Cheshire West and its impact on Mental Health and Mental Capacity Lawyers

The Supreme Court gave judgment on 19th March 2014 in two linked appeals: (1) P v Cheshire West and Chester Council and another; (2) P and Q v Surrey County Council [2014] UKSC 19. Both appeals were brought by the Official Solicitor, who had acted as litigation friend for all of them.

This paper attempts to provide a brief summary of the judgments and then looks at the potential impact on the work of mental health and mental capacity lawyers. It represents the writer's personal views and does not purport to give legal advice.

The Issues

This case concerned the living arrangements of 3 adults without capacity to consent to their residence and care arrangements. The question was whether the arrangements amounted to a deprivation of liberty. A feature in respect of all 3 individuals was that it was not suggested that the arrangements were more restrictive than any of them required. Nor did any of them appear dissatisfied with the arrangements which were all held to be benevolent and in the person's best interests.

If the arrangements constituted a deprivation of liberty then the appellants would be entitled to the procedural safeguards of Article 5-

- Article 5 ECHR:
- 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 of unsound mind…..
- Procedure prescribed by law: Mental Health Act 1983, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Article 5(4) : provides the right to challenge detention

The European Court of Human Rights ("the ECtHR") has made clear that a deprivation of liberty has three elements:

(a) "the objective element of a person's confinement to a certain limited place for a not negligible length of time": Storck v. Germany (2005) 43 EHRR 96; the “concrete situation”Guzzardi v Italy (1980) 3 EHRR 333.

(b) the "additional subjective element [that] they have not validly consented to the confinement in question":

(c) the confinement must be "imputable to the State": Storck at [89].

The Facts

Re MIG and MEG [2010] EWHC 785 (Fam) P and Q [2011] EWCA Civ 190

MIG and MEG were sisters from a chaotic and abusive background. They became the subject of care proceedings in 2007. MIG had moderate to severe learning disability (mental age 2.5); impaired sight and hearing, communication difficulties. She lived with her foster mother who provided intensive support for her, and to whom she was devoted.

MEG had mild/moderate learning disability (mental age 4); her behaviour was more challenging than her sister's and she required medication and sometimes restraint.

Both sisters had access to education, family contact and social lives.

Parker J held that neither was deprived of her liberty and that their lives were “dictated by their own cognitive limitations….they are there to receive care”.

This was upheld by Court of Appeal, with the comment:

"I entirely ignore the fact that, were this appeal to be allowed, the vast, if unquantifiable, number of necessary reviews of such a character would surely be beyond the present capacity of the Official Solicitor's department and in particular of the Court of Protection. To have an eye to that factor would be to raise to it the wrong end of the telescope. The importance of the right to liberty is paramount

(*McKay v. UK* (2006) 44 EHRR 827, at [30]) and the state's positive obligation to provide the facilities necessary for its effective exercise is absolute."[para 5]

Cheshire West and Chester Council v P [2011] EWHC 1330 (Fam); [2011] EWCA Civ 1257

P had cerebral palsy and Downs Syndrome. He needed 24 hour care including prompting with activities of daily living including hygiene and continence. He wore a “bodysuit” and required invasive interventions including “fingersweep” to mouth to stop him ingesting harmful substances, such as his incontinence pads. Baker J held that placement was a deprivation of his liberty

The Court of Appeal decided this was not a deprivation of liberty:

Munby LJ gave the judgment. He was concerned that the need to identify the concrete situation of the person concerned could lead to the "worrying and ultimately stultifying conclusion that the detail in every case can be safely arrived at only after a minute examination of all the facts in enormous detail."[para 38]

The answer was the question of the relevant comparator: who should you compare P with?

The relevant comparator was “the kind of lives that people like X would normally expect to lead”.

The Supreme Court

All seven judges upheld P's appeal; and a majority of 4 upheld MIG's and MEG's appeal. It was noted that s 64(5) MCA provided that "In this Act, references to a deprivation of liberty have the same meaning as in article 5(1) of the European Convention." Rather than simply take account of European jurisprudence (s2 HRA 1998) the Supreme Court accepted the need to turn directly to the Strasbourg authorities.

