UKSC/2025/0042

IN THE SUPREME COURT OF THE UNITED KINGDOM

IN THE MATTER OF

A REFERENCE FROM THE ATTORNEY GENERAL FOR NORTHERN IRELAND

UNDER PARAGRAPH 34 OF SCHEDULE 10 TO THE NORTHERN IRELAND ACT 1998

IN RELATION TO WHETHER THE PROPOSED EXERCISE OF THE MINISTER OF HEALTH'S POWER UNDER SECTION 288(4) MENTAL CAPACITY ACT (NORTHERN IRELAND) 2016 WOULD BE INVALID BY REASON OF SECTION 24 OF THE NORTHERN IRELAND ACT 1998

JOINT SUBMISSIONS ON BEHALF OF MENCAP, MIND AND THE NATIONAL AUTISTIC SOCIETY

Introduction

1. Mencap, Mind and the National Autistic Society ('the charities') file these submissions to address the following matters:

   a. The factual context in which the reference is made.

   b. The broader social and policy context of relevance to the reference.

   c. The legal arguments relied on in support of their contention that the proposed approach under which a person could lack the mental capacity to consent to their care arrangements yet at the same time be capable of providing valid consent to them for the purposes of Article 5 ECHR is wrong.

2. The charities have already expressed concern about the attempt by the Secretary of State and Social Care (**SSHSC**) to revisit the decision in *Cheshire West* as to the objective element of Article 5(1). Despite having only had one clear working day since receipt of the SSHSC's written case which is substantially focused on this issue, which is not raised by the AGNI's reference, outline submissions are made at the conclusion of this document. A separate annex has been prepared to respond to the SSHSC's annex in respect of existing legal safeguards.

3. In summary, the charities submit that:

   a. The court should take particular care determining the reference in the absence of a clear factual matrix.

   b. The appropriate test of lawfulness of the draft Code is whether there is a "*a real risk"* it will breach a person's fundamental rights and common law right to access to justice to challenge their de facto detention.

   c. The Supreme Court in *Cheshire West and Chester Council v P* [2014] UKSC 19 (hereinafter *Cheshire West*) proceeded on the unchallenged basis that a person who lacks mental capacity to consent to their care arrangements cannot give valid consent to those arrangements for the purpose of the subjective limb of Article 5. Its decision – which concerned the objective limb of Article 5 and included consideration of whether a person needed to display an objection to their care arrangements for the objective limb to be satisfied - does not need to be interfered with for the reference to be determined.

d. The objective limb of Article 5 does not fall to be considered at all under the reference but if it is considered, the decision in *Cheshire West* should be followed.

e. The European Court of Human Rights (ECtHR) caselaw supports the view that people who lack the mental capacity to consent to their particular care arrangements cannot give valid consent. To the extent the ECtHR caselaw allows for a person to lack capacity and be able to provide valid consent, this is where the lack of capacity has been determined on a global basis, not where there has been a finding of a lack of capacity with respect to the particular care arrangements. There is no basis in the ECtHR caselaw for the test proposed in the Minister of Health's draft Code, namely whether a person has a '*positive attitude'* to their care arrangements.

f. The proposed approach of the AGNI is unworkable and removes vital safeguards from disabled people who are at risk of Convention breaches absent those safeguards.

g. There is no proper basis for the argument that Article 8 might require the safeguards of Article 5 to be weakened for disabled people.

4. Narrowing the scope of the subjective limb of Article 5 ECHR in the way proposed will significantly reduce existing legal protections for disabled people. Article 5 ECHR provides safeguards to those who are, as a matter of fact, deprived of their liberty, ensuring that detentions must have a lawful basis (here, under Article 5(1)(e)), and that a person has a right of access to court to challenge their detention under Article 5(4). Defining a de facto detained or confined person as being, as a matter of law, not deprived of their liberty, does not reduce any restrictions on them in reality – it only removes the safeguards the person has against arbitrary or unlawful detention, access to independent advocacy/representation, and access to a court to challenge the lawfulness of that detention.

The approach to be taken to determining what Article 5(1)(e) requires in the abstract

5. Pursuant to paragraph 34 of Schedule 10 to the Northern Ireland Act 1998 ("**NIA 1998**") the Attorney General of Northern Ireland ("**AGNI**") "*may refer to the Supreme Court any devolution issue which is not the subject of proceedings*." The court is,

however, rightly cautious about dealing with such a reference in the absence of any clear factual matrix:

> *"In general, it is desirable that legal questions be determined against the background of a clear factual matrix, rather than as theoretical or academic issues of law."*
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> ***Attorney General for Northern Ireland's Reference of Devolution Issues to the Supreme Court pursuant to Paragraph 34 of Schedule 10 to the Northern Ireland Act 1998 (No 2) (Northern Ireland)*** [2019] UKSC 1 (hereinafter '*Devolution Issues')* HB3251; quote at [28] HB3257

6. As the witness evidence filed by the charities sets out, disabled people who are presently viewed as deprived of their liberty under Article 5(1)(e) present a wide range of factual scenarios, none of which have been subject to the proposed approach in the draft Code, let alone been the subject of decisions by lower courts. The charities' witness evidence attempts to provide some factual context, but it is, inevitably, not a substitute for a clear factual matrix or a decided case.

7. If the Supreme Court grants the reference and holds that a lack of mental capacity does not prevent the giving of valid consent for the purposes of Article 5, none of the parties or intervenors would be able to make an application to the European Court of Human Rights because there are no 'victims' for the purpose of Article 34 of the Convention. Thousands of disabled people who lack the mental capacity to consent to their care arrangements would be affected, not just in Northern Ireland but across all jurisdictions of the UK. Any right to advocacy and representation in respect of Article 5 would fall away, making it difficult if not impossible for them to bring an individual case before the domestic courts or Strasbourg.

8. If the matters raised by the AGNI are considered in the abstract, the correct test to apply in considering the lawfulness of the policy is set out in *R (UNISON) v Lord Chancellor (Equality and Human Rights Commission intervening) (Nos 1 and 2)* 2017 UKSC 51, namely that the policy is unlawful if there is a "*a real risk"* it will breach a person's fundamental rights and common law right to access to justice to challenge their de facto detention. The proposed approach of the AGNI creates an obstacle to people exercising fundamental rights, and in particular Articles 5(4) and 6 ECHR and common law access to justice. In such cases, "*it is sufficient if a real risk of prevention of access to justice is*

demonstrated. This means that, in order to test the lawfulness of a measure on this basis, it is legitimate to have regard to evidence regarding its likely impact and the court has to make an overall evaluative assessment whether this legal standard is met or not (and statistics might have a part to play in making such an assessment)." R(A) v Secretary of State for the Home Department [2021] UKSC 37 at [80]

9. Particularly for people with mental disabilities who require support to make the exercise of Article 6 and Article 5(4) rights "*practical and effective*" rather than "*theoretical or illusory*"[1] the absence of any formal recognition or legal framework for their de facto detention will be a very significant impediment to their having access to justice should they disagree with the state's finding that they are providing valid consent to their de facto deprivation of liberty. Instead of being able to use clear pathways which are available in domestic legal frameworks to allow people to access to courts to challenge detentions (generally supported by independent advocacy, access to legal aid, and a right to speedy consideration by the court), these individuals would be in legal limbo of first having to demonstrate that they are detained, secure legal assistance, and then to construct some of form of remedy which is not designed for their situation (such as a judicial review or petition for habeas corpus).

10. The Lord Advocate's submissions regarding *Christian Institute v Lord Advocate* [2016] UKSC 51, 2017 SC (UKSC) 29 at [88] and *In re Abortion Services (Safe Access Zones) (Northern Ireland) Bill* [2022] UKSC 32 do not provide sufficient context that the particular focus in those matters was on Article 8 ECHR, a qualified right which itself focuses on proportionality.[2] The clearer articulation of the standard for an ab ante challenge to a policy is set out in *R(A) v Secretary of State for the Home Department* [2021] UKSC 37: a policy will be unlawful if *"it imposes requirements which mean that it can be seen at the outset that a material and identifiable number of cases will be dealt with in an unlawful way."* [63] The charities have set out in detail in their evidence why a material and identifiable number of cases will be dealt with in an unlawful way, as extensive and corroborated research demonstrates there will be a very significant number of people who will be wrongly taken to agreeing to restrictions imposed on them in their best interests by virtue of their disabilities.

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[1] *Airey v Ireland* [1979-80] 2 EHRR 305 at [24]. HB4112-HB4113

[2] *In re Abortion Services* at [14]. HB3779

Broad factual context

11. The court is concerned with the group of people who lack the mental capacity to consent to their care arrangements. People with mental health problems or learning disabilities and autistic people have a wide range of abilities and care needs. Some are able to communicate through speech, some are non-verbal and use Makaton or assistive technology, and some communicate through sounds or gestures. Some are able to understand the different possible options for their care but not able to weigh them up to make a choice; others are unable to understand what their support needs are, let alone different ways and places in which they could be met.

12. There is a huge spectrum of care arrangements in the community for disabled people who lack capacity to decide on their residence and care. A person may live in their own home which they own or rent, or with their parents in the family home. They may live in a supported living placement (with a tenancy agreement that is signed on their behalf) which has communal areas and shared staff, or they may live in a care home with other residents. There is similarly a broad spectrum of care arrangements for those who are detained in institutional settings and hospitals, ranging from those who are detained in 'open' hospitals to those who are confined to a small space under close supervision. While the Minister's Written case at [57] says that the Draft Code would not apply to mental health hospitals in Northern Ireland, a redefinition of the subjective limb of Article 5(1)(e) would, as a matter of logic, necessarily affect all settings, including hospitals, care homes, children's homes, hostels, supported living arrangements and people's own private homes.

