UKSC/2025/0042

IN THE SUPREME COURT OF THE UNITED KINGDOM

IN THE MATTER OF A REFERENCE BY THE ATTORNEY GENERAL FOR NORTHERN IRELAND UNDER PARAGRAPH 34 OF SCHEDULE 10 TO THE NORTHERN IRELAND ACT 1998

WRITTEN CASE ON BEHALF OF THE SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE

A. Introduction

1. This is the written case on behalf of the Secretary of State for Health and Social Care ("the Secretary of State"). The Secretary of State has policy responsibility for health and social care in England (health and social care generally are devolved under each of the devolution statutes, subject to particular reservations). The Mental Capacity Act 2005 ("the MCA") extends to England and Wales, and the subject-matter of the MCA is a reserved matter under the Government of Wales Act 2006, so is reserved to the UK Parliament. The Secretary of State has policy responsibility generally for deprivation of liberty in the adult health and social care context, as well as having policy responsibility for those parts of the MCA that concern deprivation of liberty within the meaning of Article 5 of the European Convention on Human Rights ("the Convention")[1]. These submissions are made on behalf of the UK Government.

2. This reference is concerned with the meaning of the term "deprivation of liberty" in Article 5(1) of the Convention. The term is an autonomous Convention concept. In *Storck v Germany* (2005) 43 EHRR 96 (*"Storck"*), the European Court of Human Rights ("the ECtHR") concluded that a deprivation of liberty for the purposes of Article 5 has three components:-
    (1) The objective component of confinement in a restricted space for a non-negligible period of time (limb (a));
    (2) The subjective component that the person has not validly consented to that confinement (limb (b)); and
    (3) The detention being imputable to the State (limb (c)).

3. As the Attorney General for Northern Ireland ("AGNI") has identified, this reference involves consideration of the scope and correctness of the Supreme Court's decision in *Surrey County Council v P (Equality and Human Rights Commission intervening); Cheshire West and Chester Council v P* [2014] AC 896 ("*Cheshire West*"). As a result of *Cheshire West,* approximately four hundred thousand incapacitated people in England and Wales are now deprived of liberty on an annual basis[2]. The United Kingdom is in the throes of what has been termed *"a great confinement"* – the mass authorisation of deprivation of liberty of a significant proportion of the disabled population[3]. If an individual is deprived of liberty, a lawful process to authorise

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1 The Secretary of State for Justice has overall policy responsibility for the MCA, and the Lord Chancellor is under a duty to issue a statutory Code of Practice under section 42 of the MCA. The Secretary of State for Education has policy responsibility for the deprivation of liberty of most children and young people, including 16 and 17 year olds to whom the MCA applies.

2 See further at §52 below. This is approximately five times the prison population of England and over seven times the number of recorded detentions under the Mental Health Act 1983 (52,731).

3 See Allen, N. *"The (not so?) great confinement"*, (2015) Elder Law Journal 45-51.

the same will confer extensive safeguards upon them. However, this cohort includes many whose lives are enriched by the care and treatment provided to them, who are happy and fulfilled in the place where they live, and do not object to the restrictions that may be in place. *Cheshire West* has created the *"paradoxical outcome*[4]*"* that a person who is positively happy with their living arrangements, and has no desire to leave them, has ended up in a situation where they are being deprived of liberty by the State. They face significant State intrusion into their lives, and those of their families, as a result of the need to authorise that deprivation of liberty. The Secretary of State is anxious to ensure that those who require the protections of Article 5 receive them, without needless intrusion into the lives of those who do not.

4. The Secretary of State has intervened in these proceedings to assist the Court in determining what Article 5(1) of the Convention means by "deprivation of liberty" for incapacitated persons. The Secretary of State and the AGNI are at one in contending that a significant proportion of those currently treated as being deprived of liberty are not deprived of liberty under Article 5(1) of the Convention at all, and would not be found to be deprived of liberty by the ECtHR. The AGNI submits that this Court can resolve the "paradox" by changing the current understanding of the concept of "valid consent" under limb (b) of the *Storck* test, and she asks this Court to determine whether revising the (Northern Ireland) Deprivation of Liberty Safeguards Code of Practice in this way would be incompatible with Article 5. The Secretary of State submits that the factors that the AGNI relies upon - particularly the absence of coercion and evidence that the individual has no objection to the arrangements in question - are properly considered by the ECtHR under limb (a) of the *Storck* test, and go to the question of whether the individual is confined in the first place.

5. The Secretary of State recognises that this submission is contrary to the decision of the (bare) majority in *Cheshire West.* However, for the reasons set out below, the Secretary of State contends that the law took a wrong turn in *Cheshire West,* and invites this Court to return to the ECtHR approach. Further, there are now extensive safeguards for incapacitated persons who are provided with care and support, which were not in place at the time of *Cheshire West* (see Annex 1). As such, the "policy rationale"[5] for extending the scope of deprivation of liberty in order to provide checks on the vulnerable is much reduced.

6. In summary, the Secretary of State's position is as follows.

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[4] See Series, L. *"Deprivation of Liberty in the Shadows of the Institution"* (Bristol University Press, 2022), at pg. 30, 195-200.

[5] As Lady Hale described it at §57 of *Cheshire West.*

(1) First, *Cheshire West* was wrongly decided, and went far beyond the ECtHR case law. This Court is invited to depart from it. The ECtHR has never adopted an "acid test" and continues to carry out a multi-factorial analysis.

(2) Secondly, if the Court does not accept (1), the Secretary of State invites the Court to accept the AGNI's submissions on valid consent, subject to the caveats set out in Section F.

B. Article 5 and the domestic legal framework

(1) Article 5 of the Convention

7. The relevant parts of Article 5 of the Convention provide that:-

> *"1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:*
> *….*
> *(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants…*
> *….*
> *(4) Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if his detention is not lawful.*"

8. Article 5 of the Convention protects liberty in the "classic sense" of physical liberty: see *Engel v The Netherlands (No 1)* (1979-80) 1 EHRR 647 ("*Engel*") at §58. The aim of Article 5 is to ensure that no one is deprived of this liberty in an arbitrary fashion. The ECtHR has repeatedly held that (a) the difference between restrictions on liberty such as to constitute a deprivation of liberty, and mere restrictions on liberty of movement governed by Article 2 of Protocol 4, is one of "*degree or intensity*", and not one of "*nature or substance*"; and (b) the starting point for determining whether a person has been deprived of liberty is the person's "*concrete situation*" and "*account must be taken of a whole range of criteria, such as the type, duration, effects and manner of implementation of the measure in question*": see, for example, *Engel* at §59; *Guzzardi v Italy* (1981) 3 EHRR 333 ("*Guzzardi*"), at §§92-3; *Creangă v Romania* (2012) 56 EHRR 361, (GC) at §92; *De Tommaso v Italy* (2017) 65 EHRR 19 (GC) at §80.

9. The "paradigm" case of deprivation of liberty is detention in a cell: *Guzzardi,* §95. So far as Article 5(1)(e) is concerned, this has been extended to include detention in psychiatric hospitals: see, for example, *Ashingdane v United Kingdom* (1985) 7 EHRR 528 *("Ashingdane")* and *HL v United Kingdom* (2005) 40 EHRR 32 ("*HL*"). The ECtHR has also found there to be a deprivation of liberty when an individual is placed in certain social care institutions: see, *Stanev v Bulgaria* (2012) 55 EHRR 22, (GC)[6].

[6] This was a "specialised institution" with capacity for over 100 people, where conditions breached Article 3.

10. However, as Dr Series points out[7]:-

> *"Each of these cases originated in countries from the former Soviet Union, which are still heavily reliant on large-scale, isolated, and highly institutional social care facilities… Each country operated guardianship laws which typically deprive a person of 'legal capacity' across all areas of life, including even the ability to challenge one's placement or being put under guardianship. These "concrete situations" were so very similar to mental health detention in large-scale institutions, and their legal situation so plainly problematic, that it is not surprising the court ruled as it did."*

11. The ECtHR has never found that a person of "unsound mind" (as Article 5 puts it) is deprived of liberty in an "ordinary" care home, where they are cared for in the community, or where they are looked after in their own home.

12. Detention is only lawful if it falls within one of the permitted purposes listed in Article 5(1)(a)-(f), including "persons of unsound mind". Given the importance of the right to liberty, the ECtHR has laid down extensive substantive and procedural safeguards before deprivation of liberty can be lawful under Article 5(1)(e): see the *Winterwerp* requirements[8]. These are reflected in the domestic law requirements for authorising deprivation of liberty, particularly in the DOLS safeguards in Schedule A1 to the MCA[9] (requiring an age assessment, eligibility assessment, mental health assessment from a medical practitioner evidencing that P is of unsound mind, mental capacity assessment, no refusals assessment and a best interest assessment) and the *Re X* judgments[10]. An individual must be able to take proceedings to challenge the lawfulness of his detention, and the lawfulness of that detention must be reviewed at "*reasonable intervals*". Under the MCA, any authorisation of a deprivation of liberty must be reviewed at least annually[11].

(2) The Mental Capacity Act 2005

13. Key principles of the MCA are set out in section 1, including (a) that any act done or decision made on behalf of a person who lacks capacity must be done, or made, in his best interests (section 1(5)); and (b) the "less restrictive" principle (section 1(6)). The MCA contains a statutory test for determining when a person lacks capacity in relation to a particular matter (section 2 and 3). The test is satisfied if a person is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in, the functioning of, the

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7 See Series,L. *Deprivation of Liberty in the Shadows of the Institution* (2022), Bristol University Press, pg 94.