Lady Hale gave the lead judgment, with which Lord Sumption agreed. She stressed the universal nature of human rights and said

"It is axiomatic that people with disabilities …have the same human rights as the rest of the human race….This flows inexorably from the universal charter of human rights…and is confirmed in the UNCRPD" [para 45]. Disability places special obligation on state and others to cater for special needs of the disabled. Deprivation of liberty is the same for those with or without disabilities [para 46]. Lady Hale rejected the concept of relative normality. The homelike settings of MIG and MEG did not equate to the lives of other teenagers [para 47].

Lady Hale asked if there was an "acid test" for deprivation of liberty. She identified the key features from the Strasbourg jusrisprudence. The issue of whether P was under continuous supervision and control and not free to leave was a key feature in the following cases: HL v UK (2004) 40 EHRR 761, Stanev v Bulgaria (2012) 55 EHRR 696, DD v Lithuania (Application 13469/06, 12.2.2012;Kedzior v Poland (Application 45026/07, 16.10.2012, Mihailovs v Latvia (Application 35939/10)
under continuous supervision and control and not free to leave [para 49]. There is no list of criteria but some factors are NOT relevant.

IRRELEVANT FACTORS:

- compliance or lack of objections
- relative normality
- reasons/ purpose

Tacit acceptance, or contentment, did not affect the question. That raised the risk that those with least capacity to object would lose protection [55,67,81].
It was right to err on side of caution because of the extreme vulnerability of people like P, MIG and MEG [57]. Lady Hale was at pains to stress that no stigma arises from the fact that the procedural safeguards of Article 5 are needed and these could be simplified.

Lord Neuberger agreed with Lady Hale and Lord Sumption and stated that "the approach proposed by Lady Hale appears to me to be attractive and should be

adopted unless there is good reason not to follow it. He allowed both appeals as did Lord Kerr.

Lords Clarke, Hodge and Carnwath did not agree with the "acid test" approach:

- Lady Hale's approach went beyond Strasbourg jurisprudence and cases bore alternative interpretations. There is no decisive test.
- A court had authorised the arrangements for MIG and MEG as being in their best interests
- Comparator is person with unimpaired health and capacity; but it is relevant that intrusion no greater than required
- No one would describe "people living happily in a domestic setting as deprived of their liberty."

"Grey areas"

On the face of the judgment the following seem to be areas for future dispute:

- Lady Hale envisaged the potential for someone to be under continuous supervision and control but still free to leave; or not free to leave but where there is not continuous control and supervision. In these cases the person would not be deprived of his/her liberty.
- Where does "support" become "supervision" and control?
- In what circumstances might there be "good reason" not to adopt Lady Hale's approach?

The Implications

A week before the judgment the House of Lords Select Committee on the MCA was highly critical of the Deprivation of Liberty Safeguards and recommended that the Government should "start again". The Committee also criticised the inconsistent arrangements for access to legal aid and suggested that the resources of the Official Solicitor's office could be increased. The Government has until May to respond to the

report. The comments of Lady Hale at paragraphs [9[(when she referred to the "bewildering complexity" of the safeguards and [10] of her judgment when the referred to the bureaucracy of the procedures, and at [57] add to the case for change.

The Department of Health has issued guidance and a copy of the letter is attached to this paper.

This part of the seminar looks at particular groups of people who may seek advice, either directly or through third parties, and the kind of issues solicitors may find themselves advising on.

A. Informal patients at psychiatric hospitals, lacking capacity.

S131 MHA allows the informal treatment of patients with their consent. Patients lacking capacity to consent to admission and treatment to hospital can be admitted and treated under the MCA . The Code of Practice deals with this at paragraph 4.14. But that does not allow deprivation of liberty. HL v UK *45508/99)*dealt with the position of such a patient.