13. Care plans – even including those for people who live in their own homes in the community – can involve a wide range of restrictive measures that are considered to be in the person's interests, but which have obvious potential to be overused, misused and abused. As set out in the charities' evidence (and reflected in the findings of bodies such as the Care Quality Commission, and cases that have come before the Court of Protection),[3] care plans for disabled people may, for example:

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[3] See for example, CQC's "Out of sight – who cares?", 2020; HB7292 and CQC's "The state of health care and adult social care in England 2023-24". HB7664

a. Authorise the use of sedative medication by staff if the person receiving support is agitated or distressed.

b. Permit the use of physical restraint, including by multiple staff members holding the limbs of the person on the floor to prevent them causing harm to themselves or to other people.

c. Where the person has meltdowns or displays behaviour that challenges, authorise staff to withdraw, leaving the person alone in a confined space with a locked door where they can be observed at a distance.

d. Permit the use of solitary confinement in rooms with padded walls and no furniture, where a person who is distressed can be looked after safely. Other rooms may have only basic furnishings with furniture fixed to walls, and viewing windows and hatches for observation and communication.

e. Constant supervision of the person by carers at all times, including checks throughout the night.

f. Permit the use of CCTV or other forms of electronic monitoring to monitor the person when staff are not in the same room.

g. Permit the person's living area and property to be searched to prevent access to harmful implements or material that is legal but deemed inappropriate (like a pornographic magazine).

h. Prevent the person having access to the internet or social media or restrict the way in which the internet can be used, and limit the contact they can have with friends and family members, as well as members of the public.

i. Include the use of physical restraint devices such as harnesses when using vehicles, clothing which is designed to physically restrain the person as in the case of P in *Cheshire West*, or beds with raised sides so that the person cannot get out of bed overnight.

j. Provide for a set number of hours each day or week when sufficient staff are available for the person to 'access the community' which means leave their home.

k. When the person does access the community they are to be accompanied at all times by a carer. If they try to leave without support then they will be brought back to the care setting. If they do successfully leave then the police will be called to find and return the person.

l. Where a person lives in shared settings, provide that the person is not able to access communal areas such as the kitchen, living room or garden, if other residents are using them.

m. Require locks on both internal doors and external doors and grills or one-way screens on windows.

14. It would be wrong for the court to assume that because a disabled person is cared for in a community setting, their care arrangements are less restrictive than in a psychiatric hospital, or to assume that a person subject to restrictive care arrangements would inevitably object to them or indicate that they were not happy to live in the particular setting. The charities' evidence demonstrates the difficulty of identifying whether a disabled person subject to such measures is agreeing to them, objecting to them, or otherwise has a "*positive attitude to the care arrangements*" per the draft Code at para 2.12.

Legal submissions

Whether the domestic and international law supports the proposed revision to the Code of Practice in respect of the subjective limb of Article 5

15. Section 24 of the NIA 1998 provides that, "*A Minister or Northern Ireland department has no power to make, confirm or approve any subordinate legislation, or to do any act, so far as the legislation or act - (a) is incompatible with any of the Convention rights […]*". The Minister has no power to approve the revised Code of Practice as drafted because to do so would breach the Article 5(1) and 5(4) ECHR rights of adults in Northern Ireland who lack capacity to make decisions about residence/care but do not actively object to their living arrangements.

The Strasbourg jurisprudence does not support the proposition that that a person without mental capacity to consent to their care arrangements is not in fact deprived of their liberty if there is "evidence of a positive attitude to the care arrangements"

16. The Strasbourg jurisprudence shows that:

a. Compliance with care arrangements is not enough to demonstrate valid consent: *HL v UK*; and

b. Valid consent has been found to be present where a person lacks legal capacity, where, on a fact-specific analysis, the person was deemed (after the event) to have had sufficient understanding of the options for their care (*Mihailovs*, op cit, which was considered in *Cheshire West*).

17. Where the AGNI argues that the Strasbourg court "*focuses on the person's own subjective perception of the arrangements*",[4] this is in the specific context that in the domestic legal regimes of some ECHR contracting states, a person's legal capacity may be removed on a blanket basis (for example, on the basis of diagnosis of a mental disorder), which does not necessarily speak to the person's ability to make the specific decision to consent to a particular confinement. In such circumstances, the ECtHR may look behind this overarching removal of legal capacity to determine the validity of the person's consent. The legal regimes in Northern Ireland, Scotland, and England and Wales do not adopt this approach but instead assess mental capacity in relation to particular decisions taken at particular times. Where a blanket removal of legal capacity occurs, it may make sense to ask whether the person in fact is or was able to validly consent to the arrangements. It does not make sense where there has been a specific finding that the person does not have the mental capacity to consent to the particular care arrangements in question.

18. The Supreme Court in *Cheshire West* considered the Strasbourg jurisprudence that touches on subjective consent, in the context of deciding whether an objection to one's arrangements was a necessary component of the objective limb of Article 5 [50]. The court considered all the pre-2014 cases now cited by the AGNI in that context. There have been no significant cases on this issue since *Cheshire West* which support the AGNI's case. The only post-2014 Strasbourg case cited by the AGNI in her Written Case which focuses on the detention of incapacitous individuals is *Červenka v Czech Republic* (62507/12, 13 October 2016), which does not engage with the issue of whether incapacitous compliance could be valid consent.[5] Nor are there any reported

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[4] AGNI's Written Case at [22]. HB55

[5] The applicant in *Cervenka* was compulsorily placed in a care home "*on the basis of an agreement signed by his public guardian. While he did not show clear disagreement on the day of his admission to the social care home or shortly beforehand, from his subsequent conduct it was obvious that he had not consented to his placement there*." [103] HB5251

cases, domestically or in Strasbourg, which set out or endorse the proposed test for valid consent by a person lacking mental capacity to decide on their care arrangements of an "*expression of current wishes and feelings that go beyond mere acquiescence"*.[6]

19. In *HL v UK*, the court was concerned with Mr HL who was unable to speak and had limited understanding, and lacked "*capacity to consent or object to medical treatment*" [9]. HL had lived for a number of years in hospital but then moved to live with carers. After three years with his carers HL was admitted to hospital as an 'informal' patient when his behaviour deteriorated whilst at day care. He did not object to his admission. His carers objected and were prevented from having contact with him. He was eventually discharged after five months. Relevant guidance at the time on whether a person was or was not detained included language highly relevant to the issues in this matter, specifically stating that for individuals who lacked capacity but were not objecting to being in hospital, they should be admitted as 'informal' patients rather than being detained under the MHA 1983. [71] The ECtHR definitively rejected this, stating that valid consent to arrangements which constitute an objective deprivation of liberty cannot be given by a person who lacks the capacity to give that consent at [90]:

> *90. ... The Court reiterates that the right to liberty is too important in a democratic society for a person to lose the benefit of Convention protection for the single reason that he may have given himself up to be taken into detention (see De Wilde, Ooms and Versyp v. Belgium, judgment of 18 June 1971, Series A no. 12, p. 36, §§ 64-65), especially when it is not disputed that that person is legally incapable of consenting to, or disagreeing with, the proposed action.*

20. The ECtHR applied this approach in *Storck* the following year at [75]. While the patient in the *Storck* case was clearly objecting (and thus no valid consent was given), the ECtHR also found in the alternative that: *"assuming that the applicant had no longer been capable of consenting following her treatment with strong medicaments, she could, in any event, not be considered as having validly agreed to her stay in the clinic.*" [76]

21. The ECtHR again used nearly identical language to that in paragraph 90 of *HL* in *M v Ukraine* [2012] ECHR 732 at [69] and [75]-[77], which emphasised that valid consent

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[6] AGNI's Statement of Facts and Issues at [34(b)]. HB22

to an inpatient admission for psychiatric treatment required careful assessment including "*sufficient and reliable evidence suggesting that the person's mental ability to consent and comprehend the consequences thereof has been objectively established in the course of a fair and proper procedure and that all the necessary information concerning placement and intended treatment has been adequately provided to him.*" [77]

22. In the case of *Stankov v Bulgaria* (25820/07, decided on 17 March 2015, a year <u>after</u> *Cheshire West*) at [90] the Court cited the principle elucidated in *M v Ukraine* (above) and stated, "*The Court considers that this principle is also applicable when it comes to the consent to be obtained for the placement in a social care home of a person whose legal capacity is impaired due to his mental health, as in the present case. It notes that, while the Government does not contest the applicant's capacity to consent, it does not demonstrate that this consent was sought according to such an appropriate procedure or that the necessary information was given to the applicant*." At [91], the Court found a violation of Article 5(1) due to factors including the applicant's lack of consent.

23. The cases of *H.M. v Switzerland* and *Mihailovs* (relied upon in the AGNI's submissions) were both considered by the court in *Cheshire West* which specifically noted that both cases could be viewed as saying that tacit agreement or satisfaction with care arrangements meant that an individual was not deprived of their liberty. The Supreme Court decided that these two cases did not cover the scenarios in *Cheshire West*, with the majority finding at [55]:

> *Several objections may be raised to the conclusion that both MIG and MEG are being deprived of their liberty. […] Another is that they are both content with their placements and have shown no desire to leave. If the "tacit acceptance" of the applicant was relevant in* Mihailovs, *why should the same tacit acceptance of MIG and MEG not be relevant too? I have found this the most difficult aspect of the case. But* Mihailovs *was different because he had a level of de facto understanding which had enabled him to express his objections to his first placement. The Strasbourg court accepts that there are some people who are not capable of expressing a view either way and this is probably the case with both MIG and MEG. As HL 40 EHRR 761 shows, compliance is not enough.*

24. As noted above, it is pertinent that Mr Mihailovs had his legal capacity removed by court order and a guardian appointed years previously. There was no contemporaneous evidence that he lacked capacity to consent to his care arrangements during any particular period of detention. *Mihailovs* is thus an unusual case which does not have the import in Strasbourg case law which the AGNI seeks to place on it.