8 See *Winterwerp v Netherlands* (A/33) (1979-80) 2 EHRR 387, §39.

9 Applicable in hospitals and registered care homes.

10 Applicable in all other settings: see *X (Deprivation of Liberty)Nos 1 and 2* [2015] 1 WLR 2454; and [2016] 1 WLR 227. The evidential requirements are now reflected in the detailed (31 page) COPDOL11 application form which must be completed whenever an application is made to authorise a deprivation of liberty.

11 And more frequently if circumstances change: see §§42(1),51(1),51(2), 55(1)(c), 64 of Schedule A1 to the MCA, and *Re X* §22.

mind or brain. A person is unable to make a decision for himself if he is unable (a) to understand the information relevant to the decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision. Section 5 enables decision makers to carry out acts in connection with personal care, health care, or treatment of a person who lacks capacity to make their own decisions about the same, by conferring protection from liability (as long as the act is done in the reasonable belief that capacity is lacking and that the act is in the patient's best interests)[12]. As originally enacted, section 6(5) included a limitation to section 5, and provided no protection for action that amounted to a deprivation of liberty for the purposes of Article 5.

14. In *HL*, the ECtHR held that an autistic man who lacked capacity to consent to admission to hospital for treatment was deprived of his liberty when he was admitted informally to Bournewood Hospital. The House of Lords had concluded that HL had not been detained, and if he had been, was not falsely imprisoned, relying on the common law doctrine of necessity[13]. The ECtHR concluded that HL was being deprived of his liberty. Article 5(1) and (4) had been breached because (a) the deprivation of liberty was not in accordance with a procedure prescribed by law and so was arbitrary (§§120, 123-124); and (b) the procedures for challenging the deprivation of liberty by way of judicial review and/or *habeas corpus,* did not comply with Article 5(4) as there was no procedure by which HL could seek a merits review of his detention (§140). Amendments were made to the MCA by the Mental Health Act 2007 to "*fill the Bournewood gap*" (i.e. to remedy those breaches of Article 5). In summary, the MCA was amended to repeal section 6(5), and to insert new sections 4A and 4B, which set out the circumstances in which P may lawfully be deprived of liberty. Section 4A(5) permits deprivation of liberty if the deprivation is authorised by Schedule A1 (which contained a new system of administrative authorisation). Section 4A(3)-(4) provided that D may lawfully deprive P of his liberty if D is giving effect to a relevant decision of a court (essentially an order made by the Court of Protection in a relation to a matter concerning P's personal welfare)[14].

15. Crucially, the 2007 Act also inserted section 64(5)-(6) into the interpretation section of the MCA. This tied the definition of "deprivation of liberty" to Article 5(1) of the Convention:-

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[12] In essence, D does not incur any liability in relation to the act that he would not have incurred if P had had capacity to consent in relation to the matter, and had consented to D's doing the act. It does not exclude civil or criminal liability resulting from negligence.

[13] See *R v Bournewood Community and Mental Health NHS Trust ex p L* [1999] 1 AC 458.

[14] Section 4B provides that D may lawfully deprive P of liberty if that deprivation is necessary for life-sustaining treatment or doing a vital act while a decision on relevant issues is sought from the court.

" In this Act, references to deprivation of a person's liberty have the same meaning as in Article 5(1) of the Human Rights Convention[15]"

16. The MCA extends to 16 and 17 year olds. Children can also be deprived of liberty by court order under section 25 of the Children Act 1989 (if a secure accommodation order is made[16]) or under the inherent jurisdiction of the High Court[17]. Those in need of care and treatment may also be detained under the Mental Health Act 1983 ("the MHA") if the conditions for detention contained therein are made out. The interaction between the MHA and the MCA is dealt with in Schedule 1A to the MCA.

(3) ECtHR case law before Cheshire West

17. Before *Cheshire West,* the ECtHR had considered the circumstances in which a person of "unsound mind" would be deprived of liberty. The *Engel/Guzzardi* "multi-factorial", test was applied routinely by the ECtHR throughout this period (and has continued to be applied by it since, see §§24-31 below). The following factors have been crucial in any case where limb (a) was satisfied:-

    (1) Whether the individual is free to leave the place they are residing at the time: *Ashingdane,* §§24, 42*; HL,* §91*; Storck,* §73; *Shtukaturov v Russia* (2012) 54 EHRR 27, §107-109 *("Shtukaturov"); HM v Switzerland* (2004) 38 EHRR 17 (*"HM"),* §32. If the placement has doors that are locked, this will be indicative of confinement: *Ashingdane,* §24; *Storck, §*73; *Shtukaturov,* §101. The fact that doors are locked/lockable is not determinative, and an individual may be detained during a period on an open ward with regular unescorted access to the unsecured hospital grounds, and unescorted leave outside the hospital: *Ashingdane,* §§24, 42; *HL,* §§91-92; *Stanev,* §§25-27, 116 (home management kept hold of identity papers, only permitted to leave with special permission from the director); *DD v Lithuania* [2012] MHLR 209 (*"DD"),* §146 (not free to leave institution without the management's permission); *Kedzior v Poland* [2013] MHLR 115, §57 (not free to leave without management permission, any request for leave of absence could only be made by applicant's guardian); *Mihailovs v Latvia* (35959/10, 22 January 2013), §132 (could not leave without management permission, permission conditional on state of health and only

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15 A term itself defined in section 64(1) as having the same meaning as "the Convention" in the Human Rights Act 1998.

16 Or under s.119 of the Social Services and Well-being (Wales) Act 2014 ("the Welsh Act").

17 See discussion in *In Re T* [2022] AC 723. The increasing number of applications to invoke the inherent jurisdiction to authorise the deprivation of liberty of children has resulted in the President of the Family Division setting up a *"National DOLS List"*.

provided if accompanied by staff or another patient; no evidence applicant had ever received permission to leave first placement).

(2) Whether the person succeeded in leaving, and has been forcibly returned: *Storck,* §73 (returned by police when managed to escape); *Stanev,* §§28, 127 (located by police and collected by staff of care home); *DD,* §146 (left the home without informing management and brought back by police); *Mihailovs,* §132 (if patient left without permission, they were taken back there by police)

(3) Whether the individual has been physically restrained: *Storck,* §§73, 76 (applicant shackled to bed to prevent her absconding); *Shtukaturov,* §101 (after attempting to leave the hospital, was tied to his bed); *DD,* §§130, 149 (placed in isolation in secure ward, tied down and forcibly medicated for 30 minutes). The distinction between actual restraint and restraint conditional on a person attempting to leave is not of central importance under the Convention: see *HL,* §§90-91 (treating psychiatrist confirmed that had HL resisted or tried to leave, she would have prevented him from doing so and considered detention under the MHA).

(4) Whether the individual has been subject to chemical restraints (e.g. sedated so as to make them tractable or to overcome their will): *HL,* §§46, 99; *Storck,* §75 (treatment with strong medicaments); *Shtukaturov,* §101 (given increased dose of sedative medication); *Stanev,* §31 (anti-psychotic medication administered); *DD,* §146 (management has complete and effective control by medication and supervision over assessment, treatment, care, residence and movement).

(5) The degree of supervision and control over the person's movements: *HL, §*91 (health professionals exercised strict control over his assessment, treatment, contacts, movement and residence, and he would only be released when those professionals considered it appropriate); *Stanev,* §124 (identity papers and funds retained by management, could go to nearest village but only with permission of director, located by police when late returning, activities and daily routine controlled by home employees); *DD,* §146 (management has complete and effective control by medication and supervision over assessment, treatment, care, residence and movement); *Kedzior,* §57 (management exercised complete and effective control over treatment, care, residence and movement); *Mihailovs,* §132; compare/contrast with *HM,* §46 (open institution which allowed freedom of movement).

(6) The degree of social isolation: *HL,* §91 (did not leave the unit for many months); *Shtukaturov,* §21 (denied access to his lawyer); *Stanev,* §19 (institution in remote mountain location, 8km from nearest locality, 400 km from applicant's home); *Kedzior,* §57 (was able

to undertake certain journeys and spend time with family, but only with management permission and following request made by guardian); *Mihailovs,* §§44, §132 (not permitted to stay at home, visit parents' grave or church, under constant supervision).

(7) The availability of social contacts: *HL,* §91 (foster carers were prevented from visiting HL between July and November); *Storck,* §73 (unable to maintain regular social contacts with the outside world); *Shtukaturov,* §25 (prevented from having any contact with the outside world, not allowed to keep any writing equipment or use a telephone); *Stanev,* §30 (no writing materials, reliant on staff to post sheets of paper); *DD,* §146 (management had full control over whom the applicant may see and from whom she receives telephone calls); *Mihailovs,* §132 (limited social contacts by prohibiting applicant from receiving visitors without his guardian present). Compare and contrast with *HM,* §45 (encouraged to maintain social contacts with the outside world).

(8) An element of coercion, of overbearing the individual's will, including consideration of whether the person is objecting to the arrangements: see *HM,* §§46-47 (willing to enter the nursing home, had agreed to stay shortly thereafter, hardly aware of the effects of her stay); *Stanev,* §§130-131 (applicant well aware of his situation, explicitly expressed his desire to leave, to psychiatrists and through applications to the authorities); *DD,* §§41, 130 ("*treated there by force*"; "*medicate her by force or coercion*"); *Mihailovs,* §138 (second placement was an open institution, applicant left on several occasions to spend time outside, no objection to the placement was raised, whereas the applicant had objected to the first placement). By contrast, in *HL,* the fact that HL was compliant and never attempted, or expressed the wish, to leave did not prevent a confinement arising, in circumstances where HL was incapable of consenting to, or disagreeing with, the restrictions (see §90).

