

# **The Deprivation of Liberty Safeguards (DoLS)**

## **Briefing Document**

### **The Essex Autonomy Project**

## **Introduction**

The Deprivation of Liberty Safeguards (DoLS) were included in the 2007 Mental Health Act as an addition to the 2005 Mental Capacity Act. They were introduced as a response to the HL v UK judgment of the European Court of Human Rights (known as the Bournemouth case) and were designed to remedy the incompatibility between English law and the European Convention (known as the Bournemouth gap).

### **HL v UK 45508/99 [2004] ECHR 471 (The Bournemouth case)**

The case concerned a severely autistic man, HL, who lacked capacity to consent to, or to refuse, hospital treatment. 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 the common law doctrine of necessity.<sup>1</sup> This was a common practice at the time.<sup>2</sup>

HL remained in hospital for weeks and was prevented from leaving. He was also denied access to his carers. The carers brought legal proceedings against the hospital for unlawful detention which went up to the House of Lords and eventually to the European Court of Human Rights. The Court found that

- HL was deprived of his liberty in the hospital
- This deprivation was unjustified as the informal admission of HL was not sufficiently 'prescribed by law' and therefore violated Art. 5(1) of the Convention. The Court complained about the 'lack of any formalised admission procedure' which would indicate who can propose admission, for what reasons or for what period of time. The health care professionals assumed full and unqualified control over the admitted patients (paras. 120-121).
- There was a breach of Art. 5 (4) as well because HL was not able to apply to a court to see if his deprivation of liberty was lawful.

To prevent similar breaches of the ECHR, the system of DoLS was introduced in 2007. It entered into force on 1 April 2009. Five and a half thousand DoLS assessments were conducted in the first nine months of implementation.<sup>3</sup> There were 125 cases where a person had been found to be deprived of

---

<sup>1</sup> The common law doctrine of necessity was relied on as early as *Rex v Coate* (1772) and *Scott v Wakem* (1862). The doctrine of necessity permits the detention of those who pose a danger, or potential danger, to themselves or others, insofar as this is shown to be necessary.

<sup>2</sup> Anthony Maden and Tim Spencer-Lane, *Essential Mental Health Law* (London: Hammersmith, 2010) at 208.

<sup>3</sup> Briefing on Mental Capacity Act Deprivation of Liberty Safeguards (Department of Health, April 2010)

their liberty but the assessors had not recommended an authorisation because it would not have been in the 'best interest' of the concerned individual.<sup>4</sup>

## What is a deprivation of liberty?

The ECtHR has drawn a distinction between 'deprivation of liberty' and 'restrictions on the liberty of movement'. When assessing if a restriction amounts to a deprivation, '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'. The distinction is 'merely one of a degree or intensity and not one of nature or substance'. (Engel v The Netherlands, paras. 58-59; Guzzardi v Italy, para. 92; HL v UK, para. 89)

While deprivation of liberty is always unlawful unless authorised in accordance with Art. 5 of the ECHR, restrictions can be imposed on someone without further statutory guarantees. Such restrictions are also called **restraints** in the MCA. A restraint is:

1. the use of force to make someone do something that they are resisting;
2. the restriction of a person's freedom of movement, whether they are resisting or not.<sup>5</sup>

Restraint usually protects from immediate harm and lasts for a short period of time (e.g. preventing someone to cross a dangerous road). **The frontier between restraint and deprivation of liberty is vague and largely case-specific.**

## Cases where restrictions did NOT involve a deprivation of liberty

### Engel and Others v The Netherlands 5100/71 (1976) ECHR 3

An early case in which the ECtHR had to consider whether disciplinary measures involving restriction of movement imposed on conscript soldiers constituted deprivation of liberty. 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 (paras. 60-69).

