A practical guide to the impact of the
Supreme Court’s ruling in *Cheshire West*

Cheshire West changed the interpretation of a Deprivation of Liberty in relation to someone who lacks capacity. As a result, significantly more patients will come within this category. If you are depriving a patient of their liberty you should ensure that you are doing so lawfully.

Some key phrases were coined by the Court, which received its leading judgment from Lady Hale. In particular, she indicated that “a gilded cage is still a cage”. This has resulted in a significant change in the test which is applicable to determine if someone is deprived of their liberty.

**The test – is it a deprivation of liberty?**

Two elements must be present for there to be a deprivation of liberty.

1. Is the person subject to continuous supervision and control? and
2. Is the person free to leave? Consider, if the patient tried to move out permanently (rather than seeking to leave the premises temporarily) would those in charge of their care seek to prevent them from doing so?

**What should be considered when assessing a potential deprivation of liberty?**

The Court’s decision represents a cultural shift for assessing a deprivation of liberty for those who lack capacity. A golden rule to follow is that what would be a deprivation of liberty for a person without disabilities, will also be a deprivation of liberty for someone with a disability. In order to assist those deciding whether a person may be deprived of their liberty, the Court offered guidance on what could and what should not be considered.

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<th>Do consider...</th>
<th>Don’t consider...</th>
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<td>Having control over who the person can have contact with.</td>
<td>The reason for, or purpose of, the placement. For example, to keep the person safe.</td>
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<td>Controlling the activities that the person is allowed to participate in.</td>
<td>The normality of the placement. For example, the fact that it is common for lots of people with the same or a similar presentation to live in the same type of setting.</td>
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<td>Not allowing the person to leave the placement without supervision.</td>
<td>The person’s compliance with the placement or a lack of objection. The fact that someone is not actively seeking to leave or voicing that they would like to does not mean that it is not a deprivation of liberty. You must look objectively at the situation.</td>
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<td>The person not being free to leave the placement permanently in order to reside elsewhere in a different type of setting.</td>
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How can you authorise a deprivation of liberty for a patient?

A deprivation of liberty may well be required in order to treat someone safely and effectively. If you have appropriate authority for doing this, the patient will have safeguards in place to ensure that their case is independently monitored. Consider whether the MCA or the MHA applies. In an emergency provide the necessary care and seek to commence the authorisation process as soon as possible. Seek urgent advice if you are unclear which regime applies or it appears a Court application is required.

The chart on the next page sets out the circumstances under which the various means of depriving a patient of their liberty are applicable.
Under which regime can I lawfully deprive a patient of their liberty?

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<th>Patient has capacity</th>
<th>Detain under Mental Health Act 1983</th>
<th>Mental Capacity Act 2005 Standard Authorisation</th>
<th>Seek a declaration from the Court of Protection</th>
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<td>If the patient meets the criteria for detention under the Act.</td>
<td>Cannot be used</td>
<td>If there is a query re the applicability of the MHA and/or whether treatment can be provided under it (including applications re section 63).</td>
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| Patient lacks capacity and is compliant | If they are detainable and their capacity may fluctuate or they may not be compliant in the future. This includes patients who are considered a danger to themselves or others. | A standard authorisation can only be granted for acute, mental health and nursing/residential home settings. If it is considered that a patient can be safely and effectively treated and you do not need to rely on any extra safeguards that would be provided by the MHA. This is only likely to be appropriate where the patient’s capacity does not fluctuate and they are likely to remain compliant. A DOLS authorisation cannot override a valid and applicable Advance Decision. If family members object to the placement, seek legal advice re obtaining a Court Order. | If the patient is in supported accommodation and their care plan amounts to a DOL. If intervention would constitute serious therapeutic medical treatment or a non therapeutic intervention (e.g. sterilisation). If there is disagreement about the DOL from a person involved in their care, or a query over whether it is the least restrictive option or in the patient’s best interests. Where the DOLS exists to protect a third party. An application may be needed where there is state involvement in a package of care delivered in the person’s home, which would amount to a deprivation of liberty. |

| Patient lacks capacity and will not co-operate | If the patient meets the criteria for detention under the Act. | If the proposed authorisation relates to deprivation of liberty in a hospital wholly or partly for the purpose of treatment for mental disorder, then the relevant person will not be eligible if: They object to being admitted to hospital, or to some or all the treatment they will receive there for mental disorder; and they meet the criteria for an application for admission under section 2 or section 3 of the MHA (unless an attorney or deputy action within their powers had consented to the things to which the person is objecting). | If there is a question mark over whether you should use the MCA or the MHA. An application may be required if the patient is detainable under the MHA but the DOLS is required for physical treatment which can not be delivered without a Court Order (e.g. major surgery or sustained treatment such as dialysis). Where the person is in a supported living environment (i.e. not a hospital or nursing/residential home) |

| Patient is under 18 | If the patient meets the criteria for detention under the Act. | Cannot be used | The Court of Protection can make a declaration re a DOLS for those aged 16-18. An application to the High Court under the Inherent Jurisdiction will be required for under 16s where it is believed their circumstances amount to the equivalent of a DOL. |
What do I do if I spot a deprivation of liberty?