(9) The type of setting: see *Ashingdane* (high security psychiatric hospital); *HL* (psychiatric hospital); *Storck* (psychiatric institution); *Stanev* (large State social care institution, 400km from home, sharing 16sqm room with four other residents, where conditions were so bad they also amounted to inhuman and degrading treatment under Article 3 of the Convention); *DD* (state social care home for individuals with general learning disabilities); *Kedzior* (state run social care home), *Mihailovs* (two different specialised state social care institutions)). See in contrast, *HM* (ordinary nursing home).

(10) The duration of stay: *Storck* (held in psychiatric institutions for years over various periods between 1974 to 1993; *Shtukaturov,* §107 (confined in psychiatric hospital for several months); *Stanev* (placement was indefinite and had lasted more than 8 years); *DD,* §148 (functional adult who had spent more than 7 years in the Kedainiai Home, with negligible

prospects of leaving it); *Kedzior* (10 years in social care home); *Mihailovs* (held in state social care institution for more than 10 years against his will).

(11) Control of funds: *Stanev,* §18 (entire invalidity pension transferred to the home); *Kedzior,* §57 (home controlled what remained of applicant's disability pension).

18. These cases identify the type of factors that the ECtHR considers when determining whether restrictions amount to a confinement for the purposes of limb (a). The two limbs of the "acid test" have been referred to in a number of ECtHR cases. However, properly analysed, they are a necessary, but not sufficient, requirement for determining whether limb (a) is satisfied. In each case, the ECtHR considers *all* the material factors to determine whether the type and nature the nature of the restrictions satisfies that test.

C. *Cheshire West*

19. The decision of this Court in *Cheshire West* is addressed at §§10-21 in the Statement of Facts and Issues. The summary of the facts and the analysis set out therein is not repeated here. In short, a bare majority of this Court (Lady Hale, with whom Lord Sumption agreed, Lord Neuberger and Lord Kerr) laid down the "acid test" for determining whether an incapacitated person is confined for the purposes of limb (a) of *Storck*. The lead judgment was given by Lady Hale[18].

(1) Lady Hale started from the assumption that disabled persons have the same right to liberty as has everyone else, and that what it means to be deprived of liberty must be the same for everyone, whether or not they have physical or mental disabilities: §§1, 45. As such, she rejected the "relative normality" approach of the Court of Appeal, where the life that P was leading was compared with the life which another person with his disabilities might be leading: §46.

(2) Lady Hale analysed the relevant ECtHR case law (§§19-32), and derived from that case law what she termed as an "acid test", namely that an individual will be confined where the person concerned is "*under continuous supervision and control and not free to leave*" (§§48-49).

(3) Lady Hale also identified a series of factors that are not relevant to the assessment, including (a) "*the person's compliance or lack of objection*"; (b) the relative normality of the placement (whatever the comparison made); and (c) the reason or purpose behind a particular placement: see §50.

[18] Lord Neuberger agreed with Lady Hale at §59; Lord Kerr agreed with Lady Hale and Lord Neuberger at §75.

20. Lady Hale was influenced by what she identified as the policy objective that those who are extremely vulnerable need a *"periodic independent check on whether the arrangements made for them are in their best interests"* (see §57). This led Lady Hale to *"err on the side of caution"* in deciding what constitutes a deprivation of liberty in these cases. However, as explained below, the "checks" available in domestic law changed significantly in the years after *Cheshire West,* such that, even if was permissible to rely on this policy rationale, the weight to be attached to it is now much reduced.

21. By contrast, the minority (a joint judgment from Lord Carnwath and Lord Hodge, with a concurring judgment from Lord Clarke[19]) held that: (1) the majority's approach went further than the ECtHR case law, contrary to section 64(5) of the MCA; (2) while a universal test had attractions, the ECtHR remained wedded to a case-specific test, examining the "concrete situation" taking into account a whole range of criteria such as the type, duration, effects and manner of implementation of the measure in question; and (3) nobody using ordinary language would describe people living happily in a domestic setting as being deprived of their liberty[20].

22. The Court was unanimous in concluding that P was deprived of liberty, but split 4:3 in concluding that MIG and MEG were also deprived of liberty. It is the approach to MIG's case in particular that has led to the significant expansion in the number of those now considered to be deprived of liberty.

23. The question of "valid consent" was not expressly in issue in *Cheshire West* (see §37). It was common ground that all three individuals lacked capacity to make relevant decisions about where they lived and the care and treatment they received there. Once the majority decided that MIG, MEG and P were confined under limb (a), it was assumed that all three individuals were deprived of liberty, as limbs (b) and (c) were also satisfied. Lady Hale and Lord Neuberger considered *Mihailovs* and the ECtHR's approach to "tacit acceptance" of the placement. In her discussion of limb (a), Lady Hale distinguished *Mihailovs* on the basis that the applicant there had a *"level of de facto understanding which had enabled him to express his objections to his first placement"*. She recognised that the ECtHR accepted that there are some people who are not "*capable*" of expressing a view one way or another[21]. She concluded that this was "*probably*" the case with both MIG and MEG, but this was not explored further: see §55. Lady Hale appears to be accepting that those with a *"de facto level of understanding"* could

[19] who agreed with the conclusions and reasoning of Lord Carnwath and Lord Hodge: §105.
[20] see §§88-110.
[21] as was the case in *HL*, §§90-91.

give tacit acceptance to the placement (although this is difficult to reconcile with the categorical conclusion in §50 that "lack of objection" is never relevant in the assessment). Lord Neuberger approached the issue through the prism of limb (b) and valid consent. He cited *Mihailovs,* noting that there might be "*rare cases where the absence of objection can be said to amount to consent*", without explaining what those cases might be (§68). Lord Kerr considered that deprivation of liberty is determined "*primarily*" on an objective basis, is not "*solely dependent*" on the reaction or acquiescence of the person whose liberty has been curtailed, and "*contentment….does not determine whether she is restricted in her liberty*" (§76).

D. The position after *Cheshire West*

(1) Strasbourg case law

24. In summary, the ECtHR case law in the eleven years since *Cheshire West* has continued to cite the *Guzzardi* test, and has continued to carry out the multi-factorial analysis. The ECtHR has never adopted an "acid test" for identifying when an individual of unsound mind is confined under limb (a) of the *Storck* test. The factors set out above have continued to be considered by the ECtHR when determining whether an applicant is deprived of liberty.

25. In *Akopyan v Ukraine* (App. No 12317/06) (5 June 2014), the ECtHR again emphasised that in order to determine whether there has been a deprivation of liberty, "*account must be taken of a whole range of factors arising in a particular case*" (§67). The applicant was confined within a psychiatric hospital for a considerable period of time (three years), despite repeatedly asking to be discharged and lodging complaints about her internment. She was treated with antipsychotic medication. She was not free to leave the hospital, and her contact with the outside world was seriously restricted. She finally escaped from the hospital after numerous unsuccessful requests to be discharged (§§67-68).

26. In *Atudorei v Romania* [2018] MHLR 1 the applicant was admitted to a remote psychiatric hospital at her parents' request. She was given psychotropic drug treatment, prevented from contacting her fiancé, and was not discharged for four months. The ECtHR concluded that she had been deprived of liberty. The medical staff exercised complete and effective control by means of medication and supervision over the assessment, treatment, care, residence and movements of the applicant throughout her time there. She was not able to leave without asking the medical team's permission. The hospital was in a remote area, and could be reached only by car. The medical staff had full control over whom the applicant could see or speak to, and she was denied access to the police officer who came to speak to her (see §§126-134). The placement lasted 8 weeks, which was sufficiently lengthy for her to have "*felt the full adverse effects of the restrictions on her*". The ECtHR distinguished *HM,* noting that, "*each case has to be*

decided taking into account its particular "range of factors". The ECtHR was satisfied that the applicant had not agreed to stay at the hospital: §133[22].

27. In *Stankov v Bulgaria* (25820/07), 17 June 2015, the domestic courts declared that the applicant was partially incapacitated, his mother was appointed his guardian, and she applied to social services to place her son in a social care institution. He remained there for three years: the home was not adequately heated, and food was insufficient/poor quality. He received no therapeutic care (only psychotropic medication). He had no social or cultural activities. He made regular attempts to escape, was brought back by police and restrained to deter further attempts. He was later transferred to another institution. There, he had access to a courtyard and certain areas within the home, and various trips were organised. He shared a 16m^2 room with three other people, and residents' clothes were interchangeable. The buildings were not locked, and the applicant could go to the neighbouring village on excursions organised for groups of residents, attending once. However, those outings were only possible with express authorisation by the management of the institution. Further, the applicant ran the risk of being searched for by police if he left the homes without permission. The applicant was under constant supervision and was not free to leave the home without permission at any time he wished. While he did not explicitly express his objections with the placement, he demonstrated his objections by his repeated attempts to escape from the home. The applicant had been at the two homes for more than 15 years, which was long enough for him to fully feel the negative effects of the restrictions to which he was subject (see §§88-89).

28. In *Cervenka v The Czech Republic* [2017] MHLR 195, the applicant was declared fully incapacitated, and had been admitted to a psychiatric hospital repeatedly with alcoholic dementia. He was placed involuntarily in a social care institution by his guardian. He had initially agreed to go there, but then strongly objected to the placement, and made his objections clear (writing repeatedly to the director of the care home, his guardian and the police). He could not send correspondence independently, his mail was opened, and he was prescribed medication and threatened it would be administered by injection if he refused to take it. He was only permitted to leave the institution with a supervisor, he had approached the management repeatedly seeking to leave, had submitted a request to the court and instructed lawyers to assist him. The ECtHR concluded that he was deprived of liberty, taking account of all the circumstances of the case, including that the applicant could not leave on his own during the day without being accompanied or with the psychiatrist's approval, he

[22] This formed part of the consideration of the objective element. The ECtHR considered the subjective element later in the judgment, from §135 onwards.

was compulsorily placed in the care home by his guardian, and it was obvious from his subsequent conduct that he objected to the placement and had not consented to it: see §§102-104.