---

<sup>4</sup> Despite the large volume of applications, there are still considerable gaps in the DoLS system. As Bartlett points out, DoLS do not apply to underage people and only partly to those under guardianship. Moreover, psychiatric patients with capacity are often given the 'choice' by their physicians: either they come in 'voluntarily' for the treatment or will involuntarily be treated under section 3 of the MHA. Fearing the stigma of sectioning, these people often opt for informal admission. See Peter Bartlett: Informal Admissions and Deprivation of Liberty under the MCA 2005 in L. Gostin, P. Bartlett, P. Fennell (eds.), Principles of Mental Health Law and Policy (Oxford: Oxford University Press, 2010) at 386-88.

<sup>5</sup> DoLS Code of Practice p. 19.

### **Nielsen v Denmark 33488/96 (2000) ECHR 81**

A 12-year-old boy with nervous disorder was treated in a hospital's psychiatric ward for five and a half months. 'The door of the ward was locked to prevent children exposing themselves to danger or running around disturbing other patients. However, the applicant was free to leave the ward with permission and to go out if accompanied by a member of staff.'<sup>6</sup>

### **HM v Switzerland 39187/98 (2002) ECHR 157**

An 84-year-old woman was placed in a nursing home by state authorities. She was free to move within the home and to have social contacts with the outside world. Initially undecided, after moving into the home, she did not object to staying there.<sup>7</sup> [She was not incapacitated as opposed to HL. Where a person has capacity, consent to their confinement may be inferred from the fact that the person does not object].

## **Cases where restrictions DID involve a deprivation of liberty**

### **Guzzardi v Italy 7367/76 (1980) ECHR 5**

A man, suspected of criminal activities, was put under special police supervision and was sent to the island of Asinara where he was, among other things, obliged to:

- report to the supervisory authorities twice a day and whenever called upon to do so;
- not return to his residence later than 10 p.m. and not go out before 7 a.m.;
- not frequent bars or night-clubs;
- lead an honest and law-abiding life.

### **Storck v Germany 61603/00 (2005) ECHR 406**

A young woman was placed in a psychiatric institution. 'She was kept in a locked ward and was under continuous supervision and control ... and was not free to leave the clinic during her entire stay of 20 months. When she attempted to flee, she was shackled. When she succeeded one time, she was brought back by the police. She was unable to maintain regular contact with the outside world.'<sup>8</sup>

---

<sup>6</sup> Ibid. 23.

<sup>7</sup> Ibid. 24.

<sup>8</sup> Ibid. 26.

As it becomes apparent from this case, the **'deprivation of liberty' test** of the ECtHR has three main prongs:

1. The **objective element** of a person's confinement to a certain limited place for a not negligible length of time (para. 74) [Note: the previous cases were mainly concerned with this element.]
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.
3. The confinement must be **imputable** to the State (para. 89)

#### **HL v UK 45508/99 (2004) ECHR 471 (The Bournewood case)**

1. As for the **objective elements**, the ECtHR found that the hospital exercised complete and effective control over the movement of HL (para. 90). Although it was unclear whether the ward of HL was locked or not, the Court found that this was not a determinative question, since deprivation of liberty can occur in open wards as well (para. 92 with reference to **Ashingdane v UK [1985] 7 EHHR 528**).
2. As for the issue of **consent**, since HL lacked capacity he could not validly consent to his confinement. Compliance does not mean consent in the case of those who lack capacity.

#### **Who can be deprived of his or her liberty under DoLS?**

DoLS applies 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 are in their best interests**.<sup>9</sup>

Ad 1: Mental disorder within the meaning of the Mental Health Act but not excluding learning disabilities. This means any disorder or disability of the mind, including learning disabilities, but not including drug or alcohol dependence.

Ad 3: The safeguards apply to all hospitals and care homes but do not apply to people living in their own homes or in supported living arrangements other than a 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.

---

<sup>9</sup> Anthony Maden – Tim Spencer-Lane, *Essential Mental Health Law* (London: Hammersmith Press, 2010) pp. 209-210.

Ad 3: The deprivation of liberty authorisation does not authorise the treatment itself of the incapacitated person. For that, a separate authorisation is needed (*cf.* section 5.10-5.11 DoLS Code of Practice). Treatment can be necessary for both mental and physical illnesses: DoLS authorisations are often requested to treat the physical illnesses of mentally incapacitated persons.

