

Briefing

For: Health and Social Care Providers

Date: 16/04/2014

Deprivation of liberty in health and social care

Issue

On 19 March 2014, the Supreme Court handed down its judgment in the case of “P v Cheshire West and Chester Council and another” and “P and Q v Surrey County Council”.

[Read the full judgment on the Supreme Court's website](#)

The judgment is important for deciding whether arrangements made for the care and/or treatment of an individual who might lack capacity to consent to those arrangements amount to a deprivation of liberty: it has widened and clarified the definition of deprivation of liberty.

A deprivation of liberty in such a situation must be authorised in accordance with one of the following legal regimes: a deprivation of liberty authorisation or Court of Protection order under the Mental Capacity Act Deprivation of Liberty Safeguards, or (if applicable) under the Mental Health Act 1983, or, in some rare situations, under the inherent jurisdiction of the High Court.

Information for providers and CQC Inspectors

Following the Supreme Court judgement on 19 March 2014, health and social care staff, and CQC inspectors, must be aware of how they should now judge whether a person might be deprived of their liberty.

It is clear that the intention of the majority of the Supreme Court was to extend the safeguard of independent scrutiny.

They said: “A gilded cage is still a cage” and that “we should err on the side of caution in deciding what constitutes a deprivation of liberty.” They also highlighted that a person in supported living might also be deprived of their liberty.

It is certain that, following this judgement, many more requests for authorisations under the deprivation of liberty safeguards will be made for people in hospitals or care homes. Since the deprivation of liberty safeguards apply only in hospitals and care homes, it is also certain that many more applications will be made to the Court of Protection for those in domestic settings with support.

The deprivation of liberty safeguards code of practice lists the factors which may indicate a deprivation of liberty: these are still relevant but must now be read in the light of this decision of the Supreme Court.

[Read the deprivation of liberty safeguards code of practice](#)

The Supreme Court has now confirmed that there are *two key questions* to ask:

Is the person subject to continuous supervision and control? *It is still not clear what exactly this means: but the three cases in the Annex to this guidance show how wide the definition appears to be.*

AND

Is the person free to leave? *The person may seem happy to stay, but the issue is about how staff would react if the person did try to leave or if relatives/friends asked to remove them permanently.*

It is now clear that if a person lacking capacity to consent to the arrangements is subject both to **continuous supervision and control and not free to leave**, they are deprived of their liberty.

It may not be a deprivation of liberty, although the person is not free to leave, if the person is not supervised or monitored all the time and is able to make decisions about what to do and when, that are not subject to agreement by others.

The Supreme Court ruled that the following factors **are not relevant to whether or not someone is deprived of their liberty**:

1. the person's compliance or happiness or lack of objection;
 2. the suitability or relative normality of the placement (after comparing the person's circumstances with another person of similar age and condition); or
 3. the reason or purpose leading to a particular placement
- though of course all these factors are still relevant to whether or not the situation is in the person's best interests, and should be authorised.

If a provider suspects, from the initial care plan or prior knowledge of the person, that someone coming in to their care may be deprived of liberty, the authorisation should be in place before the person arrives. It protects the person's rights; it does not mean they have to restrict the person's freedoms unless they have to do so in the person's best interests.

Whenever a person might lack the mental capacity to make their own decisions about care or treatment, providers must work within the principles of the Mental Capacity Act, for example by doing everything possible to empower people to make as many decisions for themselves as they can.

Care plans for people lacking mental capacity to agree to arrangements for their care or treatment should show evidence of best interests decision-

making in accordance with the Mental Capacity Act, based on decision-specific capacity assessments.

In particular, providers should ensure that restrictions on the freedom of anyone lacking capacity to consent to them are proportionate to the risk and seriousness of harm to that person, and that no less restrictive option can be identified. Useful guidance on care planning within an empowering ethos is available in the Mental Capacity Act main code of practice.

[Read the MCA code of practice on the Ministry of Justice website](#)

Points to note, arising from this judgement:

(1) *Widening of scope:* The annex to this guidance gives a short account of the cases that were considered by the Supreme Court. These clarify for providers of care to people with learning disabilities the sort of situations that now may come within the definition of deprivation of liberty, but which might not have been recognised as such before the Supreme Court judgement. It is clear, however, from the way the deprivation of liberty safeguards are used already, that the many of the people who might be deprived of their liberty in their own best interests are older people, often in care homes (currently about 75% of all authorisation requests). Following this judgement, more older people at risk of deprivation of liberty are likely to be identified in domestic settings such as supported living or extra-care housing. They are living with dementia or with acquired brain injury, for example from a stroke, or with neurological conditions such as Parkinson's disease or Huntington's disease; they often have complex health and care needs.

A typical situation that might now fall within the expanded definition of deprivation of liberty is that of an older person with dementia, living at home with considerable support. Staff monitor her well-being continuously at home because she forgets to eat, is unsafe in her use of appliances, and leaves the bath taps running; she is accompanied whenever she leaves her home because she forgets where she lives and is at risk of road accidents or abuse from others. She shows no sign of being unhappy or wanting to live elsewhere, but, in her best interests, she would not be allowed to leave to go and live somewhere else even if she wanted to.