29. Finally, in *Kaganovskyy v Ukraine* (2023) 76 EHRR 30, the applicant had been declared legally incapable, and was admitted to the Kyiv Psychoneurological Residential Institution ("the KPRI"), which was a state-run social care institution. The KPRI was a residential institution, where the applicant could move freely both within and outside, he was able to leave to see his relatives and acquaintances, could visit a local rehabilitation centre on his own and could visit external doctors and have contact with human rights organisations. He was never prevented from leaving the premises and was encouraged to lead a social and multifaceted life (§9). The KPRI also operated what was described as an "enhanced (intensive) supervision unit". The unit was separated from the rest of the residential building by a door with metal bars, which could be opened only from the outside. Approximately 20 patients resided on the unit. The applicant was required to share the larger room with five other residents, the windows could not be opened and some residents smoked so there was no fresh air. The unit had around the clock uninterrupted supervision, and there were visits every day by doctors for monitoring any changes in the residents' condition. Residents were not allowed to walk outside, they could visit the locked toilet only with the nurse's permission, and there was no access to drinking water. They were only permitted to take a shower in another building when they started having an unpleasant smell. He remained in the unit from 27 June to 6 July 2017: see §§18, 79.

30. The ECtHR accepted that the applicant was not deprived of liberty in the KPRI generally (although it is not clear whether this is because he was never confined there, or because his stay was "voluntary", and so he had provided valid consent): see §80. The ECtHR again reiterated that, "*In order to determine whether there has been a "deprivation of liberty", account must be taken of a whole range of factors arising in a particular case*". At §84, the ECtHR concluded that the applicant was deprived of liberty in the unit:-

> *"As regards the objective element, the Court notes the applicant's specific submissions (see paragraphs 18 and 79 above), not challenged as such by the Government, that he remained in the KPRI unit for ten days, during which he was not able to leave it, with the exception of the period between 27 and 30 June 2017, when he was allowed to leave the unit in order to sleep in his room in the residential block, because of the overcrowding in the unit. The applicant was also able to briefly leave the unit on 30 June and 5 July 2017, to talk to his father and his lawyer, respectively. Otherwise, he remained for the whole time in the unit, which was locked from outside and could be opened by the KPRI staff only; he was not free to leave it, including to go for a walk; and his contact with the outside world was seriously restricted… In addition, the Court cannot overlook the fact that the unit itself was referred to in medical records as a "closed" one ..which implied a reference to a restricted space and lack of freedom to leave it…."*

31. The case law summarised above (a) confirms that the ECtHR has continued to apply the multi-factorial test, and (b) provides a clear indication of the nature and extent of restrictions that are required before a "person of unsound mind" will be found to be confined in a psychiatric hospital or social care institution. The ECtHR has held, in the cases set out above, that restrictions can be so extensive as to amount to confinement in placements in a social care institution. However, social care provision in the UK is very different, and the restrictions are of a fundamentally different nature to those in issue in *Cheshire West,* particular for MIG and MEG.

(2) Domestic case law

32. In the years since *Cheshire West,* the domestic courts have been bound to apply the acid test. The courts have interpreted the acid test extremely broadly, with the result that approximately 400,000 incapacitated persons are now treated as being deprived of liberty in England annually. Four critical themes emerge from the domestic case law: (a)-(d).

(a) Liberty and autonomy: what can an individual do?

33. **First,** the courts have grappled with the difficult relationship between liberty and autonomy. At the heart of the ECtHR case law is the need for coercion, or for the State to have imposed restrictions on the individual that prevent them from exercising their fundamental right to physical liberty[23]. Yet initially, the "acid test" was relied upon to contend that a person who was so medically unwell they were unconscious in an intensive care unit was confined within the meaning of limb (a). In *R (Ferreira) v HM Senior Coroner for Inner South London* [2017] EWCA Civ 31; [2018] QB 487, the Court of Appeal rejected this argument, concluding that:-
    (1) Any deprivation of liberty resulting from the administration of life-saving treatment falls outside Article 5(1), by analogy with *Austin v United Kingdom* (2012) 55 EHRR 14 (as a "*commonly occurring restriction on movement*"). If the acute condition of the patient is not the result of action which the state wrongly chose to inflict on him, and if the treatment could properly be given to a person of sound mind in the same condition, then there is no deprivation of liberty: §§88-90.
    (2) *Cheshire West* is distinguishable since it is directed to a different situation, namely that of living arrangements for persons of unsound mind: §91. The policy reasons for finding a violation in *Cheshire West* did not apply, as there is no need in the case of physical illness for a person of unsound mind to have the benefit of safeguards where the treatment is

[23] Or where positive obligations under article 5 require the State to take steps to bring confinement and absence of valid consent by a private actor to an end.

given in good faith and is materially the same treatment as would be given to a person of sound mind with the same physical illness.

(3) However, even if the "acid test" applied, it was designed to apply only where the second element (lack of freedom to leave) was the consequence of state action, particularly state action constituting the continuous supervision and control. In the case of a patient in intensive care, the true cause of their not being free to leave is their underlying illness, which was the reason they were taken into intensive care in the first place. The state is not responsible for that underlying illness: see §§98-99. In any event, if the question had been asked whether Ms Ferreria was free to leave, that question would have been answered in the affirmative on the facts: §96.

34. *Ferreira* thus both sought to nuance the acid test, while also seeking to distinguish *Cheshire West*. However, the ECtHR does not draw any principled distinction between deprivation of liberty in hospitals and social care settings, and nor does it have any regard to the policy concerns that so troubled Lady Hale. The logic of the third reason in *Ferreira* would apply equally to social care settings: if the "true cause" of the person not being free to leave is their underlying disability, the state is not responsible for that either. Permission to appeal to this Court was refused on 26 May 2017, with the panel concluding that the application did not raise an arguable point of law and that the Court of Appeal was right *"for each of the reasons they gave"* [24].

35. Similar arguments had been considered in the social care context in *Rochdale MBC v KW* [2015] 2 FCR 244. KW suffered serious brain damage and was living in her own home with 24/7 carers, she had powerful delusions and a tendency to try to wander off to find her small children (now all adults). KW's ambulatory functions were very poor and deteriorating, and soon she would not have the motor skills to even walk with her frame. It was common ground between the parties that KW was deprived of liberty. Mostyn J disagreed: foreshadowing *Ferreira,* Mostyn J drew a comparison with a person in hospital in a coma, who had no relations demanding to take them away. Such a person was still "not free to leave" and was "under continuous supervision and control", but could not possibly be deprived of liberty. For the same reasons, he concluded that KW was not, "*…in any realistic way being constrained from exercising the freedom to leave, in the required sense, for the essential reason that she does not have the*

[24] The panel was made up of Lady Hale, Lord Clarke and Lord Wilson. The Court of Appeal in *In Re Briggs (Incapacitated Person)* [2018] Fam 63 subsequently expressed the *obiter* view that *Ferreira* applied only where a person who lacks capacity is so unwell that they are at risk of dying if they were anywhere other than in hospital and therefore, by virtue of their physical condition, they are unable to leave the hospital: see §§102-3). As such, a person in a minimally conscious state was not deprived of liberty.

physical or mental ability to exercise that function" (§25). An appeal against this decision was allowed by consent, and the matter remitted. Mostyn J again concluded that KW was not being deprived of liberty[25]. An appeal was again allowed[26]. The Court of Appeal confirmed that, even if *Cheshire West* is wrong, there is nothing confusing about the judgment, and it had to be followed.

36. This issue again came to the fore in *Peterborough City Council v Mother and others* [2024] EWHC 493 (Fam); [2024] FLR 896 *("SM")*. This case concerned a 12 year old girl with profound cognitive and physical impairments, who was non-mobile and non-verbal, responding like a child of a few months old. A care order was made and SM lived with foster carers who provided her with a high quality of care and support (detailed in §7). The local authority considered that SM was deprived of her liberty and applied for an order to authorise the same. Lieven J held that the application took the principles in *Cheshire West* to a logical, but extreme, conclusion that defied common sense. The reason why SM could not leave where she was living was her profound disabilities, not any action of the State, whether by restraining her or failing to meet the State's positive obligations to enable her to leave. At §38, Lieven J held:

> *"At a conceptual level it is difficult to see how one can be deprived of something that one is incapable of doing. Equally, how can one be deprived of a right that one is incapable of exercising, not through the actions of the State or any third party, but by reason of one's own insuperable inabilities."*

37. Lieven J recognised that SM was under constant supervision and control, but this was not to prevent her leaving: she was wholly incapable of leaving, both because of physical inability but also because she was unable to form any desire or intent to leave (*"It is simply not a concept of which she has any consciousness"*). Lieven J explained when the State's positive obligations under Article 5 might apply (if a disabled person could not do something through their own volition, by reason of their disability, but could do it with appropriate support (e.g. a disabled person who cannot move without a wheelchair and so cannot leave a property without assistance)). She concluded that that was a wholly different situation to SM, where she was both physically incapable of exercising her right to liberty, and mentally incapable of asserting it[27].

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[25] See *Rochdale MBC v KW* [2015] 2 FCR 255, expressing concerns about the correctness of *Cheshire West*.

[26] See *Rochdale MBC v KW (No 2)* [2016] 1 WLR 198 at §32.