## The process of authorisation<sup>10</sup>

There are two mechanisms to authorise deprivation of liberty under DoLS: the standard and the urgent authorisation.

### The process of standard authorisation

1. 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.<sup>11</sup>
2. The application is sent to the 'Supervisory Body' (for hospitals, it is the commissioning primary care trust; for care homes, it is the local authority).
3. The Supervisory Body appoints minimum two independent assessors to assess whether the 6 criteria for deprivation of liberty are satisfied.

There are two types of assessors: the Mental Health Assessor (a doctor with appropriate qualifications) and the Best Interests Assessor (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 (i.e. the hospital or care home) but must not be involved in the person's treatment or care.

The **six criteria** of assessment are the following:

- **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.
- **The Mental Capacity Assessment:** It must confirm that the person lacks the relevant decision making capacity (see also section 3 MCA). Mental Capacity Assessment can be carried out by anyone who is eligible to be a Best Interests Assessor or a Mental Health Assessor.
- **The Mental Health Assessment:** It must confirm that the person suffers from a mental disorder (as understood in the MHA + learning disabilities). It 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'. 'Unsound mind' is a condition of Art. 5 (1) (e) ECHR for deprivation of liberty. It is sometimes

---

<sup>10</sup> In this and the following two parts (parts 4, 5 and 6), I am relying on Chapter 14 of Anthony Maden – Tim Spencer-Lane, *Essential Mental Health Law* (London: Hammersmith Press, 2010) pp 207-223.

<sup>11</sup> *Ibid.* 210.

possible that a person lacks capacity but does not have a mental disorder (typically alcohol and drug addicts). These people fall outside of the scope of the DOLS.

- **The No Refusals Assessments:** It must confirm that the deprivation of liberty is not in conflict with an advance decision of the relevant person to refuse treatment or with a decision of a deputy (appointed by the CoP) or a donee (appointed by an LPA). It can be carried out by anyone who qualifies as a Best Interests Assessor.
- **The Best Interests Assessment:** This assessment must confirm that:
  - A deprivation of liberty is occurring, or going to occur;
  - It is in the best interests of the relevant person to be deprived of liberty;
  - The deprivation of liberty is necessary to prevent harm to the relevant person and it is proportionate to the seriousness of harm.

1. It is often unclear (even to the highest courts) whether a deprivation of liberty has taken place.
2. Best interests assessment, in general, is explained in section 4 MCA and 5.13 of the main Code of Practice. It contains a checklist of what should be taken into account during the assessment procedure.
3. The assessor is required to consult a range of people connected to the relevant person (carer, donee, deputy, family members, anyone explicitly named by the relevant person, etc.)

- **The Eligibility Assessment:** This assessment relates to the protected person's status under the Mental Health Act 1983.

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 following are only rough guidelines for orientation – the exact rules can be found in the MCA (Schedule 1A). These rules are explicated in the case law of the Court of Protection, most prominently in cases **W Primary Care Trust v TB & Others** and **GJ v The Foundation Trust**.

**The person who lacks capacity is eligible to DoLS if:**

- the proposed authorisation relates to a care home and not a hospital treatment
- the proposed authorisation relates to deprivation of liberty in a hospital for non-mental (i.e. physical) health treatment
- the proposed authorisation relates to deprivation of liberty
  - in a hospital for the treatment of mental disorder; and
  - the person does **not** object to the treatment.

**The person is not eligible to DoLS if:**

- he/she is already detained under the MHA
- he/she is subject to other MHA regime: guardianship, conditional discharge or leave of absence from detention
- the proposed authorisation relates to deprivation of liberty
  - in a hospital for the treatment of mental disorder;
  - the person **objects** to the detention; and

4. The six assessments must be concluded within 21 days after the request of the Managing Authority. If the person meets **all six criteria**, then the Supervisory Body issues the Standard Authorisation. This can last maximum **12 months**.

