed to those who are not mentally ill in the strict MHA sense. E has learning disabilities and is of 'an unsound mind' but does not suffer from a psychiatric condition and is not mentally ill. The problem is that the European jurisprudence derives 'exclusively from the fact that in the cases which have reached the ECtHR [such as Winterwerp], the issue has involved alleged mental illness and detention in a psychiatric hospital.'⁵² Application of the Winterwerp conditions to the DoLS would render the system unworkable. Thus, it was argued, the present system of DoLS is not thereby incompatible with the requirements of Article 5 (1) and the case law of the Strasbourg Court.

Deprivation of liberty in selected domestic law

Austin and Another v Commissioner of Police of the Metropolis [2009] UKHL 5

In the *Austin* case, the House of Lords had to deal with the application of Article 5 (1) to measures of crowd control. In particular, it examined whether the police practice of 'kettling' of protestors (i.e. the imposition of a police cordon around the crowd for several hours during a London demonstration) amounted to a deprivation of liberty.

Lord Hope of Craighead emphasises that deprivation of liberty does not merely depend on the duration of the restriction. If it would be so, than 'it would be hard to regard what happened anything other than a deprivation of liberty'.⁵³ However, as it was previously established in *Engel*,

⁴⁸ *G v E* [2010] EWCA Civ 822 (Sir Nicholas Wall, Thorpe LJ, Hedley J) para. 28.

⁴⁹ *Ibid.* para. 39. Emphasis as in the original.

⁵⁰ *Ibid.* para. 35.

⁵¹ *Ibid.* para. 58.

⁵² *Ibid.* para. 59.

⁵³ *Austin and Another v Commissioner of Police of the Metropolis* [2009] UKHL 5 para. 17.

account should be taken of a whole range of other factors, such as the restriction's nature, intensity, effects and manner of execution. Kettling seems to fall far from the paradigm case of detention, which was described by Lord Hoffmann in *Secretary of State for the Home Department v JJ* as the case of a prisoner being detained in a cell under the complete control of his gaolers.⁵⁴ However, deprivation of liberty may take many different forms which often do not resemble to the paradigm case; the core of the concept is surrounded by a 'grey zone' of cases that might qualify as deprivations without having all of the features of the paradigm case.⁵⁵

The House of Lords also examined if it is relevant, when considering the existence of deprivation of liberty in a particular case, to have regard to the purpose for which a person's freedom of movement has been restricted.⁵⁶ Lord Hope of Craighead argues that if purpose is relevant, then it must be to enable a balance to be struck between what the restriction seeks to achieve and the interests of the individual.⁵⁷ Although the right to liberty and security is an unqualified right and there is nothing in the wording of Article 5 that implies the possibility of balancing, Lord Hope, based on the case law of the Strasbourg Court, contends that 'there is room, even in the case of fundamental rights as to whose application no restriction or limitation is permitted by the Convention, for a pragmatic approach to be taken which takes full account of all the circumstances.'⁵⁸ Public safety and public order are not considered to be legitimate reasons for deprivation of liberty, but 'the importance attached to measures taken in the interests of public safety in the context of Article 5 is indicated by Article 2 of the Convention'.⁵⁹ Balancing is necessary to reconcile two competing fundamental rights, namely the right to life and the right to liberty as the 'lives of persons affected by mob violence may be at risk if measures of crowd control cannot be adopted by the police'.⁶⁰ Thus, Lord Hope establishes that crowd control measures do not invoke Article 5 (1) if (a.) they are resorted to in good faith; (b.) they are proportionate to the situation which has made the measures necessary and (c.) they are enforced for no longer than is reasonably necessary.⁶¹

Cheshire West and Chester Council v P and M [2011] EWHC 1330 (COP) (Baker J)

P is a thirty-eight year old man. He was born with cerebral palsy and Down's Syndrome and he suffers from significant physical and learning disabilities. It is generally accepted that he lacks capacity to make decisions as to his care and residence. P lived for most of his life with his mother. As his mother's health deteriorated, P had to be taken to emergency respite care in 2009. Subsequently he was moved to Z house by the local authority.

P needs a high level of care. He can move for short distances without support, but he needs to use a wheelchair for longer distances. He has no expressive speech but he makes sounds which people who know him well are able to understand. P has a long history of challenging and self-harming behaviour. Continence management is also a particular issue in his case. He developed a habit of pulling at his continence pads and putting the pieces of padding (together with the faecal content) in

⁵⁴ Ibid. para. 20 with reference to *Secretary of State for the Home Department v JJ* [2009] AC 385 para. 37.

⁵⁵ Ibid. para. 20 with reference to the dissenting opinion of Judge Matscher in *Guzzardi v Italy*.

⁵⁶ Ibid. para. 22.

⁵⁷ Ibid. para. 27.

⁵⁸ Ibid. para. 34.

⁵⁹ Ibid. para. 34.

⁶⁰ Ibid. para. 34.

⁶¹ Ibid. para. 37.

his mouth and on occasions ingesting them. Recently the staff at Z House have adopted a new approach, involving P wearing an all in one body suit sewn up at the front, to prevent his hands touching his groin area.

The main issue before the Court of Protection was whether the restraints used in Z house to control P's behaviour amounted to a deprivation of liberty. During the proceedings before Baker J, concerns were raised regarding the reliability of the evidence provided by the local authority (i.e. that the local authority did not give a full picture of the degree of physical intervention used and that members of staff at Z house altered a number of records). An independent expert was appointed, who found that it was P's best interests to stay in Z house but made recommendations for a new care plan, with special attention to the restraints used in controlling P's behaviour.

Baker J applies the Storck test to determine whether there is a deprivation of liberty in the case. He finds that the second and the third conditions of the test are satisfied: '[t]he subjective element is satisfied because P lacks the capacity to give his consent and, as both the local authority and the Court are engaged in determining where he should live, the State is responsible for his circumstances.'⁶² As for the objective element of deprivation of liberty, he takes into account the different factors mentioned by the parties for and against the existence of a deprivation of liberty (against: Z house is a large and spacious building, P has his own room, contact with family is unrestricted, doors are unlocked, P is not controlled by medication, P never attempted to leave, P attends a day care centre and takes part in other activities as well) (for: every aspect of P's life is monitored and supervised, P is obliged to live in Z house and cannot return to his mother, he cannot leave unescorted, physical restraint is commonly used in managing his behaviour, including the wearing of a body suit). Balancing all these factors, Baker J comes to the conclusion that P is being deprived of his liberty in Z house. This is not to say that the deprivation of liberty is unjustified: 'Those actions [i.e. the restrictions imposed by the carers] will be in his best interests and therefore justifiable, but they will, as a matter of concrete fact and legal principle, involve a deprivation of his liberty.'⁶³

Cheshire West and Chester Council v P [2011] EWCA Civ 1257 (Munby LJ, Lloyd LJ, Pill LJ)

The Court of Appeal overturned Justice Baker's order and found no deprivation of liberty in the case of P. The significance of the appellate decision from P's perspective is that it determines whether P is entitled to the regular review of his detention as mandated by Article 5 (4) of the Convention.⁶⁴ From a more general viewpoint, the judgment has important implications regarding the issue of Court authorisation and review of restrictions imposed on people in similar position to P (e.g. people who reside in family homes or in supported living environments and fall outside the scope of standard and urgent DoLS authorisations).⁶⁵

⁶² *Cheshire West and Chester Council v P and M* [2011] EWHC 1330 (COP) (Baker J) para. 53.

⁶³ *Ibid.* para. 61.

⁶⁴ *Cheshire West and Chester Council v P* [2011] EWCA Civ 1257 (Munby LJ, Lloyd LJ, Pill LJ) para. 4.

⁶⁵ Obviously, the judgment also has implications for standard and urgent DoLS authorisations by potentially modifying the legal standard of deprivation of liberty. However, P's case is specifically related to the Court authorisation of deprivation of liberty (section 4A and 16 MCA 2005) because he resides in a supported living environment.

When determining whether there is a deprivation of liberty, it is important to pay attention to the concrete situation and the context in which the restriction occurs. The task is to identify the 'relevant comparator' in the case, namely what it is we are comparing the subject's concrete situation with.⁶⁶ In most cases (e.g. in control order or kettling cases), the relevant comparator is the ordinary adult. However, in the present case one cannot compare the situation of P to the situation of an ordinary adult when it comes to the assessment of deprivation of liberty. Different groups of people have different needs and deprivation of liberty seems to have different meanings in the context of each group. Locking up a capacitous adult in a police cell for three hours is 'indubitably' a deprivation of liberty while placing a one year old child for three hours in a playpen is not.⁶⁷ Munby LJ invokes the case of *R v Jackson*⁶⁸ in which Mr Jackson seized and detained his wife within the matrimonial home after she had declined to live with him. Unsurprisingly, it was found that Mrs Jackson was wrongly imprisoned and she was freed on a habeas corpus. However, if one modifies the facts of the case and presupposes that the detention of the wife takes place 'because, and only because, [she] is suffering from dementia and cannot safely be allowed out of the matrimonial home on her own', it cannot sensibly be argued that a deprivation of liberty takes place.⁶⁹ There are three possible differences between the two scenarios that might be responsible for the different outcomes concerning deprivation of liberty: the reason, the purpose and the motive of detention. These are described in paragraph 47 of the judgment:

'The *reason* why Mr Jackson acted as he did was because his wife was disobeying the decree for restitution of conjugal rights; the reason why our hypothetical husband is acting in the same way is because his wife has dementia. Mr Jackson's *purpose* was to induce his wife to restore conjugal rights; our hypothetical husband's purpose is to safeguard and protect his wife against some of the adverse consequences of her dementia. Mr Jackson's *motive* was to have his way, to coerce his wife in accordance with what he seems to have conceived to be his rights as a husband and her duties and obligations as a wife; our hypothetical husband's motive is to further his wife's best interests, acting out of love and, it may be, his sense of obligation as a husband.'⁷⁰

The role of purpose, motive and reason in determining deprivation of liberty

In a case concerning control orders, Sullivan J, with reference to *Guzzardi*, argues that if the 'purpose [of detention] is the same or similar to the purposes for which states conventionally impose 'classic detention in prison' [...], then that will be a pointer towards the restriction being a deprivation of liberty [...] Conversely, the more that any restrictions are imposed in the interests of the individual (for example, to provide support for vulnerable members of society such as mental patients or young persons), the less will the courts be inclined to regard them as being a deprivation of that individual's liberty.' (*Secretary of State for the Home Department v JJ and Others* [2006] EWHC 1623 para. 42)

Lord Walker of Gestingthorpe in para. 43 of *Austin* claims that one must be cautious when taking into account the purpose of confinement in the determination of deprivation of liberty. Purpose seems to have a more important role in the *justification* of confinement; nevertheless, by the end of his speech (para. 47) Lord Walker argues that it is 'essential' to take into account the aim for which the restriction happened in the present case (i.e. to disperse the crowd).

⁶⁶ *R v Jackson* [1891] 1 QB 671

⁶⁹ *Cheshire West and Chester Council v P* [2011] EWCA Civ 1257 (Munby LJ, Lloyd LJ, Pill LJ) para. 46.

⁷⁰ *Ibid.* para. 47 (emphasis as in the original)

Munby LJ in paras. 46-47 of *JE v DE* states that he has 'great difficulty in seeing how the question of whether a particular measure amounts to a deprivation of liberty can depend on whether it is intended to serve or actually serves the interests of the person concerned.' He adds that 'the argument, if taken to its logical conclusion, would seem to lead to the absurd conclusion that a lunatic locked up indefinitely for his own good is not being deprived of his liberty'. (paras. 46-47)

Parker J in *Re MIG and MEG* [2010] EWHC 785 (Fam) distinguishes between the purpose and the reason of restriction. She says in para. 230:

'I agree that it is impermissible for me to consider whether, if either is objectively detained or confined, this is with good or benign intentions or in their best interests. But notwithstanding that, as was observed by Lord Walker in *Austin*, 'purpose' does not figure in the list of factors to be evaluated in determining the concrete situation of the person concerned, I am of the view that in this case it is permissible to look at the 'reasons' why they are each living where they are. In the case of each there are overwhelming welfare grounds for them not to live in their family of origin. In relation to both girls, the primary intention is to provide them each with a home. Within those homes, they are not objectively deprived of their liberty. In neither of those homes are they there principally for the purpose of being 'treated and managed'. They are there to receive care.'