You should raise this issue within your organisation or with the organisation that appears to be depriving a person of their liberty. It is primarily the responsibility of the organisation providing the care (the Managing Authority) to ensure that any deprivation of liberty has lawful authority. However, commissioners of care should properly audit their case loads to ensure that they are not commissioning any unlawful care package. Professionals involved in the care of those who lack capacity should ensure that they raise concerns about care arrangements appropriately.

Children

This is a difficult category. Guidance was issued earlier this year by Sir James Munby (President of the Family Division and Court of Protection) and Ofsted re deprivation of liberty applications for those aged under 18. In summary, this guidance outlined when the Court of Protection could not be called upon for those residing in children’s homes or residential schools, as there were Regulations already in place to provide the necessary guidance in relation to this.

The guidance has been the subject of some clarification in the past few weeks. In the case of Liverpool City Council v SG & Ors [2014] EWCOP 10 Mr Justice Holman confirmed that the Court of Protection does have power to make an Order re a deprivation of liberty where someone is living in a children’s home as defined by section 1(2) of the Care Standards Act 2000 if they have reached the age of 18.

The Court in Cheshire observed that, for children living at home with their parents, being under constant supervision and control and not free to leave would not normally be a deprivation of liberty as it would be the parents and not the state who were imposing the care regime.

However, where there is Local Authority or NHS involvement in the delivery of care for a child or young person and it appears that this would amount to a deprivation of liberty, seek legal advice. This issue is more likely to arise with the expansion of Personal Health Budgets, where there are NHS continuing care arrangements in place and the child has significant learning or physical impairments.

Oversight of the Court

For those aged under 16 the application would be made under the Inherent Jurisdiction of the High Court. The same application would also be made for those who are under undue influence or duress in their decision making. For those aged 16 and over, the application would most likely fall to be decided in the Court of Protection, if they were found to lack capacity. Most applications will be heard by the Court of Protection.

A raft of applications relating to deprivation of liberty issues are currently being heard by the President of the Court of Protection, Sir James Munby. The applications cover various categories of patients, care providers and commissioners.

An initial judgment has been released. Sir Munby has indicated that a new process will be developed to deal with the increased number of cases including a new set of Court forms. In the interim he has issued guidance on making applications to the Court of Protection for authorisation of a deprivation of liberty. In particular he sets out the information that should be included in any application. This guidance is summarised in a helpful briefing by 39 Essex Street Chambers.

Readers will also be aware that the Mental Capacity Act itself has been under intense scrutiny in recent months. The highly critical report can be found here. The report expressed particular concern in relation to the application of deprivation of liberty safeguards.

The government’s response has recently been released. The Government recognised that a major issue with the Act and DOLS in particular was a lack of understanding and awareness. One key action point for the government,
following the review and also comments from Lady Hale in the Supreme Court judgment, is that the process should be looked at to see if it can be simplified.

Action points

We have been advising several clients (in both the acute and mental health arenas) on the impact of the Supreme Court decision. We have issued several applications already and anticipate more so we recommend that if you have not already done so:

1. **Providers** – ensure that a full review has been conducted of your current patient cohort to determine whether they are being deprived of their liberty. Dementia, neurology, substance misuse and informal MHA 1983 patients will be a particular issue, as will some categories of patient in ICU. Seek to set up an alert system for any patients who might be admitted into your care who are likely to require a deprivation of liberty assessment/authorisation in order to start the assessment process in good time. Communication with the local commissioners of care in this respect may assist.

2. **Commissioners** – review your CHC packages and other packages of care being provided to patients in their homes or in nursing homes. Write to your providers to ensure that they are aware of and implementing the new test imposed by the Supreme Court’s decision. Where you are concerned that there may be a deprivation of liberty which a provider is not acting on, seek advice.

Conclusion

As reported by the CQC in their 16 January 2014 update checks on the implementation of the MCA 2005 are becoming a routine part of hospital and care home inspection by the CQC.

Effective communication lines with Supervisory Bodies and inter-agency partners; ensuring that there are efficient systems for documentation completion and effective staff training/file auditing will help to ensure that your organisation is on track in this area of law.

Further useful links

- Department of Health guidance (2014)
- DOLS Code of Practice (2008)
- Our previous Cheshire West Briefing
- Post Legislative Review of MCA