### **The process of urgent authorisation**

1. An urgent authorisation 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 standard authorisation would be necessary but cannot be obtained due to the urgency of the case.
2. In the urgent procedure, the Managing Authority issues a self-authorisation (without conducting the assessment procedures!) for the deprivation of liberty, but:
  - a. Urgent authorisation can last maximum 7 days and can be extended with another 7 days by the Supervisory Body.
  - b. The Managing Authority must file, as soon as possible, a request for standard authorisation.

### **Representatives and advocates**

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 and to appeal to the Court of Protection.<sup>12</sup> The representative is chosen by:

- the person being deprived of his/her liberty, if he/she has the capacity to make that choice;
- the person's deputy (appointed by the CoP) or donee (by an LPA); or
- the Best Interests Assessor or the Supervisory Body.

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. The IMCA may also initiate a review of the authorisation at the Supervisory Body.

### **Review and appeal procedures**

---

<sup>12</sup> Ibid. 216.

The Supervisory Body must review the standard authorisation if it is requested by the relevant person, the representative or the Managing Authority. The *main* ground for review is that the person no longer meets one of the six criteria described previously.

The relevant person, his representative, his LPA donee or deputy can appeal to the Court of Protection against the Supervisory Body's authorisation without permission.<sup>13</sup> All others must seek permission to appeal.

## Conclusion

Opinions are divided about the efficiency of DoLS. On the one hand, it is undoubtedly beneficial for the vulnerable hospital patients and care home residents. On the other hand, there was confusion among practitioners during the initial implementation period and errors were inevitably made. These errors may derive from the extreme complexity of the legislation together with the lack of adequate training. Many Best Interests Assessors and their managers, who make most of the crucial decisions, will have had no previous experience and received only one day's training of the new law.<sup>14</sup>

Opinions taken from a survey conducted among practitioners:<sup>15</sup>

'Although DoLS is a very bureaucratic and at times really frustrating process we feel that it is improving life experiences for people whose care involves deprivation of liberty. We are able to put in place short term authorisation, with conditions, and ensure we review the situation.'

'Relatives and care home staff often get defensive, saying that the person is not deprived of anything, we take care of them well.'<sup>16</sup>

'We have been doing training for care homes, but the matter is so complex and knowledge base so poor that a single presentation will no more than scratch the surface of what they need to know.'

---

<sup>13</sup> Ibid. 220.

<sup>14</sup> Deprivation of Liberty Safeguards: an Initial Review of Implementation. Briefing Paper of Mental Health Alliance (May 2010) p. 8.

<sup>15</sup> Ibid. 5.

<sup>16</sup> The original intention was to call DoLS 'Protective Care' since the name 'Deprivation of Liberty Safeguards' may carry negative connotations. Ibid. 14.

## Appendix - The Case Law of the Court of Protection related to DoLS

### Eligibility Assessment

#### GJ v The Foundation Trust (2009) EWHC 2972 (Fam) (Mr Justice Charles)

This case was primarily concerned with the interface between the MHA and the MCA (DoLS) regulations.<sup>17</sup>

GJ, a 65 year old man, suffers from vascular dementia and Korsakoff's syndrome as a result of his prolonged history of alcohol abuse. He also suffers from diabetes. As a result of his mental condition, he regularly neglects his insulin injections and has suffered hypoglycaemic attacks on multiple occasions. He was admitted to hospital treatment, first under the MHA and then under standard DoLS authorisation. While in detention, he was treated for diabetes and for his mental disorder which – being chronic and irreversible – 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 (in)eligibility for standard DoLS authorisation under Schedule 1A of the MCA.

Schedule 1A determines the sphere of people who are ineligible to DoLS. The first four categories (cases A to D) apply to people who are already subject to various provisions of the MHA (hospital treatment regime, community treatment regime, guardianship regime) and establish the person's ineligibility to DoLS in such cases. Case E deals with those people who are not subject to any of the mentioned regimes but are 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'.<sup>18</sup> These tests are based on paras. 12 and 5 MCA (respectively) and further clarified by Charles J in paras. 81-99 of his judgment.