Taking into account the mentioned cases, Munby LJ clarifies the role of motivational elements in deprivation of liberty cases in paragraphs 60-77 of the Cheshire judgment. He specifies exactly which kind of reasons, motives, or purposes can have relevance when determining the presence of deprivation of liberty. It seems appropriate to quote paragraphs 76-77 in full here:

76. When used in these senses, it is legitimate, in my judgment, in determining whether or not there is a deprivation of liberty, to have regard both to the objective "reason" why someone is placed and treated as they are and also to the objective "purpose" (or "aim") of the placement. Subjective motives or intentions, on the other hand, are relevant only in the limited circumstances contemplated in *Austin*. An improper motive or intention may have the effect that what would otherwise not be is in fact, and for that very reason, a deprivation of liberty. But a good motive or intention cannot render innocuous what would otherwise be a deprivation of liberty. Putting the same point another way, good intentions are essentially neutral. At most they merely negative the existence of some improper motive or intention. That is all.

77. I can illustrate the point by returning to the example of the wife suffering from dementia. I suggested that the *reason* why our hypothetical husband was implementing the regime I described was because his wife has dementia, that his *purpose* was to safeguard and protect his wife against some of the adverse consequences of her dementia, and that his *motive* was to further his wife's best interests, acting out of love

and, it may be, his sense of obligation as a husband. Applying the foregoing analysis, both the reason and the purpose are relevant to the question of whether there is any deprivation of liberty. The husband's beneficent motive, on the other hand, is relevant only because it negates the existence of any improper purpose or any malign, base or improper motive – for example, a desire to punish or humiliate or to avoid shame or embarrassment – that might, if present, turn what would otherwise be innocuous into a deprivation of liberty.

Turning back to the issue of the relevant comparator, Munby LJ points out in paras. 83-85 that in most cases the relevant comparator will be the ordinary adult going about his normal life. However, in the present case, the comparator cannot be the 'ordinary adult'. Rather it is the 'relatively normal' life of a comparable person (i.e. a person in a similar situation with P, with similar illnesses, etc.) that should be considered. As it is stated in paragraph 97, '[...] when evaluating and assessing the 'relative normality' (or otherwise) of X's concrete situation in a case such as this, the contrast is not with the previous life led by X [...], nor with the life of the able-bodied man or woman on the Clapham omnibus, but with the kind of lives that people like X would normally expect to lead. The comparator, in other words, is an adult of similar age with the same capabilities as X, affected by the same condition or suffering the same inherent mental and physical disabilities and limitations (call them what you will) as X.'

Munby LJ applies the established legal principles to the facts of P's case in paragraphs 105-116. He points out that Justice Baker's conclusion regarding the existence of deprivation of liberty is largely informed by the fact that P is 'completely under the control of members of staff at Z House.' This accords well with the 'complete and effective control' requirement in the HL v UK case. However, 'Baker J never compared P's situation in the Z House with the kind of life P would have been leading *as someone with his disabilities and difficulties* in what for such a person would be a normal family setting. [...] P's life, wherever he may be living, whether at home with his family or in the home of a friend or in somewhere like Z House, is [...] dictated by his disabilities and difficulties.'⁷¹ The fact that P cannot go anywhere or do anything without support is dictated by his various disabilities. It is not something imposed on him by Z House.

Deprivation of Liberty Safeguards

Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards were introduced by the MHA 2007 as an addition to the MCA 2005. The DoLS regulations, which came into force on 1 April 2009, can be found in sections 4A and 4B of, and Schedules A1 and 1A to, the Mental Capacity Act. They were introduced as a response to the HL v UK judgment of the European Court of Human Rights and were designed to remedy the incompatibility between English law and the European Convention, known as the 'Bournewood gap'.

⁷¹ Ibid. para. 110 (emphasis as in the original)

The statutory framework

The Deprivation of Liberty Safeguards apply in England and Wales to people aged 18 and over, who (1) are suffering from a mental disorder; (2) lack capacity to consent to the arrangements made for their care or treatment; and (3) need to be given care and treatment in circumstances that amount to a deprivation of liberty in a hospital or a care home, where this care and treatment are necessary to protect them from harm and appears to be in their best interests.⁷² The notion of mental disorder in DoLS is wider than in the MHA: it is understood as mental disorder within the meaning of the MHA, but it includes all types of learning disabilities as well.⁷³ Schedule A1 and the authorisation procedures apply to all hospitals and care homes⁷⁴ but do not apply to people living in their own homes or in supported living arrangements other than a registered care home. In these cases, the only way to deprive someone of his or her liberty is to seek an order of the Court of Protection.⁷⁵ Moreover, a deprivation of liberty authorisation does not, in itself, authorise the treatment of the incapacitated person. For that, a separate authorisation is required.⁷⁶ Treatment can be necessary for both mental and physical illnesses; DoLS authorisations are often requested to treat physical illnesses of mentally incapacitated persons.

The process of standard and urgent authorisations

There are two mechanisms to authorise deprivation of liberty under Schedule A1: the standard and the urgent authorisation. The process of standard authorisation can be briefly summarized in the following way.⁷⁷

- ❖ The relevant hospital or care home (the ‘managing authority’) must complete an application for a standard authorisation when it appears likely that, at some point in the next 28 days, someone will need to be deprived of his or her liberty.⁷⁸
- ❖ The application is sent to the ‘supervisory body’. In the case of hospitals, the supervisory body is the primary care trust that commissions the care or treatment of the relevant person. In the case of care homes, the supervisory body is the local authority for the area in which the relevant

⁷² Anthony Maden – Tim Spencer-Lane, *Essential Mental Health Law* (London: Hammersmith Press, 2010) pp. 209-210. See also DoLS Code of Practice, section 1.7.

⁷³ Section 14 (1) of Schedule A1 MCA

⁷⁴ Care homes as understood in section 3 of the Care Standards Act 2000

⁷⁵ Section 4A (3) MCA

⁷⁶ DoLS Code of Practice, sections 5.10-5.11.

⁷⁷ When describing the process of standard authorisation, we rely on chapter 14 of Anthony Maden – Tim Spencer-Lane, *Essential Mental Health Law* (London: Hammersmith Press, 2010) pp. 207-223. See also Annex 1 of DoLS Code of Practice.

⁷⁸ *Ibid.* 210.

person is ordinarily resident or, alternatively, the local authority for the area in which the care home is situated.⁷⁹

- ❖ The supervisory body appoints minimum two independent assessors to assess whether the six statutory criteria for deprivation of liberty are satisfied.⁸⁰ The six assessments that must be conducted before a supervisory body can give an authorisation are the following:⁸¹
 1. **The Age Assessment**: It must confirm that the person is aged 18 or over. It can be carried out by anyone who qualifies as a Best Interests Assessor.
 2. **The Mental Capacity Assessment**: It must confirm that the person lacks the relevant decision making capacity as understood in section 3 MCA. The mental capacity assessment can be carried out by anyone who is eligible to be a Best Interests Assessor or a Mental Health Assessor.
 3. **The Mental Health Assessment**: The assessment must confirm that the person suffers from a mental disorder as understood in the MHA (but not excluding learning disabilities), and must be carried out by a Mental Health Assessor. The objective of this assessment is to ensure that the relevant person is of an 'unsound mind' in the terms of the European Convention. It is sometimes possible that a person lacks capacity but does not suffer from a mental disorder (such as in certain instances of alcoholism and drug addiction); these people fall outside of the scope of the DOLS.
 4. **The No Refusals Assessment**: It must confirm that the deprivation of liberty is not in conflict with the advance decision of the relevant person to refuse treatment or with the decision of a Court-appointed deputy or a Lasting Power of Attorney donee. It can be carried out by anyone who qualifies as a Best Interests Assessor.
 5. **The Best Interests Assessment**: This assessment must confirm that (1) a deprivation of liberty is occurring, or going to occur; (2) it is in the best interests of the relevant person to be deprived of liberty; (3) the deprivation of liberty is necessary to prevent harm to the relevant person and it is proportionate to the seriousness of harm.
 6. **The Eligibility Assessment**: This assessment relates to the relevant person's status under the Mental Health Act 1983. Schedule 1A contains the detailed regulations to determine whether the relevant person is eligible to be deprived of liberty under DoLS (see next chapter for more details).

- ❖ The six assessments must be concluded within 21 days after the request of the managing authority. If the relevant person meets all six qualifying requirements, then the supervisory body issues the standard authorisation. Standard authorisations can last maximum 12 months.

⁷⁹ Sections 180-183 of Schedule A1 MCA

⁸⁰ There are two types of assessors: the Mental Health Assessor (i.e. a doctor with appropriate qualifications) and the Best Interests Assessor (e.g. an approved mental health professional, social worker, nurse, psychologist, etc.) A Best Interests Assessor can be the employee of the supervisory body or the managing authority but must not be involved in the person's treatment or care.

⁸¹ Sections 12-20 and 34-48 of Schedule A1 MCA

Urgent authorisations can be completed if it is necessary to deprive someone of his liberty before a standard authorisation can be obtained. It shall only be used in cases where the managing authority believes 'that the need for the relevant person to be a detained resident is so urgent that it is appropriate for the detention to begin before they make the request for a standard authorisation' or 'before the request for a standard authorisation is disposed of' by the supervisory body.⁸² In the urgent procedure, it is the managing authority that issues the authorisation for the deprivation of liberty (without conducting the previously described assessment procedures), but the period of detention must never exceed 7 days.⁸³ This period can be extended with another 7 days by the supervisory body.

Representatives, advocates, review and appeal procedures

The supervisory body appoints a representative for everyone who is detained under a standard authorisation. The representative maintains contact with the protected person and has the right to require a review of the authorisation and to appeal to the Court of Protection.⁸⁴ The representative can be chosen by the relevant person, if he or she has the capacity to make that choice; by the relevant person's deputy or donee; by a best interests assessor; or by the supervisory body.⁸⁵ Both the relevant person and the representative have a right to access to an IMCA (Independent Mental Capacity Advocate). The IMCA helps them to understand and to challenge the authorisation and may also initiate a review of the detention at the supervisory body.⁸⁶

The supervisory body may review the standard authorisation at any time on its own initiative. It must review the authorisation if requested by the relevant person, the relevant person's representative or the managing authority. The managing authority has a duty to request a review if one or more of the qualifying requirements 'appear to them to be reviewable'.⁸⁷ The usual reason for review is that the person no longer meets one or more of the six qualifying requirements. The relevant person, or someone acting on their behalf (e.g. LPA donee or deputy), also has the right to make an application to the Court of Protection before a decision has been reached on an application for DoLS authorisation.⁸⁸ Once an authorisation has been given, the relevant person, the representative, the LPA donee or the deputy have the right to apply to the Court of Protection without seeking the permission of the Court. Others can also apply but must seek the Court's permission to appeal.

⁸² Sections 76 (2) (b) and 76 (3) (b) of Schedule A1 MCA.

⁸³ Section 78 (2) of Schedule A1 MCA.

⁸⁴ Anthony Maden – Tim Spencer-Lane, *Essential Mental Health Law*, p. 216.

⁸⁵ Appointment regulations may further regulate the selection process. Section 143 of Schedule A1 MCA.

⁸⁶ Sections 154-161 of Schedule A1 MCA.

⁸⁷ Section 103 (2) of Schedule A1 MCA.

⁸⁸ DoLS Code of Practice, sections 5.10-5.11.

The eligibility assessment

The eligibility assessment is perhaps the most confusing and complex part of the assessment procedure. Due to the interface between the MHA and MCA, it is often unclear to which legal regime a specific patient belongs. The rules of eligibility can be found in Schedule 1A of the MCA and they were interpreted by Charles J in the case of *GJ v The Foundation Trust*.⁸⁹

GJ, a 65 year old man, suffered from vascular dementia and Korsakoff's syndrome as a result of his prolonged history of alcohol abuse. He also suffered from diabetes. As a result of his mental condition, he regularly neglected his insulin injections and has suffered hypoglycaemic attacks on multiple occasions. He was admitted to hospital treatment, first under the MHA and then under a standard DoLS authorisation. While in detention, he was treated for diabetes. His mental disorder, being chronic and irreversible, was not treated; therapy mainly took the form of care and support (administering vitamins, etc.). GJ objected to his detention and the Court of Protection was called upon to determine his eligibility for a standard DoLS authorisation.