(2) *What is relevant to identifying a deprivation of liberty:* It is essential to separate the question of whether restrictions amount to a deprivation of liberty, in terms of the new Supreme Court test above, from whether staff actions are necessary, proportionate, and in the person's best interests. The former determines whether the situation must be assessed independently: the latter are crucial to deciding whether it will be authorised as being in the person's best interests. The most important step for providers who suspect that they may be depriving someone of their liberty is to reduce restraint and any restriction on the person's freedoms wherever possible.

(3) *In a hospital or care home:* where it seems likely that a person is being deprived of their liberty, and this seems to be in the person's best interests, a referral to the Local Authority deprivation of liberty safeguards team should be made by the provider. If they have not done so even after prompting, a

third party, such as a CQC inspector, can contact the local authority directly. If it is apparent that a person lacking capacity to consent to a forthcoming admission to hospital or a care home might be deprived of their liberty, the provider must seek the authorisation in advance of that admission wherever possible.

(4) *In a psychiatric inpatient setting*, clinical staff may want to review the situation of all informal patients who lack mental capacity to consent to admission, and consider if they are deprived of their liberty. If they are at risk of being deprived of their liberty, the first step is to scrutinise the care plan to see if this could be safely altered to reduce the restrictions so there is no longer a deprivation of liberty. If this is not possible then the provider must decide between using the Mental Health Act and the MCA deprivation of liberty safeguards to protect the person's rights. The criteria for deciding between these have not been changed by this judgement. Professionals should not assume one regime is "less restrictive" than the other. It is the care plan which imposes the restrictions, not the procedural safeguards that are required if these restrictions amount to a deprivation of liberty.

(5) *For all other settings*, such as supported living, adult placement/shared lives or domiciliary care, the deprivation of liberty safeguards cannot be used, so an application must be made to the Court of Protection.

In these settings, care providers (where appropriate, with local authority care managers) should examine the situation of people who lack the mental capacity to agree to their living arrangements, to see if they appear to be deprived of their liberty in the light of the Supreme Court judgement. They may wish to seek legal advice, and liaise with the commissioners of the service, if they think they might be depriving someone of their liberty and cannot find a less restrictive option for providing care or treatment.

While this is happening, they must continue to provide care and attention to the person.

(6) *CQC inspectors* must continue to expect providers to work within the law. Inspectors remain an important safeguard of the rights of vulnerable people who use services, and always have the right and duty to take action as they see fit to ensure this. In the very short term, however, while waiting for further national guidance, it will in many situations be sufficient evidence of providers' attempts and intention to work within the changes brought in by the Supreme Court judgement if they can demonstrate that they are:

- aware of the outline of the judgement, hence reviewing (where appropriate, with care managers or commissioners of their services) situations that might now be brought into the widened definition of deprivation of liberty. The purpose of this review is to assess if the restrictions can safely be reduced or the person's capacity enhanced so that they can make relevant decisions for themselves; *and*
- in discussion with commissioners of services, and as appropriate either liaising with the local authority supervisory body for the deprivation of liberty safeguards or seeking legal advice, as to how to ensure the protection of the human rights of vulnerable people who use services.

(7) Providers must notify CQC of all applications to deprive someone of their liberty, whether through the deprivation of liberty safeguards or by applying to the Court of Protection, and their outcomes.

[Read our guidance on notifying deprivations of liberty](#)

Providers and Inspectors must remember that authorisations under the Mental Capacity Act are NOT transferrable. Those given under the deprivation of liberty safeguards only cover that particular hospital or care home. Court Orders only cover what they say they cover.

This is not a full statement of law but is designed to help providers and CQC staff understand the practical implications of the Supreme Court judgement.

Annex: The examples which the Supreme Court decided were deprivation of liberty

1. An adult (P) with a learning disability living in a bungalow with two other residents, with two members of staff on duty during the day and one 'waking' member of staff overnight. He requires prompting and help with all the activities of daily living, getting about, eating, personal hygiene and continence. P requires further intervention including restraint to stop him harming himself, but is not prescribed any tranquilising medication. He is unable to go anywhere or do anything without one to one support; he gets 98 hours a week of personal support to enable him to leave the home frequently for activities and socialising.

2. A 17 year old (Q, or MEG) with mild learning disabilities living with three others in an NHS residential home for learning disabled adolescents with complex needs. She has occasional outbursts of aggression towards the other three residents and then requires restraint. She is prescribed (and administered) tranquilising medication. She has one to one and sometimes two to one support. Continuous supervision and control is exercised so as to meet her care needs. She is accompanied by staff whenever she leaves. She attends a further education unit daily during term time, and has a full social life. She shows no wish to go out on her own, but she would be prevented from doing so in her best interests.

3. An 18 year old (P, or MIG) with a moderate to severe learning disability and problems with her sight and hearing, who requires assistance crossing the road because she is unaware of danger. She lives with a 'foster mother' (commonly called adult placement, or shared lives) whom she regards as 'mummy.' Her foster mother provides her with intensive support in most aspects of daily living. She is not on any medication. She has never attempted to leave the home by herself and showed no wish to do so, but if she did, her foster mother would restrain her in her best interests. She attends a further education unit daily during term time and is taken on trips and holidays by her foster mother.