25. The applicant in *HM v Switzerland* had capacity, so that case falls outside the cohort of people affected by this reference. The arguments made by the UK government in *HL* were markedly similar to those now made by the AGNI: see *HL* at [80]-[85], including, the government placing "*considerable reliance*" on *HM.* Following argument on this point, the ECtHR specifically distinguished *HM* from *HL* at [93] in relation to the subjective limb on the basis that *"it was not established that H.M. was legally incapable of expressing a view on her position*".

26. The Strasbourg cases post-2014 which touch on the question of valid consent in the context of Article 5(1)(e) are *Stankov v Bulgaria* (op cit) and *N v Romania* (59152/08, 28 November 2017). In *N*, the question of whether 'agreement' to a deprivation of liberty by a person of 'diminished mental capacity' placed an objective confinement outside the reach of Article 5 was considered, with the court concluding that oral and even written agreement to detention in a psychiatric facility did not constitute valid consent, and that a person in such a position needed "*adequate safeguards"* [165] by way of a legal framework for the detention and access to a substantive court review of the lawfulness of detention.

27. The reference cites the post-*Cheshire West* authority of *Rooman v Belgium* [2019] ECHR 105 where at [142] the ECtHR noted, that "*[m]easures depriving persons of their liberty inevitably involves an element of suffering and humiliation"*. This comment related to the ECtHR's consideration of whether the applicant's rights under Article 3 ECHR (freedom from torture, inhuman or degrading treatment or punishment) had been breached, not his Article 5 rights. Paragraph [142] is a straightforward reiteration of a long-established principle that the Court will find a breach of Article 3 only if the measure goes beyond a minimum level of severity. *Rooman* is not relevant to this reference, as the applicant was considered capacitous and was not in a mental health or social care setting, but in prison.

28. The AGNI relies on *Re AB* [2021] UKSC 28 to say that this court has to be fully confident what the ECtHR would say if presented with a new factual scenario. *AB* does not apply to any scenario not covered by Strasbourg case law: it applies only to situations where an argument is advanced which would represent a departure from established ECtHR's principles. In situations which have not yet come before the Strasbourg Court, domestic courts should be anticipating where possible how the ECtHR would be expected to decide a case: *AB* at [59]. The Strasbourg Court has never said that a person without mental capacity to consent to their care arrangements is not in fact deprived of their liberty if there is "*evidence of a positive attitude to the care arrangements*", or similar. That is an entirely new test developed by the Minister in the draft Code. What Strasbourg has clearly said is that valid consent requires a person to have an adequate understanding of the options for their care and the ability to challenge them. The court can not be fully confident, or even mildly confident, that the proposed new approach in the draft Code would be endorsed by the ECtHR.

<u>The proposed approach to valid consent removes vital safeguards from disabled people</u>

29. In the instant reference, if the court were to permit policy arrangements that treat as not detained a person who lacks capacity to decide on residence/care and who "*is expressing consent*" (to use the wording of the draft Code) to their living arrangements, that would remove the right of access to a court to determine in a fact-sensitive manner whether or not that person is actually deprived of their liberty, because such a person would not be detained per Article 5(1)(e) ECHR, and would therefore have no means per Article 5(4) ECHR to test the lawfulness of that detention before a court or tribunal.

30. The domestic caselaw since *Cheshire West* has continued to endorse the Supreme Court's view that the universal nature of human rights means that they should not be watered down in respect of people with disabilities (most recently per Singh LJ in *J v Bath and North East Somerset Council & Ors* [2025] EWCA Civ 478).

31. While the charities of course accept that there are people whose care arrangements are the least restrictive possible (despite constituting an objective confinement), where there is little or no risk of excessive or inappropriate use of restrictive measures, and who do not need to exercise their rights under Article 5, there will be others for whom that is not the case, and for whom the procedural safeguards of Article 5 are critically

important. Hence Baroness Hale's wise observation in *Cheshire West* at [57] that one should err on the side of caution, where the group of people affected are vulnerable by reason of disability.

The proposed approach to valid consent is not compatible with domestic approaches to whether consent is freely given

32. The domestic courts have considered and applied European case law which establishes that "*agreement*" to detention will not be considered voluntary or valid where the consequences of withdrawing the "*consent*" will be the immediate imposition of a legal framework to compel that care or treatment on the person. The charities identify three examples of how the threat of immediate compulsion invalidates nominal consent:

33. Section 20 Children Act 1989: A parent may request a local authority to accommodate their child, without a local authority bringing care proceedings or orders made by a court giving the local authority shared parental responsibility for the child. In *Williams & Anor v London Borough of Hackney* (Rev 1) [2018] UKSC 37, the Supreme Court gave a unanimous and robust judgment finding that there was no valid consent for such a placement if given under the threat of proceedings. The Supreme Court was also clear that the consent may be withdrawn at any time, and, save in an emergency, it is not open to a local authority to refuse to accept that withdrawal of consent for some further period while the local authority prepares a court application.

34. Validity of consent of a child to a deprivation of liberty: In *Re T (A Child)* [2021] UKSC 35, the Supreme Court considered a challenge brought by a child to the use of the inherent jurisdiction to authorise her deprivation of liberty in the community. It had been T's consistent argument "*that she had the capacity to consent to the care regime that was proposed in each of the placements, that she wanted to be in those placements, and that she consented to the restrictions placed on her*" [19]. She argued that where she consented, there was no need for court involvement. This argument was rejected at all levels. The Supreme Court found that this issue was academic, but made the following observation at [161]:

> *"…even leaving to one side difficult issues about the pressures that circumstances may place on a child to consent to a proposed arrangement, an apparently balanced and free decision made by a child may be quickly revised*

and/or reversed. The facts of this case clearly demonstrate how insecure may be the child's apparent consent."

35. <u>'Informal' psychiatric inpatients</u>: A person may give consent to treatment in a psychiatric hospital for treatment on a voluntary basis rather than being detained under the MHA 1983. The MHA 1983 Code of Practice (for England and Wales) states at para. 24.35 that, "a person who lacks capacity is unable to consent or refuse treatment, even if they co-operate with the treatment or actively seek it."

36. The SSHSC sets out 'caveats' in response to the AGNI's proposed approach, which the in fact demonstrate the impossibility of that approach, including the incoherence of a finding of incapacity under the MCA 2005 alongside a finding of valid consent to the very same care arrangements, the undermining of the very concept of incapacity and the undermining of approaches to informed consent in medicine, and the inability to spell out the safeguards that would be needed.

The Draft Code is not compatible with Article 5

37. The Reference proposes a person who lacks capacity to make decisions regarding their care *"can give the necessary valid consent through the expression of current wishes and feelings that go beyond mere acquiescence to the confinement."*[7] While a lack of objection is not sufficient to evince valid consent, the draft Code says that "*evidence of a positive attitude to the care arrangements"*[8] could be taken as valid consent. The draft Code states this would include a person saying that they like where they live, or an apparent happiness to return home after being away, with "*no evidence of resistance or objection to the arrangements in place.*" The draft Code notes that if the person stops showing consent, "*arrangements must be taken to be a deprivation of P's liberty, and the safeguards of the Act must immediately be put in place*".[9]

38. Many people who lack capacity to decide on their care and support are not compelled to accept care arrangements against their wishes but in their best interests. If a person's wishes were determinative and they were actually free to follow an incapacitous preference not to live in a care setting, or to reject the care arrangements which

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[7] Reference paragraph 7. HB271
[8] Draft Code, paragraph 2.12. HB276
[9] Draft Code, paragraph 2.13. HB276-HB277

continuously supervised and controlled them, the objective limb of Article 5 would not be satisfied. Thus the cases within the scope of proposed Code relate solely to adults who:

a. are subject to continuous supervision and control by others;

b. have no freedom to leave the place at which they are continuously supervised and controlled in order to go and to live elsewhere;

c. lack the mental capacity to make the decision about whether or not to consent to their care arrangements, including the restrictive elements; and

d. if they were ever taken as expressing objections, arrangements would be immediately put in place to legally compel them to accept the residence and care arrangements against their wishes.

39. The draft Code is entirely incompatible with ECtHR case law where:

a. it deems incapacitous consent to the specific restrictions as 'valid', which is manifestly contrary to ECtHR case law;

b. the 'consent' is entirely illusory as the person in reality never has any freedom to leave the place of detention or disengage with care; and

c. for those individuals who may understand the consequences of withholding consent, the consent is being sought where the alternative is immediate compulsory detention.

40. The draft Code is also deeply flawed insofar as it deems "*positive attitudes*"[10] toward the care arrangements or happiness to return to the place where a person lives as evidence of consent to the restrictive measures which constitute the deprivation of liberty. Any 'valid consent' that renders care arrangements outside the scope of Article 5 would need to be in relation to the restrictive measures which would otherwise give rise to a deprivation of liberty, rather than to non-restrictive aspects of the care arrangements.[11] A person may have a positive attitude about a variety of aspects of

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[10] Draft Code, paragraph 2.15. HB277

[11] See, e.g., *A Primary Care Trust v LDV & Ors* [2013] EWHC 272 (Fam), HB2895 which considered the relevant information a person would need to be able to consider to consent to a deprivation of liberty at [39]:

> *(1) that she is in hospital to receive care and treatment for a mental disorder;*

their care without having a positive attitude about the restrictive measures of their care that may persist for the majority of the time. A person may be happy to return to the place where they live for a variety of reasons which have nothing to do with the restrictions they have there: people who prefer familiarity and routine may dislike being away from the place they think of as their home; or their placement may be an improvement on previous even more restrictive or even abusive arrangements.