Schedule 1A determines who is ineligible to DoLS. The first four categories (cases A to D) apply to people who are already subject to various provisions of the MHA and, thus, are ineligible to DoLS. These are those who are subject to the hospital treatment regime, and *are* detained in a hospital under that regime; those who are subject to the hospital treatment regime, but are *not* detained in a hospital under that regime, such as those on leave of absence or conditional discharge; those under community treatment orders; and those subject to the MHA guardianship regime. Case E deals with those people who are not subject to any of the mentioned regimes but are still 'within the scope' of the MHA. These people are ineligible to DoLS and should be treated under the MHA if they satisfy the requirements of two tests: the 'status test' and the 'objection test'.⁹⁰ These tests are based on sections 12 and 5 of Schedule 1A (respectively) and they are further clarified by Charles J in paragraphs 81-99 of his judgment.

The *status test* requires that the person is 'within the scope' of the MHA (i.e. an application could be made for that person under section 2 or 3 of the Mental Health Act). This requirement ensures, for example, that people with learning disabilities that are not associated with abnormally aggressive or irresponsible conduct are 'not ineligible' to DoLS because these learning disabilities are normally excluded from the scope of the MHA.

The *objection test* comprises three conditions. The first condition is that the instrument authorising detention (i.e. the DoLS authorisation) authorises the person to be a 'mental health patient'. A mental health patient is defined in paragraph 16 of Schedule 1A as someone accommodated (a.) in a 'hospital' (b.) for the 'purpose of being given medical treatment for mental disorder'. In practice, this means that if someone is accommodated in a care home (as opposed to a hospital), then he or she is eligible to DoLS, provided that the purpose of detention is not to give medical treatment for

⁸⁹ *GJ v The Foundation Trust* (2009) EWHC 2972 (Fam) (Charles J). Another case that deals with the issue of eligibility is the *Re Brammall; W Primary Care Trust v TB* (2009) EWHC 1737 (Fam) (Wood J). For a summary, see the appendix of this document.

⁹⁰ Neil Allen, 'The Bournemouth Gap (as Amended?)' 18 (1) *Medical Law Review* 78-85 (2010) at p. 80.

mental disorder. The second condition is that the relevant person must object to being a mental health patient. The third condition is that an LPA donee or a deputy must not make a valid decision to consent to the relevant objection.

Applying the directions provided by Schedule 1A to the facts of the *GJ* case, Charles J came to the conclusion that GJ was 'not ineligible' to DoLS. GJ was clearly accommodated in a hospital and objected to his detention but the purpose of treatment was unclear. Was he treated for mental disorder (dementia) or physical illness (diabetes)? Charles J held that eligibility assessors must first identify the 'packages' of physical and mental health care that are given to the relevant person (mental treatment can include some physical treatment but only if it is connected to mental disorder). Afterwards, they have to ask: '*but for*' the physical treatment would the deprivation of liberty be necessary to provide the mental health care? If the answer is 'no' then the person does not qualify as a mental health patient (i.e. it is predominantly a physical illness at issue) and so is eligible for DoLS. This was the case of GJ. He was mainly given treatment for his diabetes and detention was necessary to provide physical treatment to him.⁹¹ Thus, GJ was not a mental health patient and he was eligible to DoLS.

The concept of 'medical treatment for mental disorder' can include some treatment for physical illness if it is connected to a mental disorder. Case law 'has stretched the meaning of the concept' which now includes, for example, naso-gastric feeding for anorexia, personality disorder or depression.⁹² Performing a caesarean section was also authorised as treatment for mental disorder under the MHA because it was determined that delivering a child safely was likely to directly affect the patient's mental state.⁹³ In general, medical treatment for mental disorder includes physical treatment for the mental disorder's symptoms and covers the physical consequences of the mental disorder, such as self-injury or self-poisoning. Treatment for a physical disorder 'unconnected to' a mental disorder would only be included if it was likely to 'directly affect' the mental disorder. The treatment of a schizophrenic patient for gangrene was not authorised under the MHA because the gangrene was entirely unconnected with the mental disorder. The question is whether the 'but for' test proposed by Charles J can exactly separate the 'physical treatment' from 'medical treatment for mental disorder'.

Problems with DoLS

Nine main areas of concern with DoLS can be identified: the complexity of assessments; administrative burdensomeness; difficulty identifying deprivation of liberty; poor training and guidance; related populations falling outside of DoLS; effects of stricter conceptions of deprivation

⁹¹ As it is established in para. 128 of the judgment, if the need for his package of physical treatment had not existed: (i) GJ should not have been detained in hospital; (ii) the only effective reason for his detention in hospital was the need for him to be treated for diabetes.

⁹² Neil Allen, 'The Bournemouth Gap (as Amended?)', p. 82.

⁹³ See para. 52 of *GJ v The Foundation Trust* (2009) EWHC 2972 and references there.

on reviews of care; problems centring upon the Court of Protection; independence of managing authorities from supervisory bodies; and cost implications. We shall now explore these potential problems in more detail.

Some DoLS assessment criteria present special difficulties. DoLS can only be engaged when someone lacks capacity to consent to care or treatment, and so eligibility assessment inherits the difficulties of capacity assessment. In particular, practitioners and academics alike continue to argue over the proper interpretation of the ability to 'use or weigh' relevant information, which s.3 of the MCA makes necessary for capacity.⁹⁴ Similar challenges surround the determination of a person's best interests, which must mandate any deprivation of liberty. However, it is the eligibility assessment, relating to a person's status under the MHA, that has proved the most troublesome to apply in practice. It is fair to say that Schedule 1A's complexity is now infamous, and it is a challenge to comprehend even for many with legal training. In part, this may be due to the inherent complexities of navigating the dual legislative regimes of mental health and mental capacity (and thus this could speak in favour of unified legislation).⁹⁵ Nevertheless, poor drafting of the legislation is a common complaint. Unfairly or not, the administrative burden of DoLS, including reams of paperwork for managing authorities and supervisory bodies, which practitioners regularly complain about, is often traced back to the complexity in Schedule 1A.

Deprivation of liberty has also been difficult to determine in practice, especially without legal expertise, and particularly given rapid developments in case law. In their March 2011 report on DoLS, the Care Quality Commission (CQC) claimed that 'an overriding feature of the findings from all of our inspection work is an uncertainty as to what it means for a person to be deprived of their liberty.'⁹⁶ We have found no fine-grained data on how many DoLS applications were rejected because a deprivation of liberty is wrongly identified; but July 2011 figures from the NHS Information Centre show that 81% of rejected DoLS applications in England fail on the best interest assessment, which also includes cases where the proposed actions would not, in fact, amount to deprivation of liberty (alongside other reasons such as the death of the person in question).⁹⁷ More worryingly still, a widespread lack of understanding of deprivation of liberty is likely to have led to failures to flag potential deprivations of liberty for scrutiny, challenge or authorisation. Thus, many deprivations risk going unrecognised, and therefore never enter the system in the first place. In particular, the CQC has noted that staff are often insensitive to the distinction between restriction and deprivation of

⁹⁴ See, for example, Jacinta Tan, Anne Stewart and Tony Hope (2009), 'Decision-making as a Broader Concept', *Philosophy, Psychiatry, & Psychology* 16:4, 341-4.

⁹⁵ For more on proposals for unified legislation, see John Dawson and George Szmukler (2006), 'Fusion of Mental Health and Incapacity Legislation' in *The British Journal of Psychiatry* 188, 504-9.

⁹⁶ Care Quality Commission (2011), 'The operation of the Deprivation of Liberty Safeguards in England 2009/10,' 13.

⁹⁷ The Health and Social Care Information Centre (2011), 'Mental Capacity Act 2005, Deprivation of Liberty Safeguards Assessments (England) - Second report on annual data, 2010/11,' 15.

liberty, particularly in the context of cumulative use of powers of restraint under s.6 of the Mental Capacity Act.⁹⁸

The CQC recommends further training of practitioners with respect to identification of deprivation of liberty, but it is not clear how effective this would be.⁹⁹ Research led by Ruth Cairns has found widespread disagreement over what circumstances constitute deprivation of liberty, both between and within groups of specially selected experts from various relevant professions — indeed, the very people who appear best placed to deliver training.¹⁰⁰ Convergence of judgement was found to be slight ($\kappa=0.16$, $P<0.01$), being only minimally statistically significant. However, in light of recent legal rulings clarifying the conditions for deprivations of liberty, the situation may improve. This is likely to require effective dissemination of this guidance; yet, a lack of activity of this kind has been identified as another shortcoming of the current DoLS regime. For instance, the Mental Health Alliance and CQC have criticised the Department of Health for failing to issue adequate legal briefings concerning DoLS to supplement the Code of Practice.¹⁰¹ In addition to determination of deprivation of liberty, the Alliance also recommend further training of medical assessors, who are often charged with conducting the complex eligibility assessments noted above.¹⁰²

Safeguarding and disability rights concerns stem from CQC findings that practitioners lack sufficient training or awareness of DoLS regulations. Difficulty in identifying deprivations of liberty, alongside much lower than expected rates of DoLS applications, and large disparities in activity rates between comparable supervisory bodies, suggests that in some areas vulnerable adults are routinely going without protections the law affords them. Furthermore, data from the NHS Information Centre reveals that in England only around '2% of applications that were not authorised involved situations where the person was nevertheless judged as being in a situation that amounted to a deprivation of liberty.'¹⁰³ In total, less than 1% of all applications were found to be unauthorisable deprivations of liberty: 78 out of 8982 total for the year. On the surface, both the absolute numbers and percentage appear low (yet without a comparator class, it is difficult to definitively conclude this). If we accept that this is a relatively low figure, and discount the possibility that it simply reflects widespread judicious care practice, then it may indicate that DoLS is failing to act as a robust watchdog.

In addition to unevenness in the use of DoLS with respect to populations that fall within its scope, there are concerns that this scope is too restricted. DoLS excludes people outside of hospitals and care homes, as well as those under 18, and who lack capacity due to factors like alcoholism rather

⁹⁸ Care Quality Commission (2011), 'The operation of the Deprivation of Liberty Safeguards in England 2009/10,' 11-2.

⁹⁹ CQC (2011), 15.

¹⁰⁰ Ruth Cairns, Penelope Brown, Hugh Grant-Peterkin, Mizanur R. Khondoker, Gareth S. Owen, Genevra Richardson, George Szukler and Matthew Hotopf (2011), 'Judgements about deprivation of liberty made by various professionals: comparison study', *The Psychiatrist* 35, 344-9.

¹⁰¹ See the Mental Health Alliance prepublication report's draft chapter on DoLS [Available: http://www.mentalhealthlaw.co.uk/images/MH_Alliance_DoLS_report_pre_publication_draft.pdf], 4.

¹⁰² Mental Health Alliance, 7.

¹⁰³ The Health and Social Care Information Centre (2011), 3.

than mental disorder or learning disabilities. It is true that the Court of Protection has powers in relation to persons lacking capacity who are aged 16 and over, and the High Court can exercise its inherent powers of jurisdiction in relation to vulnerable persons. However, the use of these powers is dependent upon the relevant courts receiving applications; and without robust procedures for referral to the courts, where appropriate deprivations of liberty can be authorised and unlawful activity kept in check, then there looks to be a worrying absence of legal oversight of behaviour in these areas.

The narrowing of the notion of deprivation of liberty implied by rulings such as *Cheshire West and Chester Council v P* is likely to exacerbate safeguarding and rights worries, with practitioners expressing concern that the DoLS regime is too focused on ECHR compliance rather than improving care and championing people's rights. For instance, one Best Interest Assessor, taking issue with the emphasis on using a 'relevant comparator' has recently commented: 'Honestly, I feel duped. I felt we were a part of a system that was going to be finally protecting the rights of all. [...] Unfortunately what I see from these judgements increasingly, is that the purpose of the deprivation of liberty safeguards was not about protecting rights but to cover the back of the UK in terms of Human Rights legislation.'¹⁰⁴ In addition to the concern that a weaker criterion of liberty is employed for those with disabilities, we might also be concerned about how flexible 'normality' (and therefore what constitutes a deprivation) can be. If care standards fall in response to public sector cuts or other pressures on resources, then a 'normal life' for a person with a particular disability may contain fewer opportunities, less provision of alternative accommodation and more use of restraint, such that what would once have counted as deprivation of their liberty no longer does. Of course, DoLS will likely have indirect benefits to adults lacking capacity to consent to care, which extend beyond identifications of deprivations of liberty and the refusal of supervisory bodies to sanction them – such as the salutary effects of increased scrutiny and discussion of care practices around restraint and detention. Considered on this basis alone (apart from ECHR obligations), do DoLS warrant the expense and attention lavished upon them compared to alternative schemes?