- a. 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 are 'not ineligible' to DoLS and come under the scope of the MCA because learning disabilities are not associated with abnormally aggressive or irresponsible conduct.
- b. The **objection test** has two main parts (a. + b.):
  - a. The first condition is that the relevant instrument (e.g. the DoLS authorisation) authorises the person to be a **mental health patient**.
  - b. The second one is that the person must **object** to being a mental health patient.
  - c. A **mental health patient** is defined in para. 16 as someone accommodated in a '**hospital**' for the '**purpose of being given medical treatment for mental disorder**'.

---

<sup>17</sup> For an overview of this case, see Neil Allen, The Bournewood Gap (as Amended?), in Med. L. Rev. 2010, 18(1), 78-85. See also [\(http://www.mentalhealthlaw.co.uk/GJ v The Foundation Trust \(2009\) EWHC 2972 \(Fam\)\)](http://www.mentalhealthlaw.co.uk/GJ_v_The_Foundation_Trust_(2009)_EWHC_2972_(Fam)) (22.02.2011).

<sup>18</sup> Ibid. 80.

As to what this all means **in practice**, Charles J reasoned the following way:

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. has predominantly a physical illness) and 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. Thus, he was not a mental health patient and **he was eligible to DoLS**.

**To conclude**, the MHA has primacy in the application in borderline cases. If it fails on the test prescribed above, DoLS can be applied.

#### **W Primary Care Trust v TB & Others [2009] EWHC 1737 (Fam) (Mr Justice Wood)**

A similar case which had to deal with the question of 'ineligibility' to the DoLS regime. TB is a 41 year old woman with an acquired brain injury and an associated psychiatric disorder. 'She has been complaining of sensations in her head, neck and stomach ... she believes, for example, that blood is flowing from her brain into her stomach and down her left leg' (para. 4). TB, after being cared for by her parents and one of her brothers, was placed to a care home where she was detained under an urgent DoLS authorisation (after the DoLS regulations came into force in 2009). The eligibility assessor for the standard authorisation questioned TB's eligibility to DoLS stating that she (maybe) could also be detained under the MHA (she objected to being a mental health patient and is within the scope of section 2 or 3 of the MHA, therefore the status test and partly the objection test is fulfilled).

The Court, however, found that TB was not a 'mental health patient' as defined under schedule 1A (para 16.) because she was kept in a care home and not in a hospital. Thus, she is 'not ineligible' to DoLS and would be eligible to be deprived of her liberty if it were in her best interests to do so (next assessment). Best interests were not assessed in this judgment. As the Coda attached to the judgment reveals, TB committed suicide before the judgment was issued.

In both cases ineligibility failed on the first part of the objection test, namely on the definition of a 'mental health patient' (i.e. someone accommodated in a hospital for the purpose of being given medical treatment for mental disorder).

## Cases connected to the Authorisation Process

### **G v E & Others [2010] EWHC 621 (COP) (Mr Justice Baker)**

A complex case that received media attention because the local authority failed to comply with the newly enacted deprivation of liberty safeguards when removing the 'relevant person' from his foster family to a residential care home without initiating any kind of DoLS authorization. The Court found a violation of the protected person's right to liberty (Article 5 ECHR) and right to private life (Article 8 ECHR).

The application concerned E, a 19 year old man with severe learning disabilities.<sup>19</sup> Due to concerns over his care provided by his foster carer (F), 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 F or he should be cared for in a residential care home.

- (1) It was established that E lacked capacity and his detention in the care homes amounted to deprivation of liberty. Furthermore, the removal of E from F's care was an arbitrary act. There was no attempt to follow the procedure of urgent and standard DoLS authorisations which came into force **only** a few days earlier. There was a violation of E's right to liberty and private life.
- (2) It was in E's best interests to remain in the care home **until** the final hearing. No final decision was made in this judgment.