UN Convention on the Rights of Persons with Disabilities (CRPD)

41. The AGNI says at [13] of the application that her wider approach to consent is consistent with the CRPD. Article 12 of the CRPD provides that a person should have legal capacity at all times, and in all areas of their life. The UN Committee on the Rights of Persons with Disabilities recommended to the UK government in 2017 that it "*abolish*" legislation that permits substituted decision-making in any area of life, which would include the MHA 1983 and MCA 2005 in England and Wales, and the MCA 2016 in Northern Ireland. Neither the UK government nor the Northern Irish administration have any intention to do so.[12]

42. In support of the unfounded assertion that the proposed amendment to the Code is consistent with the CRPD, the AGNI cites at paragraph 13 of her Reference the Strasbourg case of *ET v Moldova* [2024] ECHR 858, and in particular [74] of the judgment in that case. There, the ECtHR simply referred to a general comment of the CRPD Committee which said that "*a person with disabilities should be able to express his or her will and preferences, including in respect of such issues as where to live and with whom*". It said nothing about whether the expression of such will and preferences can constitute valid consent for the purposes of Article 5. The importance of an

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(2) that the care and treatment will include varying levels of supervision (including supervision in the community), use of physical restraint and the prescription and administration of medication to control her mood;
(3) that staff at the hospital will be entitled to carry out property and personal searches;
(4) that she must seek permission of the nursing staff to leave the hospital, and, until the staff at the hospital decide otherwise, will only be allowed to leave under supervision;
(5) that if she left the hospital without permission and without supervision, the staff would take steps to find and return her, including contacting the police. HB2906-HB2907

[12] UN Committee on the Rights of Persons with Disabilities, 'Concluding observations on the initial report of the United Kingdom of Great Britain and Northern Ireland', 3 October 2017, CRPD/C/GBR/CO/1, at [31]. HB8303

incapacitous person's wishes is reflected in the various UK domestic legal frameworks. The proposition at [43] of the AGNI's written case, that holding a person incapable of consenting to their care arrangements both for the purposes of Article 5 and for the purposes of a domestic legal framework fails to comply with the CRPD, but holding them incapable to consent to the former but not the latter would comply with the CRPD, is difficult to understand.

Whether the proposed approach under which people who lack capacity to decide their living arrangements are nonetheless deemed to have provided valid consent to them is workable and able to protect the rights and interests of disabled people

The proposed approach is unworkable

43. The test for valid consent proposed by the AGNI is vague, difficult to apply and likely to lead to confusion, uncertainty and differential treatment. A test which requires the decision-maker to determine whether a person has a "*positive attitude*" about their care is both highly subjective and hopelessly vague. The ECtHR's finding in *HL* as summarised in *Cheshire West* that "*compliance is not enough*" is clear. The wording of the proposed Code, which seeks to define a category of behaviour which goes beyond compliance but does not constitute capacitous consent, is not. The need for clarity is obvious: it is set out in the charities' witness statements and was highlighted by Lord Neuberger in *Cheshire West* at [60].

44. In the population of people who are objectively deprived of their liberty, there will be a tremendous range of attitudes, communication styles, cultural backgrounds, life experiences and disabilities. The charities' witness evidence gives some examples, and illustrates the numerous serious problems with implementing the proposed new approach, including:

    a. the difficulty in eliciting wishes accurately;

    b. the difficulty in eliciting wishes objectively and with no conflicts of interest;

    c. the difficulty of knowing whether expressed wishes of a non-capacitous person are sufficient to meet the proposed test;

d. the difficulty of ascertaining whether 'behaviour that challenges' is due to the restrictions in place, or is part of a person's presentation (and therefore not to be viewed as an objection or lack of valid consent);

e. the difficulty of responding to fluctuations in the wishes and feelings of a non-capacitous person, and of identifying what level or nature of fluctuation would require a conclusion that valid consent was no longer present;

f. conflating wishes in respect of a placement overall with valid consent to the restrictive elements of a confinement;

g. the inability of people subject to restrictions to identify for themselves whether those restrictions are necessary or could be reduced or removed and therefore whether they should object to them;

h. the real risks of acquiescence and suggestibility among people with mental disorders and disabilities.

45. The careful judgment of Baker J (as he then was) in *Re RD & Others (Duties and Powers of Relevant Person's Representatives and Section 39D IMCAS) (Rev 1)* [2016] EWCOP 49 considered a range of scenarios in which it was not clear whether a person was objecting to detention (so that an application to the court should be made) where the person was not able to clearly communicate an objection. The conclusions in the individual cases at [88]-[107] gives an indication of the range of scenarios which might be encountered, and the difficulties in determining whether these people were exhibiting an objection to their detention:

a. People who presented as generally settled to care staff, but were adamant they would want to object to their detention and bring court proceedings when asked by an advocate;

b. People whose wishes to leave regularly fluctuated;

c. People who experienced periods of agitation and distress which may or may not have been intrinsic to their condition;

d. People who became distressed but could be distracted from that distress by skilled staff; and

e. People who thought the placement was "*fine*" but that they would prefer to go home even where that home was no longer available.

46. It is entirely commonplace for people who have learning disabilities, dementia, autism or communication difficulties to appear to agree with points put to them without actually understanding what is being asked, or seeking to explore those points in order to avoid conflict or to seek to mask that they are not understanding. The evidence of Dr Steven Carnaby and Dr Jill Bradshaw via Mencap sets out well-established research on this topic:

> *People with learning disabilities are more likely to be acquiescent and to yield to leading questions*[13].
>
> *An individual may appear to answer correctly when in fact they have not understood and have merely used their knowledge of question structure and non-verbal cues (such as tone of voice and facial expression) to give the response they think the listener is expecting*[14]*…*
>
> *The ways in which questions are asked can directly influence the answers that a person gives. Some people may be particularly vulnerable to changing their answers or agreeing with questions, depending on how they are phrased (this is called 'interrogative suggestibility')*[15]*. Memory limitations, suggestibility and the likelihood of acquiescence are all linked to lower IQ….*
>
> *The comprehension of people with [learning disabilities] can be easily over-estimated. There is a tendency to prioritise speech as the main form of communication, even when there is evidence that the individual has limited understanding of the spoken word.*

47. The evidence of National Autistic Society sets out similar issues of misinterpretation which arise for autistic people:

> *Misinterpretation of an autistic person's communication can easily occur if approached from the perspective non-autistic norms, and what is often assumed*

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[13] Clare, CH, Gudjonsson, GH (1993) Interrogative suggestibility, confabulation, and acquiescence in people with mild learning disabilities (mental handicap): implications for reliability during police interrogations. British Journal of Clinical Psychology, 32: 295–301.Google Scholar

[14] Elliott, K, Forshaw, N (2001) People with borderline-mild learning disability. In Communication and Mental Illness: Theoretical and Practical Approaches (eds France, J, Kramer, S) 236–50. Jessica Kingsley Publishers.Google Scholar.

[15] Shackleton, Hannah Lydia. "Measurement of suggestibility in adults with intellectual disabilities: an adaptation of the Gudjonsson suggestibility scales and a systematic review exploring the influence of cognitive variables." (2017).

> *to be an expression of one wish or feeling in a non-autistic person can be an expression of the opposite wish or feeling in an autistic person. For example, laughing in non-autistic people is commonly interpreted as the person expressing feelings of enjoyment, happiness, or comfort. However, some autistic people will instead laugh as an expression of distress or pain.*
>
> *Autistic people can also be particularly vulnerable to suggestion and coercion. For instance, autistic people often learn social scripts and prepare answers that they believe the recipient expects of them, or they believe is the 'right answer' in social or communicative situations, regardless of their true wishes or feelings.*
>
> *Additionally, some autistic people experience echolalia, which is the repetition of words or phrases. This can be immediate or delayed, and can include the repetition of sounds in the ambient environment (for example, the TV), or the repetition of words that have been spoken to them directly. Similarly, autistic people can also experience echopraxia, which is the imitation or repetition of another person's actions. This can mean that autistic people are vulnerable to appearing to consent via their expressions, when these are instead reflections of the environment around them.*

48. Mind's evidence similarly sets out that a person with mental health problems may appear to be expressing wishes and feelings that go beyond 'mere acquiescence' to their confinement. Several factors explain this:

    a. *There may be no one to assist or empower them, like a relative, friend or advocate;*

    b. *They may have been medicated and sedated. For example, a study looking at drug intervention in the elderly found that taking psychiatric medication had positive associations with the agreeableness and conscientiousness traits;*[16]

    c. *They may be too institutionalised to object;*

    d. *They may have been coached, coerced or intimidated by care staff or family to raise an objection. Previous or traumatic experiences with*

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[16] Linkievicz NM, Sgnaolin V, Engroff P, Behr Gomes Jardim G, Cataldo A Neto. Association between Big Five personality factors and medication adherence in the elderly. Trends Psychiatry Psychother. 2022 Jul 8;44

mental health services, may result in a person finding it difficult to express their feelings and/or may be coerced into being compliant, either consciously or unconsciously by staff. Whether or not staff consider behaviour to constitute a positive feeling or a clear objection to an admission or placement is likely to be highly subjective; and

e. *Past experiences of trauma can also have an impact on how people respond. A traumatized person may be dissociated as they are in a freeze or fawn mode where communication and decision-making are impaired.*[17] *Recent research shows that personality traits can be affected by trauma and that past experiences of trauma were associated with agreeableness.*[18] *In a 'fawn' response, the person may "seek safety by merging with the wishes, needs and demands of others. They act as if they unconsciously believe that the price of admission to any relationship is the forfeiture of all their needs, rights, preferences and boundaries".*[19] *The person may be silent when being mistreated, have trouble saying no, hold back opinions or preferences that might seem controversial in order to maintain a sense of emotional safety. In Mind's view, trauma is under-diagnosed among people with social care needs, and a traumatized person will often appear agreeable to their care arrangements to appease health and care staff, and to avoid further trauma.*

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49. Many people who are deprived of their liberty are subject to extremely high levels of restrictions, including forms of coercion, physical restraint, solitary confinement and chemical sedation. These are often justified on basis of the person's needs, including views that the person experiences 'challenging behaviour' inherently due to their condition. However, as set out in Example 'B' of Mencap's evidence, 'challenging behaviour' is sometimes one of the few ways that a person with a significant learning disability is able to communicate their unhappiness with a situation. 'Example B' sets

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[17] Fear and the Defense Cascade: Clinical Implications and Management. June 2015, Harvard Review of Psychiatry

[18] Michael Weinberg, Sharon Gil, Avi Besser, Jasmin Bass, Personality traits and trauma exposure: The relationship between personality traits, PTSD symptoms, stress, and negative affect following exposure to traumatic cues, Personality and Individual Differences, Volume 177, 2021

[19] Walker, P 'Complex PTSD: from surviving to thriving', CreateSpace, 2013.

out the case of an individual who was seen by a care provider as content in a placement where he was regularly breaking objects and hitting his head on hard surfaces; the provider felt that this was simply B's nature and not an attempt to communicate. To B's family – who were ultimately proved correct - it was clear that he was very unhappy and trying to communicate his distress. Safeguards were then triggered and the problem was solved.