The case of Steven Neary, who was found to have been unlawfully deprived of his liberty by a local authority, highlights other potential pitfalls in current practice surrounding DoLS.¹⁰⁵ Justice Jackson highlighted the disparities of power between the statutory authorities and individuals, their families and carers when he cautioned that the DoLS scheme 'is not to be used by a local authority as a means of getting its own way on the question of whether it is in the person's best interests to be in the place at all.'¹⁰⁶ The Neary case also illustrates organisational problems in the relation between managing authorities and supervisory bodies, which are not always strictly enough demarcated, especially when the same department is responsible for commissioning care, safeguarding and reviewing DoLS applications. Justice Jackson also emphasised that scrutiny of applications must be

¹⁰⁴ 'What is a Deprivation of Liberty? – Thoughts on Cheshire West and Chester Council v P' [Available: <http://notsobigsociety.wordpress.com/2011/11/11/what-is-a-deprivation-of-liberty-thoughts-on-cheshire-west-and-chester-council-v-p/>]

¹⁰⁵ *The London Borough of Hillingdon v Steven Neary* [2011] EWHC 1377 (COP) (Jackson J)

¹⁰⁶ *Hillingdon v Neary*, para. 33 (emphasis as in the original)

commensurate with their seriousness, and that '[w]here, as here, a supervisory body grants authorisations on the basis of perfunctory scrutiny of superficial best interests assessments, it cannot expect the authorisations to be legally valid.'¹⁰⁷

The failure to appoint an Independent Mental Capacity Advocate (IMCA) until very late in the process was another problematic feature of the Neary case. Evidence from the Mental Health Alliance reveals that IMCA in the first year was far below the Government's estimates, despite section 39D requiring their use when, without an advocate, representatives and persons they represent are unable or unlikely to exercise rights of review or appeal when reasonable to do so. In May 2010, they recommended when the representative is a friend or family member, then an IMCA should be appointed automatically, unless positive declined by the representative.¹⁰⁸ Furthermore, the need to pursue the matter in the Court of Protection necessitated legal counsel, which Mark Neary experienced considerable difficulties in securing, and involved significant delays due to the caseload of the Court. Both the lack of IMCAs and delays in hearing cases at the Court of Protection, alongside low use of powers of review by representatives, raise ECHR compliance concerns. Indeed, in the present case, it was noted that 'there is an obligation on the State [under Article 5(4)] to ensure that a person deprived of liberty is not only entitled but enabled to have the lawfulness of his detention reviewed speedily by a court.'¹⁰⁹ Engaging the Court of Protection will often involve lengthy trips from outside of London (although not in this case), and the lack of local legal recourse creates problems for vulnerable people who want to be present at hearings about them but who cannot travel long distances due to illness or other impediments.

Court of Protection involvement also has significant cost implications. Lucy Series has estimated that the average cost to the state in a DoLS appeal with two litigants and a local council is £35,838, before costs to the courts and the Official Solicitor are factored in.¹¹⁰ These expenses are being accelerated by the rising number of appeals under s21A of the MCA. Furthermore, research led by Ajit Shah concluded that the average cost of each DoLS assessment was £1277 (more than double the original estimate of £600).¹¹¹ The only reason that these costs did not wildly exceed original predictions is that the total number of assessments for the first two years was only 36% and 34% of those expected, respectively.¹¹²

¹⁰⁷ *Hillingdon v Neary*, para. 33.

¹⁰⁸ Mental Health Alliance (2010), 'Deprivation of Liberty Safeguards: an initial review of implementation,' 14.

¹⁰⁹ *Hillingdon v Neary*, para. 202.

¹¹⁰ Lucy Series, 'Costing the deprivation of liberty safeguards appeals process' (unpublished draft).

¹¹¹ A. Shah, M. Pennington, C. Heginbotham, and C. Donaldson (2011), 'Deprivation of Liberty Safeguards in England: implementation costs' *The British Journal of Psychiatry*, 199:3, 232-238.

¹¹² See reports by The Health and Social Care Information Centre (2010) 'Mental Capacity Act 2005, Deprivation of Liberty Safeguards Assessments (England) - First report on annual data, 2009/10' and (2011), 'Mental Capacity Act 2005, Deprivation of Liberty Safeguards Assessments (England) - Second report on annual data, 2010/11'.

Alternatives to DoLS

Do DoLS need to be replaced? Many problems with the current system, such as low IMCA use, are likely due to the scheme's being new, and will be remediable in the course of 'bedding down' the legislation within the culture of the institutions tasked with enforcing it. However, some critics have argued that other flaws are 'endemic' and point to a need for DoLS to be 'drastically revised, or be replaced by an alternative, more cost-effective way of meeting the requirements of Article 5'.¹¹³ Whether or not these critics are correct, we can ask, are there alternative models available that would meet the objectives of the DoLS scheme more successfully, taking into account the costs and disruption of introducing a new system?

Deprivation of liberty can take many different forms—from quarantining, to kettling, to criminal detention—and requires mechanisms of authorisation and review in all countries which are signatories to the ECHR. DoLS are only one solution to the general challenge of deprivation of liberty, which are addressed to a specific population whose liberty is potentially deprived. Thus, an obvious place to look is to the strategies that other ECHR countries have for ensuring Article 5 compliance, as well as domestic systems governing deprivations of liberty of other kinds. Here we shall examine three main alternatives: continental European guardianship legislation, Mental Health Act Guardianship, and the Mental Health Tribunal system.

Guardianship in continental Europe

Some legal systems are designed to ensure that alternative decision-making processes are available for only those decisions an individual is actually incapable of making (e.g. MCA 2005 England & Wales).¹¹⁴ In continental jurisdictions, which traditionally employ guardianship regulations to deal with issues of mental capacity, legal capacity – the recognition of the ability to make legally valid decisions – does not necessarily correspond to functional capacity – the psychological ability to make a specific decision. Although present-day guardianship regulations differ significantly in their level of complexity and the amount of autonomy they provide, they all seem to share the status-based approach of Roman law.¹¹⁵ In their most 'extreme' form (e.g. Russia), guardianship regulations do not allow for partial capacity at all: if someone is placed under guardianship, the person loses 'legal personhood' and the guardian acquires authority over all the decisions relating to that person (for the legal landscape in Russia and the analysis of the *Shtukurov v Russia* judgment, see the Appendix of this document).

¹¹³ Mental Health Alliance (2011), 2 and 9. Similar sentiments are expressed by the Mental Health Lawyers Association in their response to the Legal Aid, Sentencing and Punishment of Offenders Bill [Available: <http://www.mhla.co.uk/modules/smartsection/item.php?itemid=587>] who have expressed longstanding concerns about the scheme. See also their joint response (with the Mental Capacity Lawyers Association) to the MCA 2005: Deprivation of Liberty Safeguards Consultation Paper CP23/07 [Available: <http://www.mhla.co.uk/modules/smartsection/item.php?itemid=283>].

¹¹⁴ Peter Bartlett, Oliver Lewis and Oliver Thorold, *Mental Disability and the European Convention on Human Rights* (Leiden: Martinus Nijhoff, 2007) p. 149 ff.

¹¹⁵ Cf. the *cura furiosi* in the Twelve Tables of Justinian.

The statutory regulation of mental capacity through the guardianship model has the *potential* advantage of leaving fewer ‘legal gaps’ than common law regulations. However, it would be too hasty to conclude that Bournemouth-style gaps cannot or do not exist in continental jurisdictions simply because people in similar position to HL (i.e. mentally incapacitated patients who do not object to their detention) would presumably have a Court-appointed guardian and thus, would enjoy the formal safeguards necessary to comply with Articles 5 (1) e. and 5 (4) of the Convention. Many Central Eastern European (CEE) countries are increasingly criticized for using guardianship as a means to place mentally incapacitated or vulnerable people to care homes. Placement and detention in care homes happens mostly informally (resembling to a pre-Bournemouth situation); it usually takes a contractual form, on the basis of an agreement concluded between a local official and the person concerned, whose consent is given by his or her guardian. However, it is not at all clear that such deprivation of liberty can be lawfully authorised by a guardian under the ECHR, since apart from the scrutiny of the guardian, there is no regular review or control over the detention. Nevertheless, there is a strong correlation between guardianship and care home placements in CEE countries. In Hungary, for example, ‘anywhere between 80 to 100 percent of adults in social care institutions for people with psycho-social disabilities are incapacitated and placed under guardianship’ and ‘there seems to be a strong nexus [...] between institutionalisation and placement under guardianship.’¹¹⁶ As the *Stanev v Bulgaria* case illustrates, such institutional accommodations can often involve a deprivation of liberty.

Stanev v Bulgaria (app. no. 36760/06)

Stanev v Bulgaria has been described as the ‘first social care home case before the European Court of Human Rights’ (Mental Disability Advocacy Center at www.mdac.info). Currently, there has been a decision on admissibility but the final judgment on the merits is still awaited. The significance of the case is that it examines the lawfulness of the practice of placing people with disabilities in social care homes in the absence of adequate community based services (which poses the question whether states have a positive obligation to provide community-based treatments under Article 5 or Article 8 of the Convention). The case will also examine whether such placements (grounded primarily on social deprivation and not on therapeutic necessities) are in line with Article 5 (1) of the Convention.

Update: The Grand Chamber of the European Court issued its final judgment on 17 January 2012. It found violations of Articles 5 (1), 5 (4), 5 (5), 6 (1) and 3 of the Convention.

Blanket guardianship regulations are not only problematic in relation to placement issues but also for more general reasons. One of the concerns is the possibility of misuse (abuse) of such laws, particularly in the absence of sufficient procedural safeguards relating to the appointment of the guardian or to the review of its activity.¹¹⁷ A more fundamental concern is that guardianship, even if used with benevolent intentions, limits patient autonomy in a disproportionate way. It authorises

¹¹⁶ Mental Disability Advocacy Center, *Guardianship and Human Rights in Hungary* (2007), report available at <http://mdac.info/node/692> (01.12.2011)

¹¹⁷ Cf. *Shtukaturov v Russia* in the Appendix.

surrogate decision-making on behalf of the protected person, even when he or she has functional capacity to make a specific decision. However, since the Convention focuses more on procedural safeguards rather than actual provisions concerning the substance of guardianship laws, the violation of the Convention is not explicit in this case. Still, the European Court recently seems to have started taking into account issues related to the substance of guardianship regulations.

There is a trend in European jurisdictions to move away from blanket guardianship laws towards more detailed regulations that allow for ‘tailor-made responses’ (e.g. introduction of partial guardianship and supported decision-making). This movement towards decision-specificity is driven by various international documents, in particular by the Council of Europe (Committee of Ministers) Recommendation No. R. 99 (4) from 1999. The Recommendation does not only describe the procedural safeguards that are expected to be implemented by Member States (Part III) but also contains substantive guidelines concerning guardianship regulations. Consider the following principles from Part II of the document:

Principle 2 – Flexibility in legal response

1. The measures of protection and other legal arrangements available for the protection of the personal and economic interests of incapable adults should be sufficient, in scope or flexibility, to enable suitable legal response to be made to different degrees of incapacity and various situations. [...]

Principle 3 – Maximum reservation of capacity

1. The legislative framework should, so far as possible, recognise that different degrees of incapacity may exist and that incapacity may vary from time to time. Accordingly, a measure of protection should not result automatically in a complete removal of legal capacity. However, a restriction of legal capacity should be possible where it is shown to be necessary for the protection of the person concerned.

Principle 6 – Proportionality

1. Where a measure of protection is necessary it should be proportional to the degree of capacity of the person concerned and tailored to the individual circumstances and needs of the person concerned.