[27] *SM* was followed by HHJ Middleton-Roy, sitting as a High Court Judge, in *Rochdale BC v Mother (Re V: Profound Disabilities)* [2025] EWHC 200 (Fam). The local authority argued that V's case was distinguishable from that in *SM,* as V could express happiness, sadness and pain (see §12). The Court disagreed, followed *SM,* and concluded that V required support because of his profound disabilities, not by reason of any action of the State.

38. However, there remains uncertainty for decision makers, as other first instance judgments have stated that *SM* is contrary to the ratio of *Cheshire West,* is *"plainly wrong"* and declined to follow it*:* see *Blackburn with Darwen Borough Council v BM and QX (A Child)* [2025] EWHC 745 (Fam) (31 March 2025) per HHJ Burrows (sitting as a High Court Judge) at §§41-44[28].

39. The Secretary of State submits that the analysis in *Ferreira* applies equally to those in receipt of social care, and that the principled approach of Mostyn J in *KW* and Lieven J in *SM* is correct, for the reasons they set out. This accords with the analysis of Professor Eldergill, discussing the position of a person in the final sad stages of dementia, confined to bed and so cognitively impaired as to be unable to form the idea of swallowing, let alone mobilising. In this situation, no one is interfering with, limiting, or controlling their liberty to do anything they can do:-

> *"Wishing or deciding to leave fall into the category of things which the person is now incapable of doing and one cannot properly speak of being prevented by others from doing something which one is incapable of doing. Nor can anyone possibly restrain a person from doing something which they do not have the ability to do at present. Mere inability is not lack of freedom"*[29]*.*

40. Accordingly, the Secretary of State submits that there is no need to grapple with the difficulties inherent in whether this cohort of individuals can provide "valid consent" under limb (b) of the *Storck* test, as they are not confined in the first place. If they are not confined, limb (a) of the *Storck* test is not satisfied, and they are not deprived of liberty for the purposes of Article 5(1).

41. This does not result in "liberty" meaning something less for those who, because of their impairments, are unable to enjoy that liberty. Liberty means the same thing for everyone. It means physical liberty, including the freedom to go where one pleases. When it comes to people who are unable to do this because they are unconscious, in a minimally conscious state, or so profoundly disabled that they cannot conceptualise leaving, let alone physically achieve this, then the State is not depriving them of anything. The Secretary of State of course accepts that, under its positive obligations, the State is obliged to take reasonable steps to prevent a deprivation of liberty: these might include the provision of a wheelchair or other forms of aids/assistance. An individual's Article 8 rights could also come into play. However, the

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[28] The Secretary of State understands that none of these first instance judgments have been appealed, leaving the law in a state of some confusion.

[29] Eldergill, A. *"Are all incapacitated people confined in a hospital, care home or their own home deprived of liberty?"* ERA Forum 19, 511-535 (2019), pg.523. See also Eldergill, A, Evans, M and Sibley, E, *European Court of Human Rights and Mental Health* (2024), Bloomsbury Publishing (1st edition) at §3.84. Professor Eldergill was a Judge of the Court of Protection for 14 years before retiring in 2024.

crucial point is that only those who are *deprived* of liberty are entitled to the full panoply of Article 5 safeguards. Those who are not so deprived do not receive them. This approach does not leave these individuals without safeguards: see Annex 1. It simply recognises the reality that individuals in this situation are not deprived of liberty within the meaning of Article 5.

42. Nor does it amount to discrimination against those who are disabled. In order to succeed in an Article 14 claim, the discrimination must arise in relation to those within the ambit of Article 5. Even assuming for present purposes that those unconscious, in a minimally conscious state, or profoundly disabled as described above, do fall within the ambig of Article 5, an Article 14 claim would be bound to fail. As Lieven J held, a disabled person in the position of SM is not in a "*relevantly similar*" situation to a non-disabled comparator (*SM,* §§41-44). The non-disabled person is in a fundamentally different position to those that fall within the above categories – they are capable of leaving, but are prevented from doing so. Those unconscious, in a minimally conscious state, or profoundly disabled as described above, are not capable of leaving. As such, there is no less favourable treatment of people in a relevantly similar position.

(b) Coercion, suffering and objections to restrictions

43. **Second,** the "acid test" says nothing about the presence or absence of coercion[30] or the effect of the measures on the individual. Lady Hale expressly states that the person's "*compliance or lack of objection is not relevant*" to limb (a): see §50[31]. As a result, the domestic courts have not had regard to the lack of objection on the part of individuals in determining whether they are deprived of liberty[32]. This has given rise to the "paradox" described above.

44. However, the fact that a person objects to their placement is highly relevant to the question of whether the person is confined: see §§17 above. This is unsurprising: if a person (a) attempts to leave a particular place, (b) expresses the wish to leave, or (c) is evidencing by their behaviour that they wish to leave, but is then unable to do so, this is the clearest possible indicator that they are being confined. The necessary element of coercion is present if an individual is unable to leave a place that he wishes to leave, as the individual is being compelled to live somewhere he does not want to live: see, for example, *Foka v Turkey*

[30] Despite it being raised at §38.
[31] Which appears to be drawn from *HL,* §§90-91.
[32] See, for example, *AB (Deprivation of Liberty* [2020] COPLR 735 ("*AB*"), where the Judge (erroneously) focused only on *"the true powers of control"§13* and not the effect of freedoms AB had on a day to day basis.

(28940/95), 24 June 2008 at §78; *Krupko v Russia* (26587/07), 26 June 2014 at §36[33]. If objections are relevant, logically it follows that an absence of objection can also be relevant[34]. If the arrangements for an individual's care and treatment accord with their known wishes and feelings, and the person concerned is happy with them, it is difficult to see how they are confined. There is no coercion in this situation: the individual wants to be there.

45. That is not to say that a lack of objection is *always* relevant: where an individual is unaware of their situation (e.g. because of advanced dementia, or severe intellectual disability), or they are unable to object to the constraints put in place, the fact that the individual has not raised an objection says nothing about whether they are confined. Mere compliance/acquiescence cannot play any role in determining whether there is confinement, particularly if accompanied by the administration of sedative medication which is capable of suppressing objections: see *HL,* §§90-91. But a lack of objection (or, to put it the other way round) a positive expression of wishes and feelings showing that the individual is happy with the arrangements <u>is</u> potentially relevant:
    (1) First, it is relevant because one of the factors that the ECtHR always considers in determining whether there is a confinement is the "*effects and manner of implementation*" of the measure in question: see §§17 above. The effect of restrictions on an individual is inevitably going to be different if they are happy with their living arrangements, as compared to when they are objecting to them. It would be absurd to ignore the benevolent *effect* of the arrangements (as opposed to the benevolent *purpose,* which can only be considered at the stage of justification: see, for example, *Creangă* , §93).
    (2) Second, it is relevant because the ECtHR has consistently recognised that measures depriving a person of his liberty, "*inevitably involve an element of suffering and humiliation*": see, for example, *Ilascu v Moldova and Russia* (App. No 48778/99), 8 July 2004, §428; *Frerot v France* (App. No 70204/01), 12 June 2007, §37; and *Roonam v Belgium* (App. No. 18052/11); [2018] MHLR 250, §142[35]. The suffering and humiliation of those who were able to, and did, object to the placement in §§17 is obvious. *HL* may not have had enough understanding of his situation to experience humiliation, but his suffering was equally

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[33] Where the ECtHR concluded that there was an element of coercion which was indicative of a deprivation of liberty within the meaning of Article 5. While this was not an Article 5(1)(e) case, the same approach is taken to all cases of deprivation of liberty.

[34] See Eldergill et al (2024), *op cit* §§3.89 to 3.91.

[35] These observations are made in the context of Article 3 claims (which are often considered at the same time as claims under Article 5), with the ECtHR making the point that in order for punishment or treatment to be inhuman or degrading, the suffering or humiliation involved must go beyond the "*inevitable*" element of suffering and humiliation in any deprivation of liberty. Accordingly, these observations are equally important to understanding what a deprivation of liberty entails under Article 5.

obvious (being removed from his home and his family for many months, sedated and isolated in a psychiatric hospital, and under the total control of his treating clinicians)[36].

(3) However, if an individual is able to, and does, express their wishes and preferences about their living arrangements, and is happy with them, it will ordinarily be difficult to see how they are being coerced, or are suffering or humiliated as a result. This will not always be the case (see, for example, the scenario referred to by Lady Hale of a mentally disordered person kept in a cupboard under the stairs). In that scenario, the person may be happy because they do not appreciate that there is any alternative way to live. Yet there would still inevitably be suffering as a result of living in such conditions, and so there is nothing to prevent a conclusion that the person was confined[37].

46. The focus here is always on the "concrete situation" of the individual. The multi-factorial test takes account of a person's wishes and feelings, and ensures that all relevant matters can be taken into account to determine whether an individual is confined. The Secretary of State submits that this necessarily requires consideration of all the factors set out above, and not merely the two limbs of the acid test.

47. The AGNI contends that the presence or absence of coercion is relevant only to limb (b), and is an argument in favour of an incapacitated person being able to provide "valid consent" to arrangements amounting to a confinement. However, the better analysis is that these matters are also relevant to the question of whether an individual is confined in the first place: see Eldergill et al (2004) at §3.91:-

> *"..the objective and subjective conditions overlap. The disadvantage of the Storck approach…is that it risks artificially separating out the relevant facts, by placing them in one of two columns (objective, subjective), when a particular factor may be relevant to both conditions.*
> *A person's wishes and feelings, the existence of objections, their agreement or tacit agreement, and the absence of objections from someone capable of objecting, are always relevant to the objective condition, not just the subjective condition. All of these things are part of the 'whole range of criteria' that help to establish the breadth and intensity of any supervision and control, and also whether the person is being prevented from doing what they can do and what they wish to do…*[38]*".*

Further, focusing on the objective condition enables a court to take into account and give weight to the individual's wishes and feelings, and avoids the risk of watering down the test for legal capacity under the MCA[39].