It was unclear whether E had received adequate care from F. On the one hand, there were fears that F mistreated E and that she could not handle E's changing (sometimes aggressive) behaviour. On the other hand, F was an integral part of E's life who had been his carer – his mother-figure – for most of his life. There was a 'deplorable failure' (para. 85) to take into account this close relationship when simply removing E from F's care and cutting off any contact for several months between them. Further investigation was ordered by the judge.

---

<sup>19</sup> 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).

### **Subsequent judgments in the case of E by Justice Baker**

#### **G v E, Manchester City Council and F [2010] EWHC 2042 (Fam) (Mr Justice Baker)**

Baker J decided to make public the name of the local authority that he found liable for the violation of E's Article 5 and Article 8 rights. He said 'it is important that the residents and council tax payers of the city of Manchester know what has happened so that the local authority can be held responsible.' On the other hand, he refused to make public the names of individual social workers because he felt that the violations were caused by the City Council which had failed to provide adequate training to its staff to prepare them for the introduction of the DOLS provisions.

The judgment also reports that since the previous judgment (in a different, unreported judgment) E was returned to F and 'all is going well' with him.

#### **G v E [2010] EWHC 2512 (COP) (Mr Justice Baker)**

This case deals with the question of appointing G and F as personal welfare and property and affairs deputies to E. The request for their appointment was rejected by Baker J. For further details, see p. 10 of the Court of Protection internal briefing document.

#### **G v E [2010] EWHC 3385 (COP) (Mr Justice Baker)**

The Manchester City Council was ordered to pay the costs of proceedings to G and F. Baker J stated that 'local authorities ... who carry out their work professionally have no reason to fear that a costs order will be made' but in the present case there had been a 'blatant disregard of the processes of the MCA' which justified the imposition of a costs order.

### **The case of E before the Court of Appeal**

#### **G v E [2010] EWCA Civ 548 (Lord Neuberger of Abbotsbury and Lord Justice Munby)**

This decision grants permission to appeal to the judgment of Baker J in G v E & Others [2010] EWHC 621 (COP).

#### **G v E [2010] EWCA Civ 822 (Sir Nicholas Wall, Lord Justice Thorpe, Mr Justice Hedley)**

The appeal decision of G v E & Others [2010] EWHC 621 (COP). The appellant (G) complained that Baker J did not take into account the conditions necessary for deprivation of liberty in Article 5 (1) (e) cases devised by the ECtHR in the **Winterwerp decision** (Winterwerp v The Netherlands 6301/73 [1979] ECHR 4). These conditions – inter alia – require (a.) objective medical evidence of unsoundness of mind and (b.) that the mental disorder is of a kind or degree warranting compulsory confinement (ibid. para. 39). In other words, there is a minimum threshold of mental illness that is necessary for deprivation of liberty which – according to G – was not met in E's case. The Court of Appeal rejected this argument.

It contended that the MCA is mostly addressed to those who are not mentally ill in the strict 'MHA' sense of the word. 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, the issue has involved alleged mental illness and detention in a psychiatric hospital' (para 59). Application of the Winterwerp conditions to the DoLS would render the system unworkable. Thus, the present system does not violate Article 5 (1) (e) ECHR.

### **Re MB [2010] EWHC 2508 (COP) (Mr Justice Charles)**

Mrs B suffered from dementia caused by Alzheimer's disease. She was living with her husband for 56 years. Concerns were raised that Mr B was unable to continue caring for his wife because he repeatedly slapped, held or restrained her when she had become agitated (para. 14). Mrs B had been admitted to a care home under an urgent and then under a standard DOLS authorisation. 'Prior to the expiry of the standard authorisation, a further standard authorisation was sought, but the best interests assessor concluded that the best interests requirement was no longer met.'<sup>20</sup> Being away from home, Mrs B demonstrated serious signs of emotional and physical distress (e.g. she lost a significant amount of weight during her stay at the residential home). The local authority did not know what to do and after some confusion it decided to issue a second urgent authorisation to continue with the detention of Mrs B.