In 2006, the Committee of Ministers adopted an ‘*Action plan to promote the rights and full participation of people with disabilities in society: improving the quality of life of people with disabilities in Europe 2006-2015*’.¹¹⁸ This document further emphasises the importance of implementing the relevant provisions included in Recommendation No. R. (99) 4 and that there should be no automatic loss of legal capacity simply on account of disability.¹¹⁹

The trend to move away from the status-based model of mental capacity is also exemplified in the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) that came into force in 2008.¹²⁰ Articles 12 (2) and 12 (4) state that ‘States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life’ and that ‘measures relating to the exercise of legal capacity respect the rights, will and preferences of the person [and] are proportional and tailored to the person’s circumstances’.

¹¹⁸ Council of Europe (Committee of Ministers) Recommendation No R. (2006) 5

¹¹⁹ Section 3.12.3.x.

¹²⁰ For a short analysis, see the opinion of Thomas Hammarberg (CoE Commissioner for Human Rights) at http://www.coe.int/t/commissioner/viewpoints/090921_EN.asp (14.11.2011)

Unlike the European Convention on Human Rights, the Council of Europe recommendations have no binding force on Member States. However, the European Court made reference to the 1999 Recommendation in two of its judgments.¹²¹ The UN Convention (binding, but not on Council of Europe organs) was also invoked in an *amicus curiae* before the Court.¹²² The most relevant place in this respect is probably paragraph 95 of *Shtukaturov v Russia*:¹²³

'The Court refers in this respect to the principles formulated by Recommendation No. R (99) 4 of the Committee of Ministers of the Council of Europe, cited above in paragraph 59. Although these principles have no force of law for this Court, they may define a common European standard in this area. Contrary to these principles, Russian legislation did not provide for a 'tailor-made response'. As a result, in the circumstances the applicant's rights under Article 8 were limited more than strictly necessary.'

This paragraph implies that Member States which fail to adopt sufficient decision-specific measures in their guardianship regulations might be found to be in violation of Article 8 of the Convention.

Germany has been cited as a positive example in the context of reforming guardianship regulations.¹²⁴ In 1992, Germany replaced its old guardianship laws and it now endorses the principle that persons with disabilities have the absolute right, 'in line with his [or her] abilities' to form his or her life according to his or her wishes and ideas.¹²⁵ The custodianship regulations of the German Civil Code seem to provide more decision-making autonomy than plenary guardianship and they also seem to allow for a more individualised ('tailor-made') approach (e.g. specifying groups of tasks, reservation of consent, etc). Concerning deprivations of liberty, a 'striking' characteristic of the German regulations (both on the federal and the state level) is that they give a higher priority to formalised, Court-based procedures, while in Britain 'the function of the courts is that of control rather than of decision-making itself'.¹²⁶ In practice, this means that placing a person under custodianship in an accommodation that is associated with deprivation of liberty must always be approved by the custodianship court in advance. Obviously, this involves a huge amount of cases that must be handled by the courts. In 2008, custodianship courts approved more than 140.000 cases of deprivation of liberty under § 1906 (1) and (4) BGB.¹²⁷ Despite being more individualised than some other continental guardianship regimes, the German system is less decision-specific than England and Wales, and so arguably less able to facilitate individual self-determination. Furthermore, even with the oversight of the courts, the protections offered by the guardianship system hang to a great extent on who the guardian is and whether they exercise their powers responsibly. There is more information available on the German custodianship system in the Appendix of this document.

¹²¹ *H.F. c. Slovaquie* (requête n° 54797/00) (available only in French); *Shtukaturov v Russia* (application no. 44009/05).

¹²² Amicus brief submitted by The European Group of National Human Rights Institutions in the case of *D.D. v Lithuania* (application no. 13469/06; currently pending before the Court).

¹²³ *Shtukaturov v Russia* (app. no. 44009/05), judgment of 27 March 2008.

¹²⁴ Amicus brief submitted by The European Group of National Human Rights Institutions in the case of *D.D. v Lithuania* (application no. 13469/06; currently pending before the Court) p. 8.

¹²⁵ *Ibid.* p. 8.

¹²⁶ Hanns Rüdiger Röttgers and Peter Lepping, 'Treatment of the mentally ill in the Federal Republic of Germany: Sectioning practice, legal framework, medical practice and key differences between Germany and the UK', 23 *The Psychiatrist* (1999) 601-603 at p. 602.

¹²⁷ 52,811 approvals were granted under § 1906 (1) and 91,823 approvals under § 1906 (4). <http://wiki.btprax.de/Genehmigungspflichten> (01.12.2011)

MHA Guardianship

Some have suggested that a more limited kind of guardianship, under the provisions of the Mental Health Act, would suffice to replace the DoLS regime.¹²⁸ Under s.8(1)(a)-(b), guardians are accorded:

- (a) the power to require the patient to reside at a place specified by the authority or person named as guardian;
- (b) the power to require the patient to attend at places and times so specified for the purpose of medical treatment, occupation, education or training;

Furthermore, under s.18(3) and s.137, the guardian has powers to return the relevant person to the place where the guardian requires them to reside. Richard Jones has argued that such powers authorise deprivations of liberty, for, given ECtHR and domestic case law concerning deprivation of liberty, 'how can it possibly be argued that a person who is subject to the operation of such powers is not being deprived of his or her liberty?'¹²⁹ Furthermore, guardianship under the MHA would provide a pathway to the Mental Health Tribunal system, which provides readymade review functions required for deprivation of liberty under sections 2 and 3 of the Act.

If DoLS were to be abolished, could and should MHA guardianship be used to plug any resulting Bournemouth gap? Firstly, contra Jones, it is not clear that a guardian has powers of detention that would satisfy Article 5(1) conditions, requiring any deprivation of liberty be undertaken according 'procedure prescribed by law', even if they can determine residence and return persons to it on specific occasions. In other words, Article 5(4) compliant review procedures and extensive powers to decide upon and return persons to a chosen residence may not be sufficient to authorise deprivation of liberty. Stigmatisation, associated with the Mental Health Act, but which DoLS have avoided for the most part, would be another concern. So too, the effectiveness of guardianship will in large part depend upon the choice of guardian and their willingness to engage their powers. The diligence of individuals or local services authorities appointed as guardian is potentially extremely variable, which would weaken effective review for those without proactive guardians.

Furthermore, in its current form, MHA guardianship does not extend to much of the population covered by DoLS. Jones – writing before DoLS was implemented – clearly has persons such as HL in mind, who are in contact with psychiatric services based in hospitals. However, many persons currently covered by DoLS authorisations would not meet the conditions for guardianship – in particular, most persons with learning disabilities – those not displaying the requisite 'abnormally aggressive or seriously irresponsible behaviour' – would be ineligible (although a similar broadening

¹²⁸ See Richard Jones (2007), 'Deprivations of Liberty: Mental Health Act or Mental Capacity Act?' *Journal of Mental Health Law* 117, 170-3 and Mental Health Lawyers Association in their response to the Legal Aid, Sentencing and Punishment of Offenders Bill [Available: <http://www.mhla.co.uk/modules/smartsection/item.php?itemid=587>]

¹²⁹ Jones (2007), 170.

of the MHA criteria as DoLS uses could be legislated). Thus, MHA guardianship does not appear to be as well-placed to replace DoLS as it might first appear.

Tribunals

Entry into Mental Health Tribunals would be a significant benefit delivered by a system using MHA guardianship to exercise powers of authorisation and review of deprivation of liberty. However, guardianship need not be the only route to the tribunal system. Currently, tribunals are integral to the system of review of detention for sectioned psychiatric patients, and they contribute to Convention compliance. Several features make them suited for this task: their judicial character, including evidence-gathering powers; impartiality towards the parties of the case; and independence from the executive.¹³⁰ The introduction of a new First-Tier Tribunal for Mental Capacity with these features under the Health, Education and Social Care Chamber, or the extension of the current Mental Health Tribunal, might provide a mechanism to fulfil core functions of the DoLS regime whilst avoiding some of its pitfalls.

Other than providing a setting for use of powers of authorisation and review of potential deprivations of liberty, the use of tribunals would have further advantages over the current system. First, impartiality and independence from managing authorities may be easier to achieve, since the members of the review process would be clearly demarcated (contra the Neary case), and lay members would introduce scrutiny from outside the medico-legal world (alongside broadening and demedicalising decision-making). Second, tribunals are able to be much more local, and so provide a mediating function to resolve problems without involving the full expense of Court of Protection and lessening obstacles such as travel difficulties, delay and the need to find highly specialised legal counsel. Extending the scope of Tribunals would also provide an opportunity to cover people who currently fall between the cracks of the current DoLS and MHA systems, such as those in supported living accommodation, should it be deemed appropriate to do so.

Implementing such a regime would face its own challenges, of course. There would still be a need to determine eligibility for entering the tribunal system and to facilitate referrals to it. Training gaps concerning identification of potential deprivations of liberty amongst front-line practitioners would therefore remain a problem. So too, as with using MHA guardianship, extending the scope of Mental Health tribunals risks the stigmatisation associated with mental health legislation. The inextricability of best interest decisions and authorisations of deprivation of liberty may also pose problems for tribunals given the complex care needs of people coming before them. It is not clear whether tribunals would be well-placed to make best interest determinations (especially if they are to combine impartiality of their members and increased efficiency compared to full courts); yet, authorisations of deprivation of liberty can hinge on making just such determinations. The current tribunal system has its own difficulties too, which must be faced by proposals based upon it. For instance, criticisms include that there is undue deference to psychiatric judgements, low rates of

¹³⁰ For more on the relation between tribunals and the ECHR, see Peter Bartlett, Oliver Lewis and Oliver Thorold (2007), *Mental Disability and the European Convention on Human Rights* (Leiden: Martinus Nijhoff), 62f.

recommendation that detention be ended, chronic delays, reliance on anecdotal evidence, lack of enforcement powers, and poor legal representation in many parts of the country.

Appendices

Appendix 1

Guardianship regulations in Russia

The following excerpt from a report of the Mental Disability Advocacy Center describes the legal landscape in Russia:¹³¹

‘In Russian law, only so-called full or plenary guardianship is provided for adults with intellectual/mental health disabilities.¹³² [...] There are no alternatives, so the system is over-used and abused because guardianship is the only way the law can currently respond to people who may need support in making certain decisions. Guardianship is often described as ‘civil death’ because a person subjected to the measure is fully stripped of his or her legal capacity in a wide range of matters, including financial and property decisions, the right to vote, the right to consent to or to refuse medical treatment (including forced psychiatric treatment), the right to marry, etc. [...] The impact of guardianship on a person’s freedom and autonomy is exacerbated by weak regulation of guardians’ responsibilities and deficient procedural safeguards related to withdrawing and restoring legal capacity and appointing a guardian. These insufficient legal guarantees make it shockingly easy for a person to find themselves deprived of legal capacity. It is almost impossible to have one’s legal capacity restored, because a person placed under guardianship does not have the right to apply to court to initiate proceedings, and the matter rests effectively with their guardian. [...] [Guardianship orders are based on expert reports] and Courts are overwhelmingly deferential to these reports prepared by state psychiatric institutions, which are the only institutions that are allowed to perform assessments in legal capacity cases.’

In 2008, the European Court of Human Rights delivered a landmark judgment in the case of *Shtukaturov v Russia*.¹³³ The significance of the judgment is that it looks, for the first time, into the substance of guardianship regulations based on the standards set out in the 1999 Council of Europe Recommendation. The applicant of the case, Mr. Shtukaturov was suffering from mental disorder which was diagnosed later as ‘simple schizophrenia with a manifest emotional and volitional defect’.¹³⁴ In 2003, the applicant’s mother lodged a guardianship application with the District Court claiming that her son was inert and passive, rarely left the house, sometimes behaved aggressively and, on a more general level, ‘was incapable of leading an independent social life’.¹³⁵ The expert opinion, commissioned by the Court, reported that although the applicant’s ‘intellectual and mnemonic abilities were without any impairment’, his behaviour was characterised by several typical features of schizophrenia, such as ‘formality of contacts, structural thought disorder [...], lack of judgment, emotional emasculation, coldness, reduction of energetic potential’.¹³⁶ The District Court, in a brief hearing of which the applicant was not notified, placed Mr. Shtukaturov under the

¹³¹ ‘New Project on Reforming Guardianship in Russia – Why focus on legal capacity?’, article available at <http://mdac.info/content/new-project-reforming-guardianship-russia> (09.12.2011)

¹³² An exception is the case of alcohol or drug addiction where partial guardianship is possible.