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[36] It is difficult to see how MIG was suffering or humiliated as a result of the arrangement in *Cheshire West,* §13, particularly in circumstances where she was "devoted" to her foster mother.

[37] *Cheshire West,* §35. These circumstances are also likely to breach Article 3 of the Convention.

[38] See also §§3.89-3.91, *op cit.*

[39] See Eldergill, (2019) *op cit* p.533.

(c) "Continuous supervision and control"

48. **Third,** the "continuous supervision and control" part of the acid test has been applied in an extremely wide manner, without the factors identified by the ECtHR as giving rise to "continuous control" being present: compare/contrast the position of HL (health professionals exercising complete control over HL's assessment, treatment, contacts, movement and residence) with that of AB (required to live in a flat in a supported living placement as a condition of guardianship, support available to her if she chose, but at liberty to do as she pleased in her own flat, free to come and go as she pleased, and free to do as she pleased in the community once she left the property). HL was under continuous control. AB's life was very different. Yet the courts held that she was also under continuous control, essentially because (a) she was subject to "theoretical" control as the state could require her to return to the property if she was otherwise unwilling to do so (although in fact this had never happened), (b) staff observed when she left and returned, and (c) staff were able to enter her flat for the purpose of inspecting, cleaning or repairing (see also *London Borough of Havering v AEL* [2021] EWCOP 9)..

49. Many individuals may be under "continuous supervision". Indeed, it would be surprising if patients in a hospital, or any form of residential care, were not being supervised by those responsible for keeping them safe and well[40]. However, "continuous control" is properly understood as making all decisions of importance in the person's life, including the place they live, the activities the person undertakes, who they are in contact with, and their care and treatment. Yet if decisions are being made in order to facilitate the incapacitated person's wishes and feelings, this is not "control". There is a clear distinction between (a) supporting the incapacitated person to live their life in accordance with that person's views and preferences[41]; and (b) controlling what the individual does at any given time. In short, if the individual is supported to act consistently with their wishes and feelings, through the provision of support enabling them to live as they wish to live and/or to participate in activities that they wish to participate in, those measures are not controlling the individual. Rather, they are enabling the individual to do that which they would be unable to do without

[40] Although the nature and extent of the supervision may vary, which will impact whether it is "continuous".

[41] See, for example, the evidence given to the Joint Committee on Human Rights by Mark Neary about his son Stephen's care arrangements, Oral evidence: *The right to freedom and safety: Reform of the deprivation of liberty safeguards*, HC 890 Wednesday 21 March 2018. The contrast between Stephen's detention in an Assessment and Treatment Unit in *Hillingdon LBC v Neary* [2011] 4 All ER 584 §160 and his life in his own home in the community, supported by carers, is illustrative of the distinction. Yet Stephen was treated as deprived of liberty in both settings.

that support. An individual is not under the continuous control of others if the result of the measures is to put the individual's wishes and feelings into effect.

50. If the "continuous supervision and control" limb of the acid test is properly understood, there is no need to grapple with the difficulties inherent in whether this cohort of individuals can provide "valid consent" under limb (b) of the *Storck* test, as they will not be confined in the first place. If they are not confined, limb (a) of the *Storck* test is not satisfied, and they are not deprived of liberty for the purposes of Article 5(1).

(d) Type of setting: own home cases

51. **Fourth,** the "acid test" takes no account of the type of setting where the individual is receiving care and treatment, and draws no distinction between the position of an individual in a Category A prison and a person supported to live as independently as possible in their own accommodation or with their family[42]. The inherent (and fundamental) flaw in this approach is demonstrated by a range of cases in which individuals have been found to be confined when: living in an ordinary home with an adult foster carer (MIG), living in a small home in the community (MEG and P), living in her own flat in a supported living placement in the community (AB); when living in the family home that KW had chosen as such before she lost capacity; and living in the family home with members of AEL's family[43]. The ECtHR has never held that an individual living in an "own home" type case is deprived of liberty (see §§17, 24-31 above). This does not mean that an individual living in their own home could *never* be confined. However, if an individual is living in their own home, in accordance with their wishes and feelings, it makes it considerably less likely that the individual is being confined[44]. The restrictions imposed would need to be far more extensive in order to amount to confinement: requiring, for example, restraint, medication, seclusion, social isolation, no contact with the outside world. Again, if this approach is recognised, there is no need to grapple with the difficulties inherent in whether this cohort of individuals can provide "valid consent" under limb (b), as they will not be confined in the first place. If they are not confined, limb (a) of *Storck* is not satisfied, and they are not deprived of liberty.

(3) The practical consequences of Cheshire West

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42 Indeed, as the minority pointed out, the acid test was likely to result in HL being found to be deprived of liberty not only while detained in a hospital psychiatric ward, but also when he was released and returned to live in his family home with his loving foster parents: the very place that he wanted to be: see §100.

43 In *W City Council v Mrs L* [2015] COPLR 337, the Court considered that the fact that Mrs L was living in her own home was a consideration that was a factor in the mix in determining whether she was confined, but this has not been followed in subsequent case law.

44 See Series (2019) *op cit*, pg. 207.

52. The practical impact of *Cheshire West* has been significant and stark. The number of persons considered to be deprived of liberty which needed to be authorised under the MCA increased enormously overnight. In the year before *Cheshire West,* 13,700 referrals were made for a DOLS authorisation. In 2023/24, 332,455 referrals for a DOLS authorisation were made in England, with a backlog of 123,790 cases. A further 19,337 applications were made for a DOLS authorisation in Wales over the same period[45]. These figures do not capture people who are deprived of liberty in settings not covered by the DOLS, including supported living, shared lives and private and domestic settings. The Government's best estimate it that there are around 60,000 cases of deprivation of liberty in these settings[46]. Backlogs in the processing of DOLS authorisations and applications for court orders means that hundreds of thousands of people are being deprived of their liberty unlawfully.

53. After *Cheshire West,* the Government referred the issue of mental capacity and deprivation of the liberty to the Law Commission. The Law Commission produced its final report in March 2017[47]. At that time, the Law Commission estimated that the full cost of compliance with *Cheshire West* would be £2.2 billion per year – approximately two per cent of the entire budget of NHS England. Parliament subsequently gave effect to the Law Commission recommendations for reform in the Mental Capacity (Amendment) Act 2019 ("the 2019 Act"). This introduced a new streamlined procedure for authorising deprivation of liberty: the Liberty Protection Safeguards ("LPS"))[48].

54. Before the 2019 Act was introduced to Parliament, the Joint Committee on Human Rights ("JCHR") considered the Law Commission recommendations. The JCHR heard evidence from family members of those who were treated as being deprived of liberty, who reported distress at the intrusion and stigma[49]. For present purposes, the JCHR's key findings were that (a) it is important that resources are, as far as possible, directed to care rather than to legal and bureaucratic processes; (b) *Cheshire West* created an "*unsustainable situation and has captured*

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45 See Mental Capacity Act 2005, Deprivation of Liberty Safeguards, 2023-24; Official statistics (August 2024) and Deprivation of Liberty Safeguards Annual Monitoring Report for Health and Social Care 2023 – 2024, Care Inspectorate Wales (2024).

46 See impact assessment published in December 2020 by the Department of Health and Social Care in Westminster to accompany the Mental Capacity (Amendment) Act 2019 at page 10, § 3.4. The Law Commission found that public authorities were not taking many so-called "community DOLs" to court to obtain authorisation of the deprivation of liberty: see Law Com No 372, §1.4, Impact Assessment §4.2.

47 *Mental Capacity and Deprivation of Liberty* (Law Com No 372). The Law Commission was not asked to examine the meaning of the term "deprivation of liberty" in light of the recent decision in *Cheshire West.*

48 Inserting a new Schedule AA1 into the MCA.

49 See Graham Enderby and Mark Neary Q8 Oral evidence: *The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards*, 2018 HC 890, HL Paper 161 ("the JCHR Report"), evidence Wednesday 21 March 2018.

many people within the definition who may object to being categorised as deprived of their liberty"; and (c) Parliament should set out a statutory definition of deprivation of liberty which clarifies the application of the acid test: *"This should extend safeguards only to those who truly need them, whilst respecting the right to personal autonomy of those who are clearly content with their situation, even if they are not capable of verbalising such consent*[50]". Attempts were made to introduce a new statutory definition, but a definition was rejected by Parliament[51].

55. The implementation of the LPS was paused by the previous government. The Secretary of State is currently reviewing whether, and if so, how, to bring the LPS into force (including potential work with the Ministry of Justice to update the relevant Code(s) of Practice) and will set out his plans for the LPS in due course.

E. Should this Court depart from, or clarify, *Cheshire West?*

(1) The Correct Legal Test

56. The correct legal test is that set down by the ECtHR in *Engel/Guzzardi,* with a focus on the concrete situation of the individual. The acid test is a necessary, but not sufficient, requirement for confinement. In other words, an individual cannot be confined *without* the acid test being met. However, in order to determine whether a person is confined, a court must also consider the factors identified by the ECtHR (see §§17). First, the majority was clearly wrong to adopt the "acid test". There was a perhaps understandable desire to promulgate a "universal" test, in an attempt to provide guidance to decision makers. However, in doing so, (a) the majority went far beyond the ECtHR and departed from a crucial, and long-standing, aspect of the ECtHR jurisprudence; (b) the acid test fails to incorporate all of the factors considered by the ECtHR (see §17 above); and (c) the acid test itself has created considerable uncertainty, as outlined above.