This is a very grey area, even for patients with capacity. Many will have advised clients who have called up from a ward and said they are informal but have been told that if they try to leave they will be sectioned. It is very questionable whether such patients are validly consenting. Many patients in this situation take a pragmatic position and do not force the issue.

The Code emphasizes that “Permission given under any unfair or undue pressure is not consent” (23.31). The most recent CQC report: Monitoring the Mental Health Act 2012/3 continued to find evidence of de facto detention in its inspection. It also commented on the amount of restrictive practices on learning disability wards and units.

http://www.cqc.org.uk/sites/default/files/media/documents/cqc_mentalhealth_2012_13_07_update.pdf

The Department of Health has issued guidance that the circumstances of patients lacking capacity should be reviewed. Cheshire West has issued a briefing to its AMHPS which states that the category of an informal patient [lacking capacity] "no longer exists. An incapacitated patient can now only be admitted to hospital either under the MHA or Deprivation of Liberty Safeguards."

What is the position of a long stay patient, perhaps with autism/LDs in a rehabilitation unit, not receiving medication, but taking part in a very structured timetable, with family visits during hospital visiting hours and trips out when his/her family were available as well as trips arranged by staff?

Applying the “acid test” this patient would probably be deprived of his liberty as s/he is not free to leave and under complete supervision and control of the staff.

They are entitled to the procedural safeguards of either the MHA or DOLS – the interface is considered below below.

- Are we going to see more detentions under the MHA? Is this going to lead to a need for increased matter starts for lawyers with mental health contracts with the Legal Aid Agency? What are the implications for s117 aftercare?
- Is it really the case that there will be *no* incapacitated patients who are not deprived of their liberty when being treated for mental disorder in hospital?

B. Patients subject to the MHA

Advisers will need to exercise caution when considering the alternative arrangements for patients detained under the MHA whose cases are to be considered by a Tribunal, if they lack capacity to consent to admission and treatment in hospital and/or to make decisions about their residence in the community. This will particularly be important if advisers are appointed under Rule 11(7) where broadly their responsibilities are:

- to ascertain and follow the patients wishes unless these are not “properly arguable”
- if they cannot ascertain the patient’s wishes- perhaps because the patient is non-verbal- to ensure the Tribunal has all relevant material and promote the patient’s right to treatment in the least restrictive setting.

AM v SLAM NHS Foundation Trust (2013) UKUT 365 (AAC), provides guidance about how the Tribunal should approach patients where the choice is between treatment in hospital under the MHA and treatment in hospital informally under the MCA or DOLS. As has been seen in paragraph A, following the SC judgment, the number of “informal” patients whose circumstances should now been seen as a DoL will probably increase. AM in any event recommended a cautious approach- if there is a possibility that cannot sensibly be ignored that the patient will be deprived of their liberty then a framework authorizing this will be needed. This should be the best and least restrictive way of ensuring that the assessment and treatment needed is provided.

In nearly all cases where treatment in hospital for mental disorder is needed, the MHA is the less restrictive way of depriving P of his/her liberty than DOLS, and this advice is strengthened by the approach of the House of Lords Select Committee. It is hard to identify a dependable advantage to being deprived of your liberty in a psychiatric hospital under DOLS rather than the MHA.

However advisers will be familiar with cases where efforts have been made to seek to avoid using the MHA because of (a) concern about objections by nearest relatives or (b) concerns about s117 liability. There may be a risk of these factors coming into play when decisions are made as to which legal framework is used.

What about the situation when P is under s3 and the plan is to discharge P to residential accommodation? P might be an elderly person with dementia where the plan is to move him/her to residential accommodation. Many local authorities and CCGs and Trusts have recognized that if P or a family member objects to such a placement an application should be made to the COP for a welfare application, even if it is intended that DOLS should be used once P has moved.

If P does not object to the move to residential care, however, the adviser needs to consider what the arrangements in the proposed home will be. On the application of the "acid test" there will be an increase in cases where a standard authorization will need to form part of P's s117 package. Advisers will need to consider raising this at CPA meetings or with care co-ordinators. Tribunals will be assisted if they know that consideration has been given to applying for an authorization, or, if P is to be deprived of his/her liberty in supported living, applying for an order in the COP.