¹³³ *Shtukaturov v Russia* (app. no. 44009/05), judgment of 27 March 2008.

¹³⁴ *Ibid.* para. 15.

¹³⁵ *Ibid.* para. 10.

¹³⁶ *Ibid.* para. 15.

guardianship of his mother. Subsequently, he was placed in a psychiatric hospital on his guardian's request. Mr Shtukatorov objected to the confinement and repeatedly requested that the hospital apply to court to review the lawfulness of his detention. His communication with his lawyer was also limited.

The European Court found violations of Articles 5 (1), 5 (4), 6 and 8 in the case. It concluded that the applicant did not have a fair trial as defined in Article 6 since he was neither heard in person during the Court proceedings nor adequately notified of them. He was unlawfully deprived of his liberty in the mental hospital under Article 5 (1) because his detention did not comply with the requirements set forth in *Winterwerp* (in particular, he 'had not been reliably shown to be of unsound mind at the time of his confinement', the detention being based solely on his guardianship status). He could not have the lawfulness of his detention reviewed by a Court (Article 5 (4)). Besides all these procedural safeguards, the European Court also established that the blanket-type guardianship regulation disproportionately interfered with the privacy rights of the applicant.¹³⁷

Appendix 2

Custodianship and deprivation of liberty in Germany

A. Custodianship – general rules

Custodianship is regulated in paragraphs 1896-1908 of the German Civil Code (*Bürgerliches Gesetzbuch* or *BGB*). The present German regulation, enacted in 1992, places emphasis on patient autonomy and, unlike other guardianship regulations, it does not deprive the person of complete legal capacity.¹³⁸ The following elements of the regulation seem to point in this direction:

1. A custodian is appointed 'if a person of full age, by reason of a mental illness or a physical, mental or psychological handicap, cannot in whole or in part take care of his affairs'.¹³⁹ However, a custodian cannot be appointed against the 'free will' of the person.¹⁴⁰ In cases of physical handicap, a custodian can only be appointed on the application of the person concerned.¹⁴¹
2. A custodian may be appointed only for groups of tasks in which the custodianship is necessary.¹⁴² Such group of tasks include, for example, health care decision-making (*Gesundheitssorge*), financial decision-making (*Vermögenssorge*), the determination of residence (*Aufenthaltsbestimmung*) and housing issues (*Wohnungsangelegenheiten*). It is possible to appoint a custodian 'for all matters' if the person, due to his illness or handicap, is completely incapable of managing his own affairs. However, such comprehensive

¹³⁷ Ibid. para. 95, quoted before.

¹³⁸ Amicus Brief in the case of *DD v Lithuania*, p. 8.

¹³⁹ § 1896 (1) BGB

¹⁴⁰ § 1896 (1a) BGB

¹⁴¹ § 1896 (1) BGB

¹⁴² § 1896 (2) BGB

custodianship goes against the 'spirit' of custodianship regulations and must remain a rare exception.¹⁴³

3. Unlike in other guardianship jurisdiction, the appointment of a custodian in Germany does not automatically lead to the limitation of legal competence (*Geschäftsfähigkeit*). Even if someone has a custodian appointed, he or she still remains legally capable of making legally binding declarations (e.g. entering into civil law contracts), unless the custodianship court orders that the person requires the consent of the custodian to make a valid declaration of intention that relates to the group of tasks of the custodian (reservation of consent under § 1903 BGB). The reservation of consent may not extend to certain personal declarations (e.g. marriage) and consent is not required for declarations that merely confer a legal advantage on the person or 'if the declaration of intention relates to a trivial matter of everyday life'.¹⁴⁴
4. The notion of best interests endorsed in § 1901 BGB is similar to the notion of best interests in the MCA:
 - a. 'The custodian must attend to the affairs of the person under custodianship in a manner that is conducive to his welfare. The best interests of the person under custodianship also includes the possibility for him, within his capabilities, to shape his life according to his own wishes and ideas.'¹⁴⁵
 - b. 'The custodian must comply with wishes of the person under custodianship to the extent that this is not inconsistent with the best interests of the latter and can be expected of the custodian. This also applies to wishes which the person under custodianship expressed before the appointment of the custodian, unless he discernibly does not wish to uphold these wishes.'¹⁴⁶
5. When appointing the custodian, the custodianship court has to consider the person's previously expressed wishes and feelings and take into account any existing EPA (Enduring Power of Attorney).
 - a. 'A person who is in possession of a document in which a person [...] has communicated suggestions on the choice of the custodian or wishes for the conduct of the custodianship, must without undue delay deliver it to the custodianship court [...] Similarly, the possessor must inform the custodianship court of documents in which the person concerned has authorised another person to take care of his affairs.'¹⁴⁷
 - b. Moreover, 'if the person of full age suggests a person who may be appointed custodian, this suggestion should be followed unless it is inconsistent with the best interests of the person of full age'.¹⁴⁸

B. Custodianship court

¹⁴³ 'Nur wenn der Betroffene auf Grund seiner Krankheit oder Behinderung keine seiner Angelegenheiten mehr selbst besorgen kann, ist ein Betreuer 'für alle Angelegenheiten' zu bestellen. [...] Diese umfassende Betreuung entspricht aber nicht dem Sinn des Betreuungsrechts und soll daher eine seltene Ausnahme bleiben.'
<http://wiki.btprax.de/Betreuerpflichten> (01.12.2011)

¹⁴⁴ § 1903c BGB

¹⁴⁵ § 1901 (2) BGB

¹⁴⁶ § 1901 (3) BGB

¹⁴⁷ § 1901c BGB

¹⁴⁸ § 1897 (4) BGB

The custodianship court (*Betreuungsgericht*) is a division of the district court (*Amstgericht*). Cases are decided either by a custodianship judge (*Betreuungsrichter*) or a judicial officer (*Rechtspfleger*).¹⁴⁹ The custodianship court appoints and oversees the activity of custodians; it also has to approve certain types of decisions made by the custodian (serious medical treatment, sterilisation, placement that involves deprivation of liberty, investment of property, reservation of consent, etc.).

In 2004 there were 1,157,819 people under custodianship in Germany.¹⁵⁰ The following figures show the number of court approvals granted:¹⁵¹

1. In relation to reservation of consent (§ 1903 BGB): **12,050** (in 2007)
2. In relation to medical treatment (§ 1904 BGB): **3513** (in 2007)
3. In relation to sterilisation (§ 1905 BGB): **55** (in 2007)
4. In relation to deprivation of liberty:
 - a. Under § 1906 (1): **52,811** (in 2008)
 - b. Under § 1906 (4): **91,823** (in 2008)

C. Deprivation of liberty under custodianship

Section 1906 BGB sets out the rules for placing a person under custodianship in accommodation that is associated with deprivation of liberty. The process is initiated by the custodian but the placement – except for urgent cases – must always be approved by the custodianship court in advance.

The conditions for placements that amount to a deprivation of liberty are:

- The deprivation of liberty must be necessary for the best interests of the person under custodianship **and**:
 - there is a danger that the person will kill or damage himself **or**
 - because an examination, operation or therapeutic treatment is necessary without which the accommodation of the person cannot be carried out ‘and the person under custodianship, by reason of a mental illness or mental or psychological handicap, cannot recognise the necessity of the accommodation or cannot act in accordance with this realisation’ (comparable to ‘lacking capacity’ in English terminology).¹⁵²

This, depending on the meaning and interpretation of therapeutic treatment (‘Heilbehandlung’) and subject to court approval, means that people lacking capacity and in need of professional care that involves deprivation of liberty can be lawfully deprived of their liberty under the BGB. Patients such as those in *Cheshire*, *Re C* or *HL v UK* would presumably have a custodian and would be deprived of their liberty under § 1906 (1)2 in order to provide them with ‘therapeutic treatment’. At the same

¹⁴⁹ Section 15 of the act on judicial officers (*Rechtspflegergesetz*) specifies the types of cases in which a judge is necessary and in which a *Rechtspfleger* can independently proceed. Cases that involve deprivation of liberty are reserved for judges.

¹⁵⁰ International Disability Rights Monitor, Regional Report of Europe (2007) p. 183.

¹⁵¹ <http://wiki.btprax.de/Genehmigungspflichten> (01.12.2011)

¹⁵² § 1906 BGB

time, they would enjoy the protection of the custodianship court, since according to § 1906 (2), their detention must be authorised by the Court.

The group of people who come under the protection of section 1906 BGB seems to be wider than those who come under DoLS:

1. If a person is a danger to themselves and is under custodianship, then deprivation of liberty can take place by means of § 1906, even if the person has capacity. This means that many people who would come under the MHA regime in England and Wales could be detained under § 1906 BGB.

This also leads to an overlap between the federal custodianship regulation (§ 1906 BGB, civil law) and state laws that regulate involuntary civil commitment (public law). The primary function of these state laws is to avert dangers to public order relating to mentally ill persons (treatment being only a secondary consideration). The Bavarian law, for example, requires that the mentally ill person ‘endangers the public order or public safety to a significant degree’.¹⁵³ This is complemented in certain States by the ‘harm to self’ condition. The law of Baden- Württemberg allows for the sectioning of a mentally ill person who ‘seriously jeopardizes his life or health or poses a significant and immediate threat to legally protected rights of others’.¹⁵⁴

The application of the federal BGB and the state laws seems to be inconsistent:

‘The frequency of compulsory admission under State commitment laws or national guardianship law is more or less the same. However, in daily routine, even among experts there is no common opinion as to which law to favour for application. Cases might even start under the scope of the State commitment law and change to national guardianship law when ongoing and vice versa.’¹⁵⁵

2. The authorisation of the custodianship court is necessary even if a patient is not ‘accommodated’ in a certain place, but if he or she is deprived of his liberty in an institution, a home or *another* establishment by mechanical devices, by medical drugs or in another way for a long period of time or regularly.¹⁵⁶ This means that the judicial protection in Germany

¹⁵³ “Wer psychisch krank oder infolge Geistesschwäche oder Sucht psychisch gestört ist und dadurch in erheblichem Maß die öffentliche Sicherheit oder Ordnung gefährdet, kann gegen oder ohne seinen Willen in einem psychiatrischen Krankenhaus oder sonst in geeigneter Weise untergebracht werden erheblichem Maß die öffentliche Sicherheit oder Ordnung gefährdet”. Article 1 of *Unterbringungsgesetz* (5 April 1992) (emphasis added), available at www.gesetze-bayern.de

¹⁵⁴ “Unterbringungsbedürftig sind psychisch Kranke, die infolge ihrer Krankheit *ihr Leben oder ihre Gesundheit erheblich gefährden* oder eine erhebliche gegenwärtige Gefahr für Rechtsgüter anderer darstellen.” Article 1 (4) of *Unterbringungsgesetz* (2 December 1991) (emphasis added), available at www.landesrecht-bw.de

¹⁵⁵ Hans Joachim Salize, Harald Dreßing, Monika Peitz, *Compulsory Admission and Involuntary Treatment of Mentally Ill Patients – Legislation and Practice in EU-Member States* (Final Report, 2002, European Commission - Health & Consumer Protection Directorate-General) p. 82.

¹⁵⁶ § 1906 (1) 4 BGB

extends to a wider subject group than the DoLS, including day-care centres, supported living schemes, etc.

Section 1906 BGB (German Civil Code)

Approval of the custodianship court with regard to accommodation

(1) It is admissible for the custodian to put the person under custodianship in accommodation that is associated with deprivation of liberty only as long as this is necessary for the best interests of the person under custodianship because

1. by reason of a mental illness or mental or psychological handicap of the person under custodianship there is a danger that he will kill himself or cause substantial damage to his own health, or
2. an examination of the state of health of the person under custodianship, therapeutic treatment or an operation is necessary without which the accommodation of the person under custodianship cannot be carried out and the person under custodianship, by reason of a mental illness or mental or psychological handicap, cannot recognise the necessity of the accommodation or cannot act in accordance with this realisation.

(2) The accommodation is admissible only with the approval of the custodianship court. Without the approval, the accommodation is admissible only if delay entails risk; the approval must thereafter be obtained without undue delay.