The proposed approach is inadequate to deal with the risks of pressure to consent and acquiescence

50. The pressure to give nominal 'consent' where the alternative is compulsory detention is very well-established in research around the Mental Health Act 1983. Surveys have shown that as many as a third of 'voluntary' psychiatric inpatients (many of whom would be considered capacitous) felt 'highly coerced' at admission, and a majority of 'voluntary' psychiatric inpatients were uncertain that they were free to leave the hospital.[20]

51. It is well established in the psychiatric literature that a significant portion of patients who are deprived in law of their liberty in psychiatric hospitals do not feel coerced (false involuntary) and a proportion of voluntary patients feel coerced (false voluntary).[21] Several studies have suggested that patients' perceptions of coercion do not always match their legal status.[22]

52. The people who would be affected by the test proposed are those who (1) lack capacity to make decisions as to their residence and care and (2) are de facto deprived of their liberty. This will include people who are suggestible by reason of their mental disability, and who are likely to react to pressure or simply the expectations of people in positions of authority and power over them. It is entirely commonplace and regularly seen by Independent Mental Capacity Advocates (IMCAs)[23] that people may be

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[20] Bindman, et.al., 'Perceived coercion at admission to psychiatric hospital and engagement with follow-up', Vol. 40 Social Psychiatry and Psychiatric Epidemiology, pages 160-166, February 2005.

[21] Lidz CW, Hoge SK, Gardner W, Bennett NS, Monahan J, Mulvey EP, Roth LH. Perceived coercion in mental hospital admission. Pressures and process. Arch Gen Psychiatry. 1995 Dec;52(12):1034-9. doi: 10.1001/archpsyc.1995.03950240052010. [https://pubmed.ncbi.nlm.nih.gov/7492255/]

[22] Griego, A. W., Datzman, J. N., Estrada, S. M., and Middlebrook, S. S. (2019) Suggestibility and false memories in relation to intellectual disability and autism spectrum disorder: a meta-analytic review. *Journal of Intellectual Disability Research*, 63: 1464–1474. https://doi.org/10.1111/jir.12668.

[23] IMCAs are used in England and Wales as statutory advocates under the Mental Capacity Act 2005 to assist people to participate in best interests decisions about them, and to ensure that their wishes and feelings are part of decision-making processes. HB721-HB733

unhappy with their care arrangements, but do not express objections or raise concerns where they do not feel that they have any power to change things, or fear consequences from those who have control over their lives. This is not a question of bad faith actors: there is an inherent power imbalance. It is not realistic to think that people who are highly vulnerable to pressure as a result of being both de facto detained and incapacitous will be able feel free to voice objections and protect themselves from abuse or mistreatment, or just overly restrictive support, without contact with independent people or legal frameworks to support them to do so.

53. Additionally, there is also likely to be a substantial pressure (whether tacit or overt) on those employed by the care providers to see people as 'consenting' to arrangements where the alternative would result in their employer having to incur the time and cost of seeking an authorisation for the person's detention.

The proposed safeguards are inadequate

54. Article 5 requires that a deprivation of liberty must be lifted immediately if the circumstances necessitating it cease to exist or change, or must be scaled down to the extent which is absolutely necessary under the given circumstances (*Hiller v Austria* [2018] MHLR 21 at [54]). Article 5(4) provides the right to a speedy judicial decision concerning the lawfulness of detention and ordering its termination, if it proves unlawful. The forms of review satisfying the requirements of Article 5(4) may vary across different contexts, and will depend on the type of deprivation of liberty in issue (*MH v UK* (2014) 58 EHRR 35 at [75]). However, the Article guarantees a remedy that must be accessible to the person concerned and afford the possibility of reviewing compliance with the conditions for a lawful deprivation of liberty.

55. Special procedural safeguards may also be called for, in order to protect the interests of persons who, on account of their mental health problems, are not fully capable of acting for themselves (*MH v UK* [2013] ECHR 1008 (App No 11577/06) at [79]-[83]; *AJ v A Local Authority* [2015] 3 WLR 683 at [35] and [36]). The right under Article 5(4) must be effective: this may give rise to a need for legal representation as part of the special procedural guarantees.

56. As set out above, the individuals affected by the Draft Code are de facto deprived of their liberty, as they are not in reality free to withdraw their consent. However, without

a legal framework authorising their deprivation of liberty, they are effectively without access to their Article 5(4) and 6 ECHR rights to challenge a detention.

57. The measures proposed in the AGNI's Written Case at [53-56] would not alleviate these pressures, as formal reviews would appear to take place only if the detaining body initiated them. There would be no independent person who would be engaged with the incapacitous person to determine if the detaining body's self-reporting that the person's "*positive attitude*" remained was accurate.

Whether the current approach engages or infringes the Article 8 rights of people with disabilities or their carers

58. Assessing a person with a view to protecting their Convention rights does not invariably or inevitably engage Article 8 ECHR. Although the threshold for engagement is not a specially high one (see *R (Razgar) v Secretary of State for the Home Department* (2004) UKHL 27), having one's capacity and best interests assessed does not come close to passing it, in the generality of situations. The nature of an assessment is a conversation in which the assessor will ask the person where they would like to live, the pros and cons of different options, and about the sorts of care that meet their needs, and their wishes and preferences. There is no reason why an annual review of a deprivation of liberty would need to be more intensive than an annual care review for a person, which it appears to be accepted is appropriate in the AGNI's Written Case at paragraph [54].

59. There are good policy reasons why capacity should be properly assessed. Failing to assess capacity has led to service providers hiding behind the presumption of capacity, which the UK Parliament has found "*is widely misunderstood by those involved in care. It is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm*".[24]

60. If a capacity assessment does constitute an interference with Article 8, then such interference is necessary and proportionate because the aim is to provide the safeguards required by Article 5(1) and Article 5(4) ECHR. Similarly, if (which is not accepted) the Article 8 rights of family members are capable of being engaged by involvement in

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[24] House of Lords, Select Committee on the Mental Capacity Act 2005, "Mental Capacity Act 2005: post-legislative scrutiny", HL Paper 139, 13 March 2014, para. 105. HB6806

an assessment for the purposes of authorising a deprivation of liberty, any interference is similarly justified under Article 8(2) because it is necessary "for the protection of the rights and freedoms of others" – i.e. their relative's Article 5 rights not to be deprived arbitrarily of their liberty.

61. Following *Cheshire West* many local authorities began reviewing individuals who were de facto detained in the community – the charities' evidence gives some examples of cases where restrictive elements of care arrangements have been reduced or removed as a result of the protections afforded by Article 5.

62. There is a wide range of systems which are deemed to be compliant to authorise a detention under Article 5 ECHR; the broad strands of these are administrative authorisations and judicial authorisations. It is possible to implement a system of authorisation and reviews of deprivations of liberty which is appropriate and proportionate – as Baroness Hale observed, such checks need not be elaborate (*Cheshire West at* [57]).

The relevance of the decision in *Cheshire West*

63. The subjective limb of Article 5 was not in issue in *Cheshire West*: it was common ground between the parties that people who lacked capacity to consent to their care arrangements could not give valid consent to the confinement created by those very arrangements.[25] The court considered the relevance of a person's objection to their care arrangements in the context of the objective limb of Article 5, not as a freestanding issue. This court has since confirmed that *Cheshire West* "*clarified the objective elements of a deprivation of liberty (limb (a)) of Storck v Germany*)" (*Re D* [2019] UKSC 42 at para 33) not the subjective element. This court can and should make a decision as to the meaning of valid consent in the context of Article 5(1)(e) without needing to reconsider *Cheshire West*.