57. Second, the majority was wrong to conclude that a "lack of objection" is never relevant to the question of confinement: see §§43-47 above. Third, the Secretary of State does not disagree with Lady Hale's conclusion that liberty must mean the same thing for everyone. However, the unintended result of *Cheshire West* is that incapacitated people are being treated less favourably than those with capacity: the latter cohort have their wishes and feelings fully taken into account in assessing whether they are confined, whereas the wishes and feelings of incapacitated persons are ignored.

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[50] See §§1, 35, 45 of the JCHR Report

[51] As a result of concerns that the definition was inconsistent with *Cheshire West.* See Notices of Amendments: 9 January 2019

(2) The Practice Statement and Dalton

58. The Court will exercise considerable caution before deciding to apply the Practice Statement (Judicial Precedent) [1966] 1 WLR 1234. The factors to be considered are set out in *In the Matter of an Application by Rosaleen Dalton for Judicial Review* [2025] AC 235 *("Dalton")* at §§46-51 (per Lord Reed); §§170-171 (per Lord Hodge, Lord Sales and Lady Rose); §§197-198, 285-295 (per Lord Leggatt); and §325 (per Lord Burrows and Dame Siobhan Keegan)[52].

59. However, the unusual starting point in this reference is that the statutory definition of "deprivation of liberty" in Northern Ireland, and in England and Wales, is expressly tied to Article 5(1) of the Convention, by providing that it will have the same meaning[53]. Accordingly, the Secretary of State invites the Court to depart from *Cheshire West* for the following reasons.

60. First, the link between the domestic law definition and Article 5 places an even greater obligation on domestic courts to mirror the ECtHR jurisprudence (even beyond that imposed by section 2(1) of the Human Rights Act 1998). Yet even under section 2, while it is open to a domestic court to apply established principles to situations that have not yet come before the ECtHR, they must not take the protection of Convention rights "*further than they can be fully confident*" that the ECtHR would go: see *R(AB) v Secretary of State for Justice* [2022] AC 487 at §§554-59. This was not the approach of the majority in *Cheshire West* (with Lady Hale instead deciding to "*err on the side of caution*" in deciding what constituted a deprivation of liberty, in light of the need to protect the vulnerable[54]). As deprivation of liberty has been interpreted so broadly, no individual is taking a matter to Strasbourg, and there is no mechanism for the Government to make these submissions before the ECtHR.

61. Second, for the reasons set out above, *Cheshire West* is "*clearly wrong*". In the 11 years since *Cheshire West,* despite repeatedly considering the test for deprivation of liberty, the ECtHR has not gone as far as the majority of this Court, has never adopted an acid test, and has always applied a multi-factorial test, taking account of all relevant circumstances. As far as the Secretary of State is aware, no other Contracting State has adopted the acid test either[55]. No

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[52] See also extra-judicial lectures of Lord Reed, "*Departing from Precedent: The Experience of the UK Supreme Court*" (20 January 2023) and Lord Burrows, "*Precedent and Overruling in the UK Supreme Court*" (20 March 2024).

[53] See section 64(5) of the MCA; and 306(1) of the Northern Irish legislation (MCA 2016).

[54] See also Lord Kerr, stating that the court had to resolve the question of whether a claim to a Convention right is viable or not "*even where the jurisprudence of the Strasbourg court does not disclose a clear current view*": see §86.

[55] See, for example, *AC v Patricia Hickey General Solicitor and Ors & AC v Fitzpatrick and Ors* [2019] IESC 73 §§115, 262-301, 302-309, 333 which draws a clear distinction between the ECtHR approach and that of the majority in *Cheshire West.* The Supreme Court of Ireland did not need to resolve the differences, as they concluded that the patient was deprived of liberty whichever approach applied §333.

other Contracting State treats hundreds of thousands of its residents as being deprived of liberty as a result of being provided with care and treatment, and no other Contracting State has in place the extensive and costly system of authorising the same. As a result, *"it is likely that England and Wales have the most far-reaching system of recognition and regulation of social care detention globally*[56]*"*.

62. Third, the majority's judgment has been highly controversial, and has been the subject of extensive academic and other criticism: see, for example, Law Commission Report, §5.36 (*"many consultees were critical of the Supreme Court judgment…and argued that it was wrong as a matter of law");* JCHR Report, §45[57]. See also the evidence provided to the JCHR from retired High Court judges[58], family members of those now found to be deprived of liberty despite their living arrangements reflecting their wishes and feelings[59] and from academics; second JCHR Report, §16 (*"..there is a danger that a scheme which applies too widely will be so light touch as to reduce protection for those who truly need it. ..use of the "acid test" alone, without further clarification, risks… (iii) infringing the Article 8 rights of cared for persons and (iv) diverting acutely needed resources away from front-line care which are essential to promote and protect the human rights of cared for persons")*[60]. The academic criticism is helpfully summarised by Dr Series (*"Reponses and backlash")*[61]. Particular criticism has come from Neil Allen[62], Professor Eldergill[63], and Dr Series herself[64].

63. Fourth, the practical implications of the judgment are now fully understood. While the Court in *Cheshire West* was provided with statistics about the number of individuals being accommodated in different settings, that data did not tell the Court anything about the number of people who would be found to be deprived of liberty applying the acid test. The scale and magnitude of the change has been unprecedented (see §§52-54 above). Even more

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56 See Series, *op cit* pg 4.
57 Chapter 5.
58 See JCHR Report, §36 and evidence provided to JCHR by Sir Nicholas Mostyn and Sir William Charles (former Vice President of the Court of Protection), both opining that the acid test is *"legally wrong and should be revisited by the Supreme Court"* (DOL0012) and (DOL0052).
59 See evidence of Graham Enderby (foster father of HL), Mark Neary (father of Stephen Neary) and Caroline Docking (mother of Eleanor, confirming that Eleanor's 2:1 care package means Eleanor has freedom to live her life, to do whatever she likes, when she likes, but has instead been found to be deprived of liberty) *op cit.*
60 JCHR, *Legislative Scrutiny: Mental Capacity (Amendment) Bill,* Twelfth Report of Session 2017-19 (HC 1662, HL Paper 208), 26 October 2008. An attempt to introduce a statutory definition was not approved by Parliament, as it was considered to be incompatible with *Cheshire West.* The Government instead undertook to provide further practical guidance in Code of Practice, and has consulted on the same (see draft Chapter 12).
61 Series, *op cit* (Chapter 8).
62 Allen *op cit*.
63 Eldergill. (2019) *op cit*, and Eldergill et al (2024) *op cit*, Chapter 3.
64 Series, *op cit*, pg 207.

fundamentally, the impact on those who fall within the acid test can now be appreciated, including the regular intrusion into family life and private homes that follows from implementing Article 5 requirements[65].

64. Fifth, the safeguards in place to protect vulnerable incapacitated people have been reformed since *Cheshire West,* with new and additional safeguards for incapacitated persons to provide for periodic checks on their welfare. These are detailed in Annex 1, but include (a) an extensive new statutory regime for delivering social care, containing new safeguards for vulnerable adults (the Care Act 2014[66]); (b) requirements for regular reviews of NHS provision and appointment of independent advocates; and (c) new powers for the Care Quality Commission (the health and social care regulator in England) to register and inspect not only health and social care providers, but also local authority commissioners, with a new assessment framework that focuses on safeguarding and rights under the MCA. Where there are concerns about restrictive practices, or the person being unhappy with their living arrangements, local authorities have considerable tools at their disposal to investigate and address these matters and are obliged to take them into account in its decision making. As Dr Series points out, "*It is not obvious what regulating this as a 'deprivation of liberty' adds..*"[67]

65. Sixth, this is not a case where the Court is considering a unanimous judgment of a 7 judge panel delivered only a year earlier, or where the facts raise "particularly sensitive issues" (as was the case with investigations into deaths in Northern Ireland in *Dalton).* While *Cheshire West* involved a 7 judge panel, it was decided by a bare majority 11 years ago, and the particularly sensitive features of *Dalton* are absent.

66. Seventh, this is not a case where departing from *Cheshire West* would have a damaging impact on legal certainty. If *Cheshire West* is found to be wrong, additional assessments and requirements, over and above those required by Article 5, were imposed on individuals (and their families) before care and treatment was provided. Going forwards, these requirements will no longer be necessary. Alternative safeguards, not in place at the time of *Cheshire West,* are now in place to protect vulnerable individuals (Annex 1).

67. The final question (with which the charity group of interveners takes issue) is whether it is necessary to decide the point in order to determine the present reference. The Secretary of

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[65] See oral and written evidence of Mark Neary, Graham Enderby and Caroline Docking, above. See also *Secretary of State for Justice v Staffordshire County Council* [2017] Fam 278 (extending to the purely private arrangements).

[66] And the Welsh equivalent, the Social Services and Well-being (Wales) Act 2014.

[67] Series, *op cit* p.199.

State submits that it is. First, it is not possible to consider the concept of "valid consent" in isolation, as the starting point is to identify to what an individual is consenting. The overarching question is, after all, whether an individual is deprived of liberty, which requires a consideration of all three limbs of the *Storck* test together. Second, for the reasons outlined above, the Secretary of State submits that the factors relied on by the AGNI in support of submissions on valid consent should be considered under limb (a), and not limb (b). Third, if the Court were to develop the law on valid consent building on the wrong starting point in *Cheshire West,* this will inevitably result in an even greater departure from the ECtHR jurisprudence.