(3) The custodian must terminate the accommodation if its requirements cease to be satisfied. He must notify the custodianship court of the termination of the accommodation.

(4) Subsections (1) to (3) apply with the necessary modifications if the person under custodianship who is in an institution, a home or another establishment without being accommodated there is to be deprived of his liberty by mechanical devices, by medical drugs or in another way for a long period of time or regularly.

(5) The accommodation by an authorised person and the consent of an authorised person to measures under subsection (4) require that the power of attorney be granted in writing and expressly covers the measures set out in subsections (1) and (4). Apart from this, subsections (1) to (4) apply with the necessary modifications.

Appendix 3

Additional cases of the European Court of Human Rights in relation to Article 5

Johnson v United Kingdom (app. no. 22520/93)

The applicant, after being diagnosed as suffering from mental illness, was detained in Rampton Hospital for 5 years in accordance with the regulations of the MHA 1983. In 1989, the Mental Health Review Tribunal ruled that, although the applicant is no longer suffering from mental illness, he can only be conditionally released because he is unable to live on his own and requires rehabilitation in a hostel environment. Despite considerable efforts, the authorities did not manage to find a suitable hostel that was willing to take the applicant, thus the applicant remained in Rampton until the Tribunal ordered his unconditional release into the community in 1993.

The applicant complained that his detention between 1990 and 1993 violated his Article 5 rights. The Court ruled that while it does not automatically follow from the third Winterwerp condition that the person no longer suffering from a mental disorder should be immediately and unconditionally released, the discharge should not be unreasonably delayed.¹⁵⁷ The onus was on the authorities to secure a suitable hostel accommodation for the applicant, which they failed to do and therefore there was a violation of Article 5 (1).

Amuur v France (app. no. 19776/92):

The applicants of the case were refugees from Somalia who had travelled via Kenya and Syria to Paris. They were refused entry to France and for twenty days, before being sent back to Syria, they were held in the transit zone of the airport (and in its extension, the floor of a nearby hotel which had been converted to a temporary transit zone). The Court rejected the argument of the Government that, since the applicants were free at any time to return to Syria or any other country which would have accepted them, the holding measures did not amount to a deprivation of liberty. The Government argued that although the transit zone is 'closed on the French side', it remains 'open to the outside', so that the applicants could have returned of their own accord to Syria, where their safety was guaranteed.¹⁵⁸

Stanev v Bulgaria (app. no. 36760/06)

This case concerns the long-term placement in a social care home of a man diagnosed with schizophrenia, who had previously been partially deprived of his legal capacity. In 2000, the Ruse Regional Court placed Mr Stanev under partial trusteeship and appointed a local council officer as trustee for him. He was subsequently transported to Pastra social care home at the request of his trustee. The applicant's identity papers were kept by the home's management and he was allowed to leave the home only with special permission from the director. He regularly went to the village of Pastra to provide domestic help to some villagers or to carry out tasks at the roadside restaurant.

¹⁵⁷ *Johnson v UK*, paras 60-67.

¹⁵⁸ *Amuur v France*, para. 46.

Between 2002 and 2006, Mr Stanev was allowed to go home to Ruse three times but on the third period of leave, he failed to return and was brought back by the employees of the care home.

There is a decision on the admissibility of the case but the final judgment is still pending before the Court. Mr Stanev complains about the violations of his fundamental rights under Article 3 (inhuman and degrading treatment), Articles 5(1), (4) and (5) (right to liberty and security), Article 6 (right to a fair trial), Article 8 (right to privacy) and Article 13 (right to an effective remedy).

As for Article 5 (1), the Government argues that there was no violation because the state was merely providing accommodation and care for the applicant at the request of his trustee (guardian) which is a positive obligation of the State under the Convention. The applicant was not detained as a person of unsound mind, but he was housed in a social care home at his trustee's request, on the basis of a civil-law contract. Persons in need of assistance, including those with mental disorders, can request various social services, either personally or through their representatives.

Update: The Grand Chamber of the European Court issued its final judgment on 17 January 2012. It found violations of Articles 5 (1), 5 (4), 5 (5), 6 (1) and 3 of the Convention.

Ashingdane v United Kingdom (app. no. 8225/78) [1985] ECHR 8

Mr Ashingdane, suffering from paranoid schizophrenia, was initially detained at a local psychiatric hospital (Oakwood Hospital). After absconding twice from here, he was transferred to Broadmoor Hospital, a 'special hospital' for those requiring treatment under conditions of special security. He was detained at Broadmoor for more than seven years under the provisions of the MHA 1959. His consultant psychiatrist in 1978 reported that Mr Ashingdane no longer posed 'the threat he previously did' and might properly be treated in an open hospital such as Oakwood. However, he was not transferred to Oakwood until 1980. Mr Ashingdane, among others, claimed that (a.) his detention at Oakwood and Broadmoor hospitals violated Article 5 (1) of the Convention; or alternatively that (b.) his detention at Broadmoor between 1978 and 1980 and the failure of the authorities to transport him to an open hospital violated Article 5 (1).

The Court found that Mr Ashingdane was deprived of his liberty both in Oakwood and Broadmoor hospitals. It held that a person could be regarded as having been 'detained' even during a period when he was in an open hospital ward (i.e. in Oakwood) with regular unescorted access to the unsecured hospital grounds and the possibility of unescorted leave outside the hospital (para. 42). It also established (echoing the judgments in *Engel* and *Guzzardi*) that in order to determine whether a person had been detained, the type, duration, effects and manner of implementation of the measure in question had to be examined (para. 41). The detention of Mr Ashingdane was found to be justified under Article 5 (1) e.

HL v United Kingdom (app. no. 45508/99) [2004] ECHR 471

The case concerned a severely autistic man, HL, who lacked capacity to consent to, or to refuse, hospital treatment.¹⁵⁹ In July 1999, he was admitted to Bournemouth Hospital and retained there against the wishes of his carers. Since he did not object or resist to the admission, he was not detained under the Mental Health Act but was 'informally admitted' to the hospital under common

¹⁵⁹ *HL v United Kingdom* [2004] ECHR 471 (app. no. 45508/99)

law. This was a common practice at the time. HL remained in hospital for weeks, was prevented from leaving, and also denied access to his carers. The carers brought legal proceedings against the hospital for unlawful detention.

The House of Lord's judgment in the *Bournemouth* case pre-dated the coming into force of the Human Rights Act 1998, which explains why the House was not primarily concerned with the question of whether there had been a deprivation of liberty within the meaning of Article 5 but rather with the question of whether there had been a detention for the purposes of the tort of false imprisonment.¹⁶⁰ The justification of the detention was built around the common law doctrine of necessity.

The applicant argued before the European Court of Human Rights that the Convention notion of detention was more flexible than that of the House of Lords and included notions of psychological detention, potential detention and the removal of the means of escape. The applicant invoked the *Ashingdane* case, claiming that the type, duration, effects and manner of implementation of the measure in question had to be examined.

The Government contended that a finding that HL was detained would mean that the care of many other compliant persons lacking capacity to consent to care, even in private houses or nursing homes, would now be considered detention – a conclusion which would have onerous legal and other implications.¹⁶¹ It was estimated that there would be an additional 22,000 patients whose detention would need to be authorised.

The Court decided in favour of the applicant and found that HL was deprived of his liberty. It established that the question whether the doors of the unit had been locked is not, in itself, the determinative factor in the case. It noted that the applicant in *Ashingdane* was also considered to have been detained even during a period when he was in an open ward. The key question in the present case was whether health care professionals exercised 'complete and effective control' over the applicant's care and movements. HL was under continuous supervision and control and was not free to leave. 'Any suggestion to the contrary is, in the Court's view, fairly described by Lord Steyn as 'stretching credulity to breaking point' and a 'fairy tale'.¹⁶²

As Munby LJ notes in paragraph 49 of *JE v DE*, the Court also 'retreated' from its previous (fairly problematic) rulings in *Nielsen v Denmark* and *HM v Switzerland* in paragraph 93 of the judgment:

'[...] while there may be similarities between the present case and *HM v Switzerland*, there are also distinguishing features. In particular, it was not established that HM was legally incapable of expressing a view on her position. [...] This, combined with a regime entirely different to that applied to the present applicant (the foster home was an open institution which allowed freedom of movement and encouraged contact with the outside world), leads to the conclusion that the facts in *HM v Switzerland* were not of a 'degree' or 'intensity' sufficiently serious to justify the finding that she was detained. [...] The Court also finds a conclusion that the present applicant was detained

¹⁶⁰ As pointed out by Munby LJ when reviewing the *HL v UK* case in *JE v DE* [2006] EWHC 3459 (Fam) para. 52.

¹⁶¹ *HL v United Kingdom* [2004] ECHR 471 (app. no. 45508/99) para. 80.

¹⁶² *Ibid.* para. 91.

consistent with *Nielsen* (cited above), on which the Government also relied. That case turned on the specific fact that the mother had committed the applicant minor to an institution in the exercise of her parental rights [...]

Appendix 4

Deprivation of liberty case law (England & Wales)

Case	Facts	Deprivation of Liberty
<i>Re Brammall; W Primary Care Trust v TB</i> (2009) EWHC 1737 (Fam) (Wood J)	TB is a 41 year old woman with an acquired brain injury and an associated chronic delusional disorder. After being cared for by her parents and one of her brothers, TB was placed to a care home where she was detained under an urgent DoLS authorization, after the safeguards came into force in 2009.	<p>The eligibility assessor for the standard authorisation questioned TB's eligibility to DoLS stating that she might possibly be detained under the MHA. Since TB objected to being a mental health patient, the objection test was (partly) fulfilled. She was also 'within the scope of the MHA' for the purposes of Case E in Schedule 1A.</p> <p>However, the Court found that TB was not a 'mental health patient' as defined in paragraph 16 of Schedule 1A because she was detained in a care home and not in a hospital (i.e. the place was registered as a care home but not as an independent hospital under the Care Standards Act 2000). Thus, she was 'not ineligible' to DoLS and could be a subject of standard authorization provided that the deprivation of liberty was in her best interests. Best interests were not assessed in the present judgment. The litigation was supposed to continue, but as the attached Coda reveals, TB committed suicide before a final judgment could have been delivered.</p>
<i>London Borough Tower Hamlets v BB</i> (2011) EWHC 2853 (Fam) (Ryder J)	BB is a 32 year old woman who suffers from schizo-affective disorder, learning disability, acute personality disorder and is profoundly deaf. After being abused by her family, she was removed from home and placed in a specialist residential unit in Birmingham known as 'Polestar'.	Ryder J lists in paras. 42-43 the factors that support the finding of a deprivation of liberty.
<i>DCC v KH</i> (2009) COP 11729380 (unreported) (O'Regan DJ)	This was an emergency application heard by a District Judge in a telephone hearing. By a previous court order provision was made for KH, a young man, to have increasing levels of contact with his mother, PJ. KH had threatened that when	The local authority relied on para. 2.15 of the DOLS Code of Practice. This paragraph states: 'In a very few cases, there may be exceptional circumstances where taking a person to a hospital or a care home amounts to a deprivation of liberty, for example where it is