64. The SSHSC seeks to engage this court in reconsidering the objective limb of Article 5. It would be wholly wrong for the court to do so, having regard to the following:

    a. The reference does not raise this issue. The draft Code of Practice that is the subject of the reference, explicitly adopts the *Cheshire West* test at 2.6-2.7 and

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[25] See *Cheshire West* at [37] HB2948 and [81] HB2959.

makes clear at 2.15-2.16 that the AGNI does not intend to depart from existing domestic case law on what constitutes an objective deprivation of liberty.

b. Contrary to the SSHSC's submissions at [67] that it is "*necessary*" to re-determine points which were settled in *Cheshire West* to determine "*to what an individual is consenting,*" it is entirely clear as to what consent must attach to in this context: the individual's residence and care arrangements, including any restrictive measures placed upon them.

c. The SSHSC has no power to make references directly to the Supreme Court for a determination of a legal issue in the abstract. Per *Devolution Issues,* it is generally preferable for legal issues to "*be ventilated against a clear factual backdrop*" [28]. The SSHSC's own submissions make plain how wide the range of factual scenarios are, and that a great many of these scenarios have already been ventilated by a variety of courts, which have refined and considered the understanding of what an objective deprivation of liberty is in a range of specific contexts.[26] The SSHSC's Written Case at [36]-[38] also makes clear how the objective test continues to be refined in High Court cases, where first instance judges have the ability to look closely into the specific circumstances of the case – which the SSHSC is of course free to intervene in should he wish to do so to make these arguments. Per *Devolution Issues*, even where a state body has the power to make a reference, the Supreme Court has declined to consider a reference where the state body may intervene in actual proceedings considering the relevant issues to allow their full determination "*by reference to the practical reality of their impact on society there, so that an insight into the outworking of the competing arguments can be obtained*" (*Devolution Issues* at [28]).

d. It would be procedurally unfair and improper to seek to revisit *Cheshire West* in circumstances where interested persons have had little or no opportunity to seek to file evidence or make representations.

e. This is a wholly inappropriate case to apply the *Practice Statement (Judicial Precedent)* [1966] 1 WLR 1234. The charities note the analysis on this point in *In the Matter of an Application by Rosaleen Dalton for Judicial Review* [2023] AC

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[26] See, e.g., the SSHSC's submissions HB106-HB107 on *R (Ferreira) v HM Senior Coroner for Inner South London* [2017] EWCA Civ 31, HB3189 in which the Court of Appeal considered whether a person who was unconscious and in intensive care was considered deprived of her liberty, and found that she was not.

235 (“*Dalton*”), and specifically the judgements of Lord Reed and the joint judgment of Lord Hodge, Lord Sales and Lady Rose. Lord Reed summarised his reasons for declining to apply the Practice Statement at [5] and [47] of *Dalton*, all of which the charities submit are present in this case.

i. *Cheshire West* was determined on three days of full, contested argument before the Supreme Court with parties with direct interest in the outcome of the litigation, relevant factual matrices and public notice of the relevant issues as a result of the cases proceeding from high-profile first instance judgments and detailed argument in the Court of Appeal to fully ventilate the issues. All seven of the judges agreed that ‘P’ in the case was deprived of his liberty (despite his apparent lack of objection) but disagreed as to whether ‘MIG’ and ‘MEG’ were confined. On any reading, the decision in *Cheshire West* was a “*tenable view*” as per Lord Reed in *Dalton* at [47]. Further, there has been no Strasbourg case law which casts doubt on *Cheshire West*. The SSHSC summarises post-2014 Strasbourg case law on deprivations of liberty, none of which specifically engaged with people in non-institutional settings, and in all of which an objective deprivation of liberty was found.

ii. The SSHSC has pointed out several academics who have criticised the court’s finding in *Cheshire West*, and a handful judges who have publicly criticised it out of the very many judges in the Court of Protection, Family Court and High Court who have considered deprivation of liberty issues arising out of *Cheshire West* since it was determined. Many other academics have lauded the decision in *Cheshire West*, including social workers.[27] HM Government said at the time that “*the judgment has been welcomed by many stakeholders and professionals*”, and “*handled appropriately*”, it “*could have a significant positive effect*” in raising awareness of

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[27] Whitaker, D, 2014, ‘Social Justice for safeguarded adults deprived of their liberty in the United Kingdom?’ *Disability & Society*, 1-5; MISSING McPherson, B, 2014, ‘All too often dementia in older age leads to professionals disregarding human rights’, *Community Care*, 28 April 2024’; MISSING James, E., Mitchell, B. & Morgan, H., 1989, ‘Social work, cats and rocket science: stories of making a difference in social work with adults’, London, Jessica Kingsley Publishers. MISSING

DoLS, "*empowering individuals and protecting their rights*",[28] . Since *Cheshire West*, no UK government has introduced legislation in Parliament to amend the subjective limb or objective limb of the deprivation of liberty, and until the filing of the Written Case in this case, the government has never said that it disagrees with the decision.

65. Should the court decide it is appropriate to revisit the objective limb as defined in *Cheshire West*, the charities will submit that:

    a. The decision in *Cheshire West* did not establish new principles of Convention law, and was entirely in line with the ECtHR's decision in *HL v UK* [2005] 40 EHRR 32. There, the ECtHR considered that the "*key factor*" in considering whether a person was deprived of his liberty was that his carers *"exercised complete and effective control over his care and movements"* [91] from the time of his admission, during which time HL was considered not to be objecting, to be compliant, and was "*making no attempt to leave*" [12]. *Cheshire West* found that whether the objective element of a deprivation of liberty was present did not turn on the "*relative normality*" [47] of the person's placement – and thus, restrictions which were considered at a certain time and place to be a "*normal*" way of living for a person with disabilities – but instead was the same test for any person whether or not they had disabilities,[29] namely: is the person subject to continuous supervision and control; and is the person not free to leave the place at which they are detained. This language was taken verbatim from that used by the ECtHR in *HL v UK* at [91] to describe why HL was objectively deprived of his liberty;[30] it was not an innovation of the Supreme Court in *Cheshire West*.

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[28] Quote at HB6909; HM Government, "Valuing every voice, respecting every right: Making the case for the Mental Capacity Act. The Government's response to the House of Lords Select Committee Report on the Mental Capacity Act 2005", June 2014. HB6899

[29] The Mental Capacity Act 2005 (MCA 2005) in England and Wales only permits detentions of those who lack capacity, and only permits those which are in the person's best interests, and have appropriate authorisation by a local authority under Schedule A1 to the Act, by the Court of Protection, or under s.4B of the Act where the detention is necessary for a vital act or life-sustaining treatment while an application for authorisation is made. Other legislation as the Mental Health Act 1983 (MHA 1983) HB580 provides a separate legal framework for the detention of people in psychiatric hospitals, whether or not they have mental capacity.

[30] "*… the Court considers the key factor in the present case to be that the health care professionals treating and managing the applicant exercised complete and effective control over his care and movements…"*. HB4627

b. The disputes over whether detentions outside of institutional settings in "*relatively normal*" accommodation arose in part due to deinstitutionalisation and the move towards care in the community for individuals who need significant support, who previously would have lived their whole lives in institutional settings such as psychiatric hospitals or care homes. As set out above, community arrangements can be just as restrictive or more restrictive than hospital or care home settings: it is the intensity of the restrictions which is key, not whether the restrictions are exercised in a home-like setting: *Cheshire West* at [47]. The lack of any similar case being decided in Strasbourg does not show that the ECtHR would have decided *Cheshire West* differently.[31]

c. While the reference emphasises the split decision of the Supreme Court in the two appeals linked to *Cheshire West v P* (the cases of *P and Q v Surrey County Council*), the decision in *Cheshire West* itself was a unanimous decision of the Supreme Court that 'P' was deprived of his liberty in a supported living accommodation despite his apparent lack of overt objections to it. The points made by the SSHSC were made and considered in *Cheshire West.* The SSHSC cites no new ECtHR cases determined since *Cheshire West* to support a different conclusion as to the relevance of the absence of objection on the part of the disabled person.

d. Prior to *Cheshire West,* there were high levels of confusion among mental health and social care professionals about what constituted a deprivation of liberty. The need for an easily understood and consistent legal definition of an objective deprivation of liberty was central in the charities' intervention in *Cheshire West*, and evidence of this confusion was set out in some detail in contemporaneous research conducted by the Institute of Policy.[32] *Cheshire West* provided a clear

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[31] Indeed, the ECtHR has found that care homes can be places where a disabled person is deprived of their liberty: *Stanev v Bulgaria* (2012) 55 EHRR 22, HB4884 considered in *Cheshire West*. HB2942-HB2949

[32] The witness statement submitted on behalf of MIND in its intervention in *Cheshire West* set out:

- A 2013 report of the House of Commons Health Committee on post-legislative scrutiny of the Deprivation of Liberty Safeguards scheme. The report found that *"application of the safeguards is variable an on many occasions those responsible for ensuring patients are protected by them have failed to do so. There is considerable confusion around the scope of the safeguards and how and when to apply them in practice. The evidence the Committee heard regarding the application of DOLS revealed a profoundly depressing and complacent approach to the matter. There is extreme variation in their use and we are concerned that some of the most vulnerable members of society may be exposed to abuse because the* and workable definition of the objective limb of Article 5 that has substantially reduced confusion for people, their families and professionals working with them as to whether or not the person is deprived of their liberty.

Conclusion

66. The charities invite the court to refuse to determine the reference in the abstract, but if it is determined, to hold that the proposed approach to valid consent for the purposes of Article 5(1)(e) is not lawful. The charities also invite the court to refuse to address the SSHSC's submissions on the objective element of a deprivation of liberty.

Victoria Butler-Cole KC
Arianna Kelly
39 Essex Chambers

Oliver Lewis
Doughty Street Chambers

Counsel for Mencap, Mind and the National Autistic Society
30 September 2025

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legislation has failed to implement controls to properly protect them." HB6675 *Post Legislative Scrutiny of the Mental Health Act 2007,* first report of the session 2013-2014, July 2013. HB6669

- The CQC's 2011/2012 Annual report *Monitoring the use of the Mental Capacity Deprivation of Liberty Safeguards*, HB6592 which suggested that the MCA and DOLS were not well understood by health and social care professionals, and the MCA was not well understood or implemented. The report found that *"[t]here continues to be confusion around the precise definition and thresholds for deprivation (as opposed to restriction) of liberty."* HB6601 This followed the CQC carrying out a series of unannounced inspections at services caring for people with learning disabilities and challenging behaviour in the wake of abuses at Winterbourne View Hospital.