Conditionally discharged restricted patients are sometimes seen to present particular problems, because of the ruling in Secretary of State for Justice v (1) RB and (2) Lancashire Care NHS Foundation Trust [2011] EWCA Civ 1608. The Court of Appeal said

"I conclude that a tribunal cannot rely on a patient's best interests as a ground for ordering conditional discharge on terms that involve a deprivation of liberty. This is more particularly so if the detention would not be for the purpose of any treatment"[para 66].

The Court was concerned that the conditional discharge regime was not Article 5 - compliant. RB had capacity to consent to his placement so the Court's attention was not drawn to the existence of DOLS or specifically to Schedule 1A Case B, which anticipates the possibility of a DOLs authorization running alongside a conditional discharge. Parliament, assuming it understood the safeguards, can only have intended it to be possible for a patient to be both deprived of their liberty in their best interests under an authorization and have their movements restricted in the public interest under DOLS.

Scenario: an elderly s37/41 patient with an anti-social personality disorder and history of serious offending is detained in a MSU. He has dementia and lacks capacity to make decisions about residence and care. He has been on s17 leave to a care home which is willing to offer him a place. He goes out only in the company of staff and this is both to ensure his safety and prevent offending. The concept of relative normality cannot now justify a finding that his situation is sufficiently similar to the sort of life 'that people like X would normally expect to lead" and that as a result he is not deprived of

his liberty. Applying the acid test, P would be deprived of his liberty. A conditional discharge alone cannot therefore impose these conditions on him. However a conditional discharge specifying the place of residence could run alongside a standard authorization. DN v Northumberland Tyne and Wear NHS Foundation Trust [2011] UKUT 327 clearly envisages Tribunals "discharging" patients to -for example- a care home where they could be subject to DOLS.

- Will these issues increase the number of "escape" cases for the purpose of legal aid?
- Will there be increased enquiries to managing authorities and supervisory bodies (ie local authorities) from Tribunals?
- The conditions of those on CTOS and under guardianship will need re-examination.

C. **Children**

What is the position concerning disabled children who are placed with foster parents? Following Cheshire West, if the living arrangements mean that the child is under continuous control and supervision and not free to leave, Article 5 may be engaged. What will be the forum for obtaining authorization? How will these cases be identified?

Guidance has recently been issued by the President of the Court of Protection and Ofsted about deprivations of liberty in children's homes and residential special schools. This confirms that :

- Applications to the Court of Protection to authorize deprivations of liberty should not be made if such an order would involve the establishment concerned in acting outside the regulations that govern it. Therefore non-secure children's homes and residential special schools (non-maintained and independent) must not apply to the Court for permission to deprive children of their liberty because the Court cannot give them permission to break the regulations.

- The Code of Practice to the Mental Health Act and other guidance may be relevant but does not over-ride the Regulations and Guidance directed towards children's homes and schools.
- Providers are reminded that no application can be made to the Court of Protection in relation to any child under 16 and that DOLS authorizations apply only to those aged 18 or over, in hospitals or registered care homes.

D. Residents of registered care homes

There is likely to be a significant increase in the use of DOLS in respect of residents in care homes.

- Apart from the workloads of assessors, are there sufficient IMCAs?
- Is this going to increase the number of challenges to the Court?
- Is this going to result in increased numbers of family members seeking advice?

E. P in supported living/their own tenancy cared for by paid carers provided directly by their LA/CCG or direct payments

The number of people receiving care in their own homes is set to increase following the post-Winterbourne view concordat. Article 5 could be engaged depending on the level of control required and the "free to leave" test. DOLS cannot be used so an application to the Court would be needed.

- Those providing or commissioning care to people living in their own homes will need to consider the proposed arrangements very carefully.
- If Article 5 is engaged then DOLS cannot be used so the only avenue is an application to the Court of Protection.
- Unlike a challenge to an authorization under DOLS P will not be eligible for non-means-tested legal aid. Given the findings of the Select Committee it would seem only a matter of time before there is a challenge to the current legal aid regulations.