	<p>he went to see his mother next time, he would not return to his placement after the meeting. The local authority sought an order authorising the deprivation of the liberty of KH for the purpose of returning him to his placement.</p>	<p>necessary to do more than persuade or restrain the person for the purpose of transportation, or where the journey is exceptionally long. In such cases, it may be necessary to seek an order from the Court of Protection to ensure that the journey is taken on a lawful basis.'</p> <p>The District Judge held that the application was not necessary because there was already a standard DOLS authorisation in place. Paragraph 2.15 only refers to cases where a standard authorisation is not yet in place.</p>
<p>Sessay v S. London and Maudsley NHS Trust [2011] EWHC 2617 (QB) (Pitchford LJ and Supperstone J)</p>	<p>The case concerned a non-compliant incapacitated patient, who was taken from her home by police and held in a psychiatric hospital pending the making of the application for her compulsory admission for assessment under section 2 of the MHA 1983. The police officers considered that Ms Sessay fell within the scope of section 135 MHA (Warrant to search for and remove patients) but they could not exercise this power because they did not have a warrant and were not accompanied by an approved mental health professional or a registered medical practitioner. Instead, they relied upon section 5 of the MCA 2005 to justify taking her to hospital.</p>	<p>Counsel for the Trust argued that there was a lacuna in the MHA in relation to situations that require a person to remain present at the hospital until the assessment/admission procedure is completed under sections 2-6 MHA; detention in these cases shall be justified by the common law doctrine of necessity. The Court rejected this argument and stated that the MHA provides a <i>complete</i> statutory code covering the whole admission process. Sections 5 and 6 of the Mental Capacity Act 2005 do not confer on police officers authority to remove persons to hospital or other places of safety for the purposes set out in sections 135 and 136 of the Mental Health Act 1983.</p>
<p>A Local Authority v A and B [2010] EWHC 978 (Fam) (Munby LJ)</p>	<p>The court was required to determine whether A (child) and C (incapacitated adult), both suffering from Smith Magenis Syndrome (a rare genetic disorder associated with self injurious behaviour, physical and verbal aggression, temper tantrums, destructive behaviour, hyperactivity, etc.), had been deprived of their liberty within the meaning of Article 5(1) ECHR. Both lived at home with their parents and, due to their behaviour, were locked in their bedrooms every night.</p>	<p>Applying the Storck test, Munby LJ came to the conclusion that there had been no deprivation of liberty in the cases.</p> <ul style="list-style-type: none"> • The restrictions imposed on A and C were not imputable to the State because the local authority was not directly involved in the cases. The Local Authority was not the decision maker and it took no active steps to implement what the families had decided. Knowledge of the situation might be enough to trigger a duty to investigate (as a positive obligation under Article 5) but it does not mean that the restriction imposed by the family is imputable to the State (see paras. 50-109). • The subjective element was satisfied because both A and C lacked the relevant capacity to consent to the restrictions they had been subjected to. • In relation to the objective element, the loving and caring regime in A and C's homes fell significantly short of engaging Article 5 because it was a reasonable, proportionate and appropriate regime implemented with the single view to the welfare, happiness and best interests of A and C. As Munby LJ in para. 150 writes:

		<p>'But for the fact that they are each locked in their bedrooms at night, Parker J's analysis and conclusions in relation to MIG would lead me, and for essentially the same reasons, unhesitatingly to the conclusion that neither A nor C is being deprived of her liberty. Their happy family life, in the heart of a caring and loving family, can hardly be further removed from the paradigm case of the prisoner or, indeed the immensely different case of someone subject to control order and curfew. Does the fact that, during the night time, they are locked in their bedrooms, alone make the difference? In my judgment it does not.'</p>
<p>JE v DE and Surrey County Council [2006] EWHC 3459 (Fam) (Munby J)</p>	<p>DE, a 76 year old man suffered a major stroke in 2003 which left him blind and with significant short-term memory impairment. He is disorientated and needs assistance with all the activities of daily living. Although he suffers from dementia he is able to express his wishes and feelings with some clarity and force. Subject to further investigation, it was established that 'available evidence strongly suggests that DE lacks the capacity to decide where he should live'.</p> <p>DE is married to JE. DE was taken to a care home by the Surrey County Council in 2005, which was of the opinion that DE should not reside with JE because there is a substantial risk of harm and neglect. DE enjoyed a significant degree of freedom within the care home. He was regularly taken for walks, had telephone contact with his family and received visitors. Although he often indicated his wish to leave and live with JE, he was not allowed to leave. Staff threatened JE with calling the police if she attempted to remove DE from the home.</p>	<p>In determining the existence of deprivation of liberty, the second and the third conditions of the Storck test are clearly satisfied. As for the objective conditions of detention, the crucial question in the case was not whether DE's freedom was curtailed <i>within</i> the institution, but whether DE was 'free to leave' the care home as formulated in the <i>HL v UK</i> case. After all, 'prisoners detained in an open prison may be subject to virtually no physical restraint within the prison, may be allowed to have extensive social and other contact with the outside world and may even be allowed to leave the prison from time to time, yet they are indubitably deprived of their liberty.' (para. 116; Munby LJ referring to the opinion of Judge Loucaides in <i>HM v Switzerland</i>)</p>
<p>C v A Local Authority [2011] EWHC 1539 (Admin) (Ryder J)</p>	<p>C, aged 18 at the time of the judgment, had been resident in a special school since 2007. He suffers from autism and severe learning disabilities and exhibits extremely challenging behaviour. C had developed a number of behaviours including self-harming, defecating, smearing and eating his own urine and faeces, stripping naked, etc. Management of his behaviour at the school included use of a padded room (the 'blue room') of about 10 feet square with a secure door that would often be held closed by the carers. In September 2010, C's mother and brother brought judicial proceedings to challenge alleged failures by the local authority to properly plan or</p>	<p>Many of the issues between the family and local authority were resolved by agreement and some issues were left to be decided at a later hearing (e.g. the violation of C's Article 3 and Article 8 rights). The judgment, nevertheless, covers a number of important issues:</p> <ul style="list-style-type: none"> • The Court held that there was no lawful authority for the deprivation of liberty, and therefore there was a breach of C's Article 5 rights. Since at least C's 16th birthday, the approach of the MCA 2005 was more relevant to his situation than the Children Act 1989 but the local authority failed to bring the case to the Court of Protection

	<p>provide for C's care, including appropriate arrangements for his transition to an adult placement at age 18 years. At the same time, the local authority started Court of Protection proceedings for declarations about C's best interests and lawfulness of the care arrangements.</p>	<p>when C had become 16.</p> <ul style="list-style-type: none"> • The repeated use of seclusion was a factor, but it seems likely that the circumstances of C's life at the school would have been held to be a deprivation of liberty in any event. The key factor was 'whether the person is, or is not, free to leave', tested by 'whether those treating him exercise complete and effective control' (paras. 47-48, 103-104, 114). • Since the Deprivation of Liberty Safeguards did not apply to C's case (as the residential school was neither a care home nor a hospital), a direct application should have been made to the Court of Protection to authorise the deprivation of liberty. • Although C was not detained under the Mental Health Act, the MHA Code of Practice, and associated guidance on seclusion in particular, showed best practice and should have been followed (paras. 68-71). • The Court gave detailed directions concerning the situations in which secluding C was lawful and in his best interests. <p>This summary is based on the analyses of Ben Troke, Alex Ruck Keene and Victoria Butler-Cole, available at: www.brownejacobson.com and www.localgovernmentlawyer.co.uk</p>
<p>Re RK; YB v BCC [2010] EWHC 3355 (COP) (Fam) (Mostyn J)</p>	<p>This case is about a 17.5 year old girl known as RK. She suffers from autism, epilepsy and severe learning disability. She has no ability to communicate verbally. RK's parents came to realise that she required greater care than they could provide. Thus, RK was moved from her parents to a care home. The Court had to decide if RK was deprived of her liberty at the care home. (See Thirty Nine Essex Street Court of Protection Newsletter: January 2011, pp. 3-4)</p>	<p>The Court ruled that the objective conditions for deprivation of liberty were not met in this case. RK has unrestricted contact with her parents and spends her weekends at her parents' place. On weekdays she stays at the care home but attends school every day. She is closely supervised to ensure that she does not harm herself or others. The front door of the care home is not locked but if RK attempted to leave she would be brought back. Justice Mostyn: 'It is said that this régime amounts to confinement in the sense that she has no autonomy. I am not sure that the notion of autonomy is meaningful for a person in RK's position.' (para. 36, <i>cf.</i> the issue of relevant comparator in <i>Cheshire</i>). Furthermore, it seems that RK's confinement (motivated by benevolent intentions) falls short from what the framers of the ECHR originally intended to consider as deprivation of liberty. '[I]t is worth remembering the historical context that informed the framing of the Convention in 1950. Art 5 was an important bulwark against totalitarian tyranny. [...] I find it impossible to conclude that the framers of the convention would even in their wildest dreams have</p>

		<p>contemplated that Art 5 might be engaged by the facts presented here.’ The Court found that the subjective conditions for deprivation of liberty were not met either. A valid consent was given to the placement, if not by RK, but by her parents who exercise parental responsibility over RK. In this regard, Mostyn J specifically follows and agrees with the decision of the European Court of Human Rights in <i>Nielsen v Denmark</i>. (para. 42) The third element of the test is not satisfied either. ‘RK’s placement at KCH is at the behest of her parents. It cannot be imputed to the state.’ (para. 43)</p>
<p>Re RK; RK v BCC [2011] EWCA Civ 1305 (Thorpe LJ, Gross LJ, Baron J)</p>	<p>The Court of Appeal upheld the judgment of the High Court.</p>	<p>As for the subjective element, it was established that ‘Mostyn J was correct to record the parents’ consent, even if his analysis is open to question.’ Concerning the objective element, the Court ruled that the measures imposed on RK amounted only to a restriction of freedom of movement. Paras. 27-28: ‘The restrictions were no more than what was reasonably required to protect RK from harming herself or others within her range. It was the parents’ case that home care was impossible without an extensive supportive care package. The purpose and effect of such a home care package would be to protect RK and others from harm. In other words wherever RK is accommodated the same restrictions on her liberty are essential.’</p>
<p>Re MIG and MEG; Surrey County Council v CA [2010] EWHC 785 (Fam) (Parker J)</p>	<p>MIG and MEG, two sisters aged 17 and 18, suffer from severe learning disabilities. MIG has the cognitive ability of a two and a half year old child. MEG has the ability of a four to five year old, with possible autistic traits. MIG is placed with a foster family, MEG stays in a small residential home. Both of them are under constant supervision and MEG receives medication against the challenging behaviour she exhibits from time to time. The question was whether these placements constituted deprivations of liberty.</p>	<p>It was established that the restrictions imposed on MIG and MEG did not constitute deprivation of liberty. Parker J refers to the ‘relative normality’ of MIG and MEG’s living conditions (<i>cf. Cheshire</i>) and argues that while the ‘purpose’ of the restrictions cannot be taken into account, it is permissible to look at the ‘reasons’ why MIG and MEG are accommodated in their respective places. Paras. 229,230 and 233:</p> <p>229. The ‘concrete situation’ is that each lives exactly the kind of life that she would be capable of living in the home of her own family or a relative: their respective lives being dictated by their own cognitive limitations. [...]</p> <p>230. I agree that it is impermissible for me to consider whether, if either is objectively detained or confined, this is with good or benign intentions or in their best interests. But notwithstanding that, as was observed by Lord Walker in <i>Austin</i>, ‘purpose’ does not figure in the list of factors to be evaluated in determining the concrete situation of the person concerned, I am of the view that in this case it is permissible to look at the ‘reasons’</p>

		<p>why they are each living where they are. In the case of each there are overwhelming welfare grounds for them not to live in their family of origin. In relation to both girls, the primary intention is to provide them each with a home. Within those homes, they are not objectively deprived of their liberty. In neither of those homes are they there principally for the purpose of being 'treated and managed'. They are there to receive care.</p> <p>233. [...] Each lacks freedom and autonomy dictated by their own disability, rather than because it is imposed on them by their carers. Each is under the continuous supervision and control of her carers (and in the case of MIG, of her foster family rather than 'staff') so as to meet her care needs rather than to restrain her in any way [...]</p>
<p><i>P & Q v Surry County Council</i> [2011] EWCA Civ 190 (Mummery LJ, Smith LJ and Wilson LJ)</p>	<p>The Court of Appeal handed down its judgment on the appeal of the MIG and MEG case on 28 February 2011.</p>	<p>The Court found that the subjective element of the Storck-test has been satisfied: neither P (MIG) nor Q (MEG) could validly consent to the confinement. However, the objective conditions have not been met; thus, there was no deprivation of liberty in these cases. The Court clarified the role that some factors might play in the objective part of the Storck-test:</p> <ul style="list-style-type: none"> • Happiness is irrelevant as to the existence of deprivation of liberty. (It plays a role in the assessment of best interests.) (para. 24) • The existence of objections is relevant both to the objective and subjective parts of the test. Objections to detention by a competent person negates the subjective element (i.e. negates valid consent). Objections will also lead to the imposition of objective physical restraints. (paras. 25-26) • The purpose behind the imposed restriction (i.e. the benevolent purpose to further the incapacitated person's best interests) does not seem to be relevant when determining the existence of deprivation of liberty. • The relative normality of the living arrangements is a relevant factor when deciding about deprivation of liberty.