F. Valid Consent

68. Alternatively, if the Court rejects the Secretary of State's submissions on limb (a) and endorses the "acid test" in full, it would follow that all individuals who satisfy the "acid test" are confined, regardless of their wishes and feelings about their living arrangements. Consideration of an individual's wishes and feelings must play a part somewhere in the analysis of whether an individual is deprived of liberty, and so the Secretary of State would then invite the Court to approach this through limb (b), and the meaning of "valid consent". In this situation, the Secretary of State would adopt the submissions of the AGNI, subject to the caveats below.

(1) Caveats and safeguards

69. First, the Secretary of State submits that the role to be played by unincorporated treaties in interpreting Convention rights has been clearly set out by this Court in *R (SC) v Secretary of State for Work and Pensions* [2022] AC 223 §§74-96. It is for the ECtHR to decide what role, if any, Article 12(4) of the UNCRPD plays in the meaning of "deprivation of liberty" in Article 5. This is particularly so when there is considerable uncertainty as to how the UNCRPD interacts with Article 5 of the Convention[68].

70. Second, the Secretary of State is concerned that there could be scope for confusion between decision making under the MCA, and the concept of "valid consent" under Article 5. This confusion could risk diluting the statutory framework in the MCA. If an individual lacks capacity to decide where they should live, and/or the care and treatment they should receive, decisions on those matters must be taken under the MCA framework – i.e. in the person's best interests, and in a way that is least restrictive of the person's rights and freedom of action. In

[68] As Article 14 of the UNCRPD states that the existence of a disability shall in no case justify a deprivation of liberty, while Article 5(1)(e) of the Convention permits deprivation of liberty of a person of unsound mind in certain conditions.

determining what is in the person's best interests, the decision maker must (a) permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any decision-making; and (b) consider and ascertain the person's past and present wishes and feelings, and the beliefs and values that would be likely to influence his decision if he had capacity. The decision maker must also take into account (if practicable and appropriate to consult them), the views of those listed in section 4(7) of the MCA.

71. Having made those decisions, decision makers would then have to go on to consider whether the individual is deprived of liberty as a result. It is only at the stage of considering deprivation of liberty that the ECtHR concept of "valid consent" would play any role. If the individual is confined, the decision maker would then have to consider whether the individual has provided "de facto" consent to the arrangements, notwithstanding that he is (by definition) unable under the MCA to make the decision about residence and care for himself. By this stage, the decision maker must already have considered the person's wishes and feelings, so far as these are ascertainable, and so would be fully aware of these. This is not a "one off" process (i.e. it would never be the case that a person's wishes and feelings are identified at the outset of a placement and never revisited thereafter). Regular reviews are carried out under the care planning process, which will ensure that the individual's wishes and feelings are considered regularly, with the assistance of family/friends/independent advocates (see Annex 1).

72. Further, the Secretary of State submits that any adoption of the valid consent doctrine should make clear that it applies only when considering limb (b) of the *Storck* test and determining whether an individual is deprived of liberty. For instance, the ECtHR has held that it is an interference with bodily integrity under Article 8 of the Convention if medical treatment is imposed on a mentally competent adult patient without their *"informed consent"*[69]. In this context, the ECtHR refers to the requirements of domestic law to determine what is meant by informed consent.

73. Third, guidance would have to be given to decision makers as to what is required to establish that the person is "de facto" able to understand his situation (even though he is unable to make a decision on residence/care under the terms of the MCA). Further, guidance would need to be given to ensure that a person's wishes and feelings are genuinely their own wishes and feelings (and not obtained via coercion or undue influence). The Secretary of State notes that these are not new issues. They are considered as standard as part of best interest decision

[69] See, for example, *YP v Russia* (2023) 76 EHRR 27 at §§49-60.

making, and are informed by consulting with those who know P best (family and/or friends) or an independent advocate (see Annex 1). If the AGNI's submissions are adopted, the Secretary of State would consult on potential guidance, or consider with the Lord Chancellor consulting on changes to the MCA Code of Practice, to set out any additional safeguards that are required.

(2) Departure from Cheshire West

74. The Secretary of State understands that the AGNI and Lord Advocate disagree as to whether there is a need for this Court to depart from *Cheshire West* on the limb (b) question. If there is a need so to depart, the Secretary of State would invite the Court to do so, for the reasons set out above at §§56-68.

(3) Concerns of the charity interveners

75. These submissions have been prepared prior to being provided with the submissions of the charity interveners. Insofar as the Secretary of State understands their position, the response is as follows: (1) the acid test is not predictable and easy to apply for decision makers in practice: see the matters outlined above; (2) the safeguards in Annex 1 outline the steps taken to identify an individual's wishes and freedoms, including through the involvement of various kinds of independent advocates; (3) Annex 1 outlines the circumstances in which independent advocates are appointed to assist P regardless of whether they are deprived of liberty; and (4) Annex 1 outlines the regulatory regimes that are now in place to ensure that providers are complying with their obligations.

G. Conclusion

76. In summary, the Secretary of State invites the Court to depart from *Cheshire West* as outlined above, and/or to confirm that the wishes and feelings of an incapacitated person are relevant to limb (a) of the *Storck* test. Alternatively, if this Court declines that invitation, then the Secretary of State invites the Court to adopt the submissions of the AGNI on valid consent under limb (b) and to answer the reference in the affirmative, subject to the caveats outlined above.

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26 September 2025

Annex 1: Safeguards

Mental Capacity Act 2005:

1. *Capacity to make decision:* s. 2/3 of MCA, determination of whether P is unable to make decision on residence and care/treatment for himself, assess whether P can understand, retain, use or weigh relevant information and communicate the decision; also consider whether inability is caused by the impairment or disturbance in the functioning of the mind or brain (so necessarily considering impact of impairment/disturbance on decision making). MCA Code of Practice, Chapter 4 (capacity should be reviewed from time to time, always reviewed when care plan being developed or reviewed, §4.29).
2. *Best interests:* if lack capacity must as far as reasonably practicable, permit and encourage P to participate, and take all reasonably practicable steps to improve his ability to participate any in decision; must consider all relevant circumstances, including P's wishes and feelings (and views of those in s.4(7)). Must also have regard to whether there are other options less restrictive of P's rights: s.1(6). MCA Code of Practice, Chapter 5 (what is in a person's best interests may well change over time, the person's best interests should be regularly reviewed: §5.14), see also §5.40 ("*[p]eople who cannot express their current wishes and feelings in words may express themselves through their behaviour. Expressions of pleasure or distress and emotional responses will also be relevant. It is also important to be sure that other people have not influenced a person's views. An advocate can help the person make choices and express their views*").
3. *IMCA:* ss.35-39, 40-41 (function - obtaining and evaluating relevant information, ascertaining what P's wishes and feelings would be likely to be, and P's beliefs/values, ascertaining what alternative courses of action are available: s.36(2)). Main role is to represent and support P. Appointed if NHS proposing to provide serious medical treatment, proposing to provide or change accommodation by NHS body or local authority. See Mental Capacity Act 2005 (Independent Mental Capacity Advocates)(General) Regulations 2006, SI 2006/1832 and MCA Code of Practice (Chapter 10) (IMCA may be instructed to support P in other types of decisions (in certain circumstances including where no one else available to be consulted (§10.59)): s.39 MCA and Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) 2006, SI 2006/2883).

Care Act 2014[1]:

4. *Have regard duty:* s.1(3) local authority in exercising any relevant function must have regard to various factors, including (b) "*the individual's views wishes and feelings and beliefs*"; see also (e), (g), and (h) "*need to ensure that any restriction on the individual's rights or freedom of action … is kept to the minimum necessary for achieving the purpose for which the function is being exercised*". *Care and Support Statutory Guidance* (22 July 2025) ("CA Guidance") at §7.20 "*Restrictions should be carefully considered and frequently reviewed*."
5. *Assessment of, and meeting, needs*: duty to assess has very low threshold, whenever it appears to local authority that an adult "*may have needs*" for care and support, financial resources are irrelevant for the purposes of assessment (s.9). Codification where assessment can be refused and protections for adults who lack capacity or at risk of abuse or neglect: s.11(2). See also change in circumstances trigger: s.11(4). The Care and Support (Assessment) Regulations 2014 (SI 2014/2827): reg. 3(1)(b) (the local authority *must* carry out the assessment in a manner which "*ensures that the individual is able to participate in the process as effectively as possible*.") And reg. 3(2) must have regard to *inter alia* (a) "*the wishes and preferences of the individual to whom it relates*"; and (b) "*the outcome the individual seeks from the assessment*". General duty to meet eligible needs if certain conditions are met including (a) financial resources below financial limit, (b) an adult requests it (in respect of non-residential care), or (c) an adult lacks capacity to arrange for the provision of care and support and there is no person authorised to do so under the MCA or otherwise in a position to do so on the adult's behalf: s. 18.
6. *Care planning* (s.24-26): s.25 contents of a care and support plan. Local authority must involve the adult (and others), and must take all reasonable steps to reach agreement with the adult: s.25(3)(5). CA Guidance, §10.2 "*The person must be genuinely involved and influential throughout the planning process…*"
7. *Reviewing care and support plans:* s.27 (1) local authority under a duty to (a) keep under review care and support plans, and (b) on reasonable request, review the plan. Where

[1] See broadly equivalent provisions in Wales under the Social Services and Well-being (Wales) Act 2014 ("SSW(W)A 2014") s.2 (well-being), 5 (well-being duty), 6, 19-20. (assessing needs of adults), 32-35 (meeting needs of adults), 54 (care and support plans), Part 7 (safeguarding) and 180-182 (advocacy). See also the Care and Support (Care Planning)(Wales) Regulations 2015, SI 2015/