Annex: Legal Safeguards

1. The legislative frameworks set out in the SSHC's Annex 1 govern various aspects community care and regulation of care providers in England and Wales. None of them purport to relate to the authorisation and assessment of deprivations of liberty, or have that purpose. Only some of them post-date *Cheshire West*, and of the newer elements, many are no more extensive than the regimes in place at the time of *Cheshire West.*

2. While there have been updates to existing legal frameworks in England and Wales since *Cheshire West*, there have not been fundamental changes as:
    a. The relevant provisions of the Mental Capacity Act 2005 which are cited were all in effect and the Mental Capacity Act Code of Practice has not been amended; (and thus all legislative provisions cited on page 1 of the Annex are identical to the position when *Cheshire West* was determined);
    b. The Mental Health Act 1983 has not been significantly amended;
    c. There were previously and there are still legal frameworks for assessing needs, providing care plans and reviewing them;
    d. At the time of *Cheshire West* and today, Advocates or family members may support people who lack mental capacity;[1]
    e. At the time of *Cheshire West* and today, there are independent regulators which oversee care settings.

3. Further, very many people who are deprived of their liberty may not be affected by changes to community care legislation, namely:
    a. People who are in hospitals (either for mental health or physical health), who are not subject to community care legislation; and
    b. People who privately fund their care (which represents approximately half of older people who reside in care homes[2]).

4. In relation to assessments and care planning, at the time *Cheshire West* was determined, the statutory guidance[3] issued under section 7(1) of the Local Authority Social Services

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[1] See, e.g., *Caring for our future: reforming care and support*, Secretary of State for Health, July 2012 at page 55 HB6668:

> *Advocacy services have been in place for more than 30 years, often providing support for people who lack mental capacity and who have no-one to act on their behalf. These services will continue to play a vital role in supporting people and we need to understand better the benefits of these services and how cost-effective they can be. We will therefore work with partners to develop and disseminate best practice and potential new business models.*

[2] Source: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/articles/carehomesandestimatingtheselffundingpopulationengland/2022to2023

[3] *Prioritising need in the context of Putting People First: A whole system approach to eligibility for social care Guidance on Eligibility Criteria for Adult Social Care*, England 2010; Department of Health. HB1962 Available at:

Act 1970 (and thus with the status of *Rixon* guidance, which could not be departed from without good cause) directed local authorities to carry out their statutory obligations in a manner closely aligned with what would become the Care Act 2014. The Guidance was also clear on the need to embed Mental Capacity Act 2005 principles in the conduct of assessments and care planning and to ensure that a person's wishes and feelings were sought, people in their lives were involved in care planning, and advocacy was used as appropriate. This included:

   a. [22]: *Councils should also consider where the use of Independent Mental Capacity Advocates (IMCAs) and other advocates – such as dementia advocates or learning disability advocates – might be appropriate to ensure that as far as possible people are supported to be involved in the decision-making process.*
   b. [89]:*Councils should also be aware of the unique position of adults who lack capacity, as defined by the Mental Capacity Act 2005. Adults who lack capacity may find it harder to communicate their needs and aspirations and may require additional support during assessment and support planning, such as the use of alternative forms of communication and information as well as access to an independent advocate. Councils should pay particular attention to the five statutory principles set out in section 1 of the Mental Capacity Act when working with people lacking capacity and their representatives.*
   c. [146]: *Adults lacking capacity are likely to need more frequent monitoring arrangements than other service users. They may be less able to communicate their needs and wishes and there may be issues around fluctuating capacity.*

5. As with the Care Act 2014, local authorities were obligated to undertake both regular reviews, and review on as required, which focused on the outcomes the person wished to achieve. [Guidance at 141-151] Regulations for choosing accommodation had existed since 1992,[4] and the key changes around this following *Cheshire West* were to extend it to supported living accommodations and shared lives care as well as care homes, and extending it to s.117 Mental Health Act aftercare rather than only social care legislation.[5]

6. In relation to the points raised in relation to regulators, the CQC and Ofsted both significantly pre-date *Cheshire West*. The main differences cited by the SSHC are that front-line providers now have obligation to take a short training course relating to learning disabilities and autism;[6] and that the CQC now undertakes reviews of local authorities and integrated care systems. These inspections operate at a systemic level, and do not offer any meaningful oversight or review for any particular individual.

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https://www.peoplefirstinfo.org.uk/Resources/myLife/library/DOH/Putting%20People%20First%20Guidance%20on%20Eligibility%20Criteria%20for%20Adult%20Social%20Care.pdf

[4] National Assistance Act 1948 (Choice of Accommodation) Directions 1992

[5] See, e.g., Care and Support and After-care (Choice of Accommodation) Regulations 2014, SI 2014/2670

[6] https://www.hee.nhs.uk/our-work/learning-disability/current-projects/oliver-mcgowan-mandatory-training-learning-disability-autism

7. In relation to criminal offences, again, overwhelmingly, these offences existed at the time of *Cheshire West*, save for additional specific offences under the Criminal Justice and the Courts Act 2015 relating to ill-treatment by a care worker.

8. The legislative safeguards are broadly in line with what existed at the time *Cheshire West* was determined. There have been no legislative changes which so shift the landscape as to realistically alter the court's analysis in that judgment.

9. In Northern Ireland there has been an ongoing stream of work regarding adult social care legislation since the Commissioner for Older People for Northern Ireland's 2016 report, 'Home Truths: A Report on the Commissioner's Investigation into Dunmurry Manor Care Home.'[7] The Commissioner's investigation found abuses which he considered rose to the level of Article 3 ECHR violations, including serious sexual and physical assaults on elderly female residents, residents leaving the care home and wandering in the community, and people coming to harm due to severe neglect (with some being found by their families dehydrated and unresponsive). Families reported the stark lack of responsiveness by the care home, which 'closed ranks' when problems were raised, and treated complaints about sexual assaults as 'an absolute joke.'

10. A series of further reports arising out of the initial report found that there were widespread problems across care homes regarding the efficacy of care planning and reviews. A report was commissioned by the Northern Ireland Department of Health to conduct a 'whole systems' review of adult social care; Evidence Paper 4 published in December 2020[8] considered Assessment and Care Management, including care planning and reviews. The report highlighted profound problems in adult social care, including the lack of a voice for people and their families in the process, care planning decisions being taken by people who did not know the individual, a lack of an ability to effectively challenge decisions and people being in overly restrictive setting rather than their own homes. The charities also note the ongoing investigation into the abuse of people with a learning disability at Muckamore Abbey Hospital up to 2021.[9] This work led to a reform of services in 2022 under the Health and Social Care Act (Northern Ireland) 2022, and the charities are not aware of more recent publications from the Northern Ireland Department of Health tracking the extent to which these legislative changes have affected the experiences people have in receiving social care.

11. Efficacy of existing legal frameworks: England: The charities agree that much of English social care legislation (and healthcare legislation which governs social care in

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[7] HB7274. https://copni.org/assets/general/resources/copni-home-truths-report-web-version.pdf

[8] HB7442 https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-cpea-evidence-paper-4.PDF)

[9] https://www.mahinquiry.org.uk/

the community) has over the last decade sought to align itself with the Mental Capacity Act 2005, and echoes the language of the least restrictive principle. These laws generally include some legislative provision to seek out the wishes and feelings of people who lack capacity. There are frameworks for the safeguarding of children and adults, and general provisions for the initial development of care plans and review of care plans over time. Where the charities disagree with the SSHC is that:

a. None of these frameworks have a statutory purpose of authorising, monitoring or reviewing people's Article 5 ECHR, nor do they purport to do so. Many of the 'safeguards' cited exist largely in theory rather than in practice (see further below).

b. There are large numbers of people who fall outside of public social care entitlements where they do not meet the means test, who would not benefit from many of the protections.

c. Regulatory assessments are not directed at the protection of the rights of individuals, but at considering institutions as a whole. CQC and Ofsted inspections are a snapshot of the quality of the service at a particular time rather than involving ongoing monitoring, and inspectors proceed by 'sampling' records:[10] There is no suggestion that a CQC review would consider all or even most of the residents in a care setting, and it is not aimed at ensuring any particular individual's rights are protected.

12. Legal framework: Neither the Care Act 2014 nor the Care and Support Statutory Guidance are prescriptive (save in very limited circumstances) as to what must be undertaken in an assessment or care review. These may be undertaken by telephone (Guidance at 6.3) and it is always the determination of the local authority as to what a 'proportionate' process should be. A local authority is not obligated to undertake assessments, care planning or care reviews itself, and may delegate these functions to others,[11] including a care provider. Care reviews are not required to be undertaken at set periods of time, and the only statutory obligation is to keep them under review 'generally' and on the 'reasonable request' by or on behalf of the adult.[12] A care plan review may be 'light-touch' per the Care and Support Statutory Guidance at 13.7; it is ultimately at the discretion of the local authority whether a review takes place, and what that review entails.

13. Assessments, care planning and care reviews are for the purpose of a local authority determining how to discharge its statutory obligations to the person: they are not for the purpose of authorising or reviewing a person's detention under Article 5 ECHR. For example:

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[10] *R(Hexpress Healthcare Ltd) v The Care Quality Commission* [2023] EWCA Civ 238 HB3846

[11] S.79 Care Act 2014 HB891

[12] S.27 Care Act 2014 HB867

a. There is no obligation to seek medical evidence to determine whether a person is of 'unsound mind' for the purposes of Article 5 ECHR, a clear requirement of Strasbourg case law.
b. There is no obligation to ensure that material which is relied upon to justify confinement is sufficiently timely, again a clear requirement of Strasbourg case law.
c. There is no requirement to ensure access a court to challenge a deprivation of liberty.
d. There is no straightforward legal route to challenging Care Act decisions at all save for making a complaint or via judicial review. There is no tribunal, and there is no means of having any speedy determination of these issues for the purposes of Article 5(4).
e. There is no statutory provision for advocacy to support the making of a complaint or a legal challenge.