- What arrangements will be made for the ongoing representation of P? P will need a litigation friend while an order is sought from the Court of Protection, but will there be an equivalent to a RPR after the orders are made?
- Who will identify these cases?

F: P living with family members providing care

For Article 5 to be engaged the arrangements have to be "imputable to the State". If the local authority is providing no support at all- not even for example through direct payments- then this test would not be satisfied.

A Local Authority v A (A Child)& Anor [2010] EWHC 978 (Fam) concerned arrangements for two disabled individuals, one adult and one child, being cared for in their own homes, by their families. The relevant local authorities were providers of support under their community care obligations and the arrangements were not "imputable to the state". However the local authority will have positive obligations under Article 5 as Munby LJ set out below:

> 95. For present purposes I can summarise my conclusions as follows. Where the State – here, a local authority – knows or ought to know that a vulnerable child or adult is subject to restrictions on their liberty by a private individual that arguably give rise to a deprivation of liberty, then its positive obligations under Article 5 will be triggered.
>
> i) These will include the duty to investigate, so as to determine whether there is, in fact, a deprivation of liberty. In this context the local authority will need to consider all the factors relevant to the objective and subjective elements referred to in paragraph [48] above.
>
> ii) If, having carried out its investigation, the local authority is satisfied that the objective element is not present, so there is no deprivation of liberty, the local authority will have discharged its immediate obligations. However, its positive obligations may in an appropriate case require the local authority to continue to monitor the situation in the event that circumstances should change.
>
> iii) If, however, the local authority concludes that the measures imposed do or may constitute a deprivation of liberty, then it will be under a positive obligation, both under Article 5 alone and taken together with Article 14, to take reasonable and proportionate measures to bring that state of affairs to an end. What is reasonable and proportionate in the circumstances will, of course, depend upon the context, but it might for example, Mr Bowen suggests, require the local authority to exercise its statutory powers and duties so as to provide support services for the carers that will enable inappropriate restrictions to be ended, or at least minimised.
>
> iv) If, however, there are no reasonable measures that the local authority can take to bring the deprivation of liberty to an end, or if the measures it proposes are objected to by the individual or his family, then it may be necessary for the local authority to seek the assistance of the court in determining whether there is, in fact, a deprivation of liberty and, if there is, obtaining authorisation for its continuance.

96. What emerges from this is that, whatever the extent of a local authority's positive obligations under Article 5, its duties, and more important its powers, are limited. In essence, its duties are threefold: a duty in appropriate circumstances to investigate; a duty in appropriate circumstances to provide supporting services; and a duty in appropriate circumstances to refer the matter to the court. But, and this is a key message, whatever the positive obligations of a local authority under Article 5 may be, they do not clothe it with any power to regulate, control, compel, restrain, confine or coerce. A local authority which seeks to do so must either point to specific statutory authority for what it is doing – and, as I have pointed out, such statutory powers are, by and large, lacking in cases such as this – or obtain the appropriate sanction of the court. Of course if there is immediate threat to life or limb a local authority will be justified in taking protective (including compulsory) steps: *R (G) v Nottingham City Council* [2008] EWHC 152 (Admin), [2008] 1 FLR 1660, at para [21]. But it must follow up any such intervention with an immediate application to the court.

- How will any such cases be identified?
- Should local authorities undertake reviews of cases where adults are being cared for at home?
- What about solicitors advising families in community care cases? There may be some cases where the level of control and supervision that the family have to use to keep P safe would engage Article 5 if the same arrangements were made by the State. It is suggested that in such cases it may be appropriate for advisers to seek instructions to write to the local authority, setting out the nature of the arrangements and inviting discussions about whether these might engage the local authority's positive obligations under Article 5; explaining the family carers' reasons why they consider no less restrictive arrangements could be made, and drawing the local authority's attention to the guidance in Re A and C above.

Sophy Miles

Miles and Partners LLP.

2 April 2014