The Court found this authorisation unlawful. According to the DOLS regulations, detention could only have been extended by a standard authorisation or by court order. Interestingly enough, the good quality of care was not disputed in the case. Contrary to the best interests assessor, the judge considered that the continued detention of Mrs B was in her best interests. However, a deprivation of liberty, even if it is in the best interests of the protected person, does not become lawful if there is no lawful authorisation or court order in place.<sup>21</sup>

The case shows the unpreparedness of authorities when it comes to the application of deprivation of liberty safeguards.

### **Re KH, DCC v KH, PJ and others (COP 11729380, 11 September 2009, unreported) (District Judge O'Regan)**

This was an emergency application heard by a District Judge in a telephone hearing.<sup>22</sup> By a previous court order provision was made for KH, a young man, to have increasing levels of contact with his

<sup>20</sup> Thirty Nine Essex Street Court of Protection Newsletter: November 2010 (eds. Alex Ruck Keene and Victoria Butler-Cole) pp. 5 ff.

<sup>21</sup> Ibid. 6.

<sup>22</sup> See Court of Protection Report 2009 p. 16. See also [http://www.mentalhealthlaw.co.uk/DCC\\_v\\_KH\\_\(2009\)\\_COP\\_11729380](http://www.mentalhealthlaw.co.uk/DCC_v_KH_(2009)_COP_11729380) (22.02.2011).

mother, PJ. KH had threatened that when he went to see his mother on Monday 14 September, he would not return to his placement after the meeting.<sup>23</sup> DCC, the local authority, sought an order authorising the deprivation of the liberty of KH for the purpose of returning him to his placement. It relied on paragraph 2.15 of the DOLS Code of Practice. The paragraph reads:

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 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.

The District Judge held that the application was not necessary because there was already **a standard DOLS authorisation in place which covers the transportation aspects** as well. Paragraph 2.15 only refers to cases where a standard authorisation is not yet in place; separate court order is only necessary in such cases.

**Re P [Scope of Schedule A1] (COP, 30 June 2010, unreported) (Mr Justice Mostyn)**

This decision is the **re-affirmation** of the previous one.<sup>24</sup> The judge considered whether the powers under an existing standard authorisation extend to coercing the protected person back to the nursing home if he or she refused to return. He noted that it would be absurd if the care home had powers to restrain someone from leaving but not to compel him to return, and that the greater power must include the lesser.

---

<sup>23</sup> Ibid.

<sup>24</sup> See Thirty Nine Essex Street Court of Protection Newsletter: December 2010 (eds. Alex Ruck Keene and Victoria Butler-Cole) pp. 1-2.

## The Notion of ‘Deprivation of Liberty’

### Re MIG and MEG; Surrey County Council v CA [2010] EWHC 785 (Fam) (Mrs Justice Parker)

The case is primarily concerned with the boundaries of deprivation of liberty.<sup>25</sup> MIG and MEG, two sisters aged 17 and 18, have 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 behavior she exhibits from time to time. The question was whether these placements constituted deprivations of liberty.

The judgment contains a thorough overview of the relevant case law of the European Court of Human Rights (*Guzzardi v Italy*, *Engel v The Netherlands*, *Nielsen v Denmark*, *Storck v Germany*, *HL v UK*). Justice Parker makes the following observations:

- It is possible for deprivation of liberty to occur in a domestic setting (para. 199). The House of Lords previously held that 18 hours a day confinement in a small flat constituted deprivation of liberty.
- The question arises whether and, if yes, to what extent **subjective** elements (e.g. intentions, motivations of the detainer) should also be taken into account. Justice Parker’s position seems to be a bit incoherent on this. She states that even if it is not the detainer’s intention to deprive someone of his liberty, deprivation can occur. Benign intentions are not relevant to the issue of whether or not someone is objectively being deprived of liberty.<sup>26</sup> See: Austin case (kettling of protestors - *Austin v Commissioner of Police of the Metropolis* [2009] UKHL 5)

The judge concludes that **neither** MIG nor MEG is deprived of her liberty (paras. 233-34) because:

- **‘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 ... so as to meet her care needs rather than to restrain her in any way...’
- **‘No other arrangements less restrictive or invasive could be devised that would meet their care needs.’**

---

<sup>25</sup> See [www.mentalhealthlaw.co.uk/Re MIG and MEG \(2010\) EWHC 785 \(Fam\)](http://www.mentalhealthlaw.co.uk/Re_MIG_and_MEG_(2010)_EWHC_785_(Fam)) (22.02.2011). See also Thirty Nine Essex Street Court of Protection Newsletter: October 2010 (eds. Alex Ruck Keene and Victoria Butler-Cole) pp. 1-2.

<sup>26</sup> It is a disputed issue if subjective elements should or should not be taken into account when determining deprivation of liberty. There is a tendency in the High Court to take subjective elements into considerations as well. See *Re RK* [2010] EWHC 3355 (COP) (parental consent as subjective element to deprivation of liberty).

**P & Q v Surry County Council [2011] EWCA Civ 190 (Lord Justice Mummery, Lady Justice Smith and Lord Justice Wilson)**

The Court of Appeal (Civil Division) handed down its judgment on the appeal of the case of MIG and MEG on 28 February 2011. Lord Justice Wilson delivered the opinion of the Court. 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. The Court clarified what elements (besides the duration, intensity, type, etc. of the detention) are relevant when assessing the objective conditions:

1. **Happiness** is irrelevant as to the existence of deprivation of liberty. It plays a role in the best interests assessment.
2. 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.
3. The relative **normality** of the living arrangements (i.e. least restrictive means).

The Court found no deprivation of liberty in the case of Q (MIG) and P (MEG). For a detailed analysis, see: <http://thesmallplaces.blogspot.com/2011/02/more-trouble-with-meg-now-q.html>. See also Thirty Nine Essex Street Court of Protection Newsletter: March 2011 (eds. Alex Ruck Keene and Victoria Butler-Cole).

**BB v AM (2010) EWHC 1916 (Fam) (Mr Justice Baker)**

This case concerned a thirty-one year old Bangladeshi woman known as BB.<sup>27</sup> She is deaf and suffers from schizoaffective disorder and learning difficulties. After being ill-treated by her parents, she was admitted to the psychiatric unit of a hospital. Two questions arose before the Court: (1) Would she be eligible to be admitted to the hospital under section 2 and 3 of the MHA instead of a DoLS authorisation? (2) Was she deprived of her liberty in the psychiatric hospital?

Ad (1): Justice Baker found that BB was not 'detainable under the Mental Health Act because she is happy to stay in hospital and take medication. She has made no attempts to leave. She reports being happy.' (para. 26)

---

<sup>27</sup> See also Thirty Nine Essex Street Court of Protection Newsletter: August 2010 (eds. Alex Ruck Keene and Victoria Butler-Cole) pp. 1-3.

Ad (2): Justice Baker found that BB was deprived of her liberty in the hospital (para. 32). She was under sedation and the staff exercised control over her care, movements, residence and contacts with the outside world.

### **Re RK; YB v BCC [2010] EWHC 3355 (COP) (Fam) (Mr Justice Mostyn)**

This case was about a 17.5 year old girl known as RK.<sup>28</sup> Among others, 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 where she resided.

The Court ruled that the **objective conditions** for deprivation of liberty have not been 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)

The Court ruled 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.

RK is obviously incapable of giving her own consent. The situation of HL in the Bournemouth case is very similar, except that HL is an adult and no one exercises parental powers over him. Thus, he becomes eligible to DoLS protection. Different levels of protection depending on age?
--

The **third element** of the test is not satisfied either. Mostyn J writes that 'RK's placement at KCH is at the behest of her parents. It cannot be imputed to the state.' (para. 43)

---

<sup>28</sup> See also Thirty Nine Essex Street Court of Protection Newsletter: January 2011 (eds. Alex Ruck Keene and Victoria Butler-Cole) pp. 3-4.