14. <u>Reality of effective assessment, care planning and care reviews</u>: The SSHC's picture of the robustness of safeguards at [75] offered in social care legislation have little relationship with the reality on the ground. In December 2022, the House of Lords Adult Social Care Committee published, 'A "gloriously ordinary life": spotlight on adult social care.' [13] The charities note the following from that report:
    a. There are severe backlogs and delays in assessments and care planning. Research quoted from the Local Government Association 'that just over half a million people are currently awaiting a care needs assessment, a care package, a direct payment or a review of an existing care plan.' [para 24][14]
    b. People who were privately funding care or had informal care 'have little or no contact with a local authority.' [56]
    c. Social care assessments were typically a 'tickbox' exercise. They made 'for a highly impersonal system that leaves no room for a person to express how they could be empowered to live a meaningful life beyond basic personal care. This is aggravated by local authorities facing reduced budgets: they are more likely to act as 'gatekeepers' to keep people out of the system.' [101]
    d. Assessments themselves were being rationed, and were not available to all people. '*The CQC's latest data shows that in January and March 2022, 61% of councils said they were having to prioritise assessments and were only able to respond to people with specific circumstances*.' [106]
    e. People did not actually feel able to challenge findings in assessments they disagreed with, and were met with concerning responses when they did so. [108]

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[13] HB7480 https://committees.parliament.uk/publications/31917/documents/193737/default/

[14] Some of these figures were attributed to the legacy of pandemic pressures; however, the most recent CQC data indicated that as of March 2024, over 418,000 were still waiting for assessment, care or direct payments to begin or a review of their care. https://www.cqc.org.uk/publications/major-report/state-care/2023-2024/access

f. While 'in principle' the Care Act 'enshrined' important principles in law about person-centred care, [para 216] these were not actually implemented on the ground: '*There is consensus, however, that the Act has never been implemented in practice and has resulted in little change on the ground for older adults and disabled people as well as unpaid carers…Even the Government admitted in its December 2021 White Paper that "the full spirit of the Care Act is not currently being met." Throughout our inquiry, we heard that this is reflected on the ground….Far from ensuring individuals' wellbeing, care services tend to be reduced to a minimum and designed to enable people to survive, rather than to live and thrive. Choice and control seem to exist mostly in legislation, whether for older adults and disabled people, or for unpaid carers. Many witnesses directly linked the failures of the social care system to the failure to implement the Act, pointing to the "disparities" between the ambitions laid out in the Act and the experiences of practitioners, unpaid carers and people with lived experience on the ground. The challenges faced by the social care sector today were therefore largely attributed to the difficulties that local authorities face to fulfil their duties as outlined in the legislation.'* [Para 216-217]

g. Councils did not actually have funding to implement the requirements of the Care Act 2014: '*The tangible explanations for the shortcomings of the Act start and finish with funding. Faced with stretched budgets, local authorities cannot afford to provide services that go beyond minimum support.'* [Para 223]

15. The provisions of s.72 Care Act 2014 which permit regulations to create a tribunal system to enable care packages to be subject to review have never been implemented.

16. . It is unrealistic to suggest that there is now a system of protections which has so radically altered since the determination of *Cheshire West* to cast doubt on the judgment.

17. The lack of safeguards is particularly evident for autistic people or learning disabilities in restrictive settings. In the 2020 letter[15] of Baroness Hollins (who had been tasked by DHSC lead the Independent Care (Education) and Treatment Review (IC(E)TR) programme for people with a learning disability and autistic people in inpatient settings) to DHSC, she wrote:

> *"The panel is particularly concerned that people's human rights are not being respected, that families are not listened to and that poorly trained and poorly motivated staff and organisations with perceived self-interests are not willing to learn from them……most of them have histories of past adverse life events and significant trauma but there was little evidence of any trauma informed care and plenty of evidence of people being re-traumatised during their hospital stay…. most are autistic people, but the hospital environments were not autism friendly or autism aware……escalation processes following concerns about*

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[15] https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews/baroness-hollins-letter-to-the-secretary-of-state-for-health-and-social-care-about-the-independent-care-education-and-treatment-reviews

> *safeguarding or possible human rights violations raised were too slow..... families are being excluded in several ways, and in most cases, they are not being recognised as essential members of the team responsible for ensuring the persons best interests are being met."*

18. <u>People who do not receive care and support funded by the state</u>: Community care support from the state is not available to all people who have needs for care and support, and entitlements are limited on the nature of the person's needs and (for social care from local authorities), the person's financial eligibility on the basis of their capital and income. The upper capital limit above which a person is responsible for fully funding their adult social care is £23,250 in assessable capital. The general entitlement for a person to have their needs met under s.18 Care Act only applies to people for whom there is <u>no charge</u> for meeting the adult's needs for care and support due to there being a prohibition in regulations from making such a charge, or the local authority choosing not to charge the person even though it has power to do so(. If there is a charge for meeting needs (from either capital or income), a local authority is only obligated to meet needs if one of three conditions are met:
    a. Condition 1: the adult has capital under the upper capital limit of £23,250;
    b. Condition 2: the adult has capital above the upper capital limit but asks the local authority to meet the adult's needs (other than by providing accommodation in a care home – as set out below); or
    c. Condition 3: the adult lacks capacity to arrange for the provision of care and support and there is no person authorised to do so under the Mental Capacity Act 2005 or otherwise in a position to do so on the adult's behalf.

19. Approximately half of older people living in care homes fund their own care. The s.18 Care Act duties in respect of self-funders were limited by Article 3 of the Care Act 2014 (Commencement No. 4) Order 2015 (SI 2015/993), which establishes that where a person is above the upper capital limit and their needs will be met by the provision of accommodation in a care home, the local authority does not have an obligation to meet the person's needs on the basis of the person's request. There is no obligation under s.18 Care Act to meet self-funders' needs where their needs are being met by a place in a care home if the person is able to arrange it, or has a person in a position to arrange care on behalf of the person. S.18 Care Act does not insist the person 'able to arrange' the care provision for the person needing care have formal authority under the MCA to do so.

20. Thus, for any incapacitated person with over £23,250 who has a person 'in a position' to make arrangements for their care in a care home, there is no obligation for a local authority to meet their needs under the Care Act at all, and thus no obligation to prepare a care plan or conduct care reviews. People in this position do not fall into Care Act entitlements for the provision of care, and would likely only come to the attention of a local authority if a specific safeguarding issue was raised in relation to them.

21. By contrast, the Deprivation of Liberty Safeguards framework covers all detained residents regardless of who made the arrangements for their care; they would not exclude the many older adults who fund their own care.

22. Advocacy: Care Act advocacy has a different purpose and function to advocates who support people who are deprived of their liberty. There is no general entitlement to an independent advocate under the Care Act 2014: the decision of whether a person needs an advocate is taken by the local authority arranging the person's care. A right to independent advocacy is only triggered if:
    a. The local authority considers there is no 'appropriate person' to facilitate the involvement of the person with care needs in certain functions of the Care Act 2014;[16] it is commissioned for these specific tasks, and does not continue in between these acts. Where the person lacks capacity, the local authority is charged with taking a best interests decision as to whether it is satisfied that it is the person's best interests to be supported by the 'authorised person';[17] and
    b. The person with care needs has 'substantial difficulty' with understanding, retaining or using and weighing information or communicating a decision.[18]

23. The 'Gloriously Ordinary Life' Report sets out some of the fundamental problems relating to Care Act advocacy, including that the efficacy of advocacy organisations is badly undermined by their being funded by the very local authorities which they would need to challenge: '*Witnesses warned us, however, that there is a risk, from the moment that a local authority is funding an organisation, that the funding is withdrawn if the organisation becomes a source of challenge to the council, which ultimately would be counterproductive. Only total independence will guarantee a level of protection against the risk of intimidation and the withdrawal of funding.'* [para 309]

24. Challenges in advocacy can be particularly severe for people with learning disabilities and autism in restrictive settings. The Social Care Institute for Excellence's report, 'Safeguarding Adults Review on Whorlton Hall' found that there was an 'illusion' of advocacy for autistic people and people with learning disabilities who are hospital inpatients or at risk of being hospital inpatients. The report (commissioned by the local authority with safeguarding responsibility for the area) found that '*Current arrangements for the commissioning and oversight of advocacy services and the skill requirements of independent advocates, are inadequate for people with learning disabilities and/or who are autistic, who are in-patients in specialist mental health hospitals or who are at risk of becoming in-patients. This leaves people in the most high-risk settings, the least well served and creates a false security that advocacy is in place.'*

25. The National Development Team for Inclusion's 2023 report (commissioned by NHS England), 'A review of advocacy,' set out how, to the extent advocacy support exists, it is typically about a particular 'issue,' leading to people not having an ongoing link to an advocate, and frequently changing the advocates who support them. There are also gaps in the provision of advocacy due to confusion and misunderstanding of responsibility for this.

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[16] These functions are conducting a needs assessment for a person or carer, preparing or reviewing a care and support plan or support plan for a person or carer, or equivalent assessments for children and young people whose needs are met under the Care Act 2014. S.67(3) Care Act 2014.HB876 There are equivalent provisions for safeguarding inquiries. S.68 Care Act 2014. HB879

[17] Ss.67(5)-(6) Care Act 2014, HB877; s.68(4) Care Act 2014, HB879.

[18] S.67(4) Care Act 2014 HB876; s.68(3) Care Act 2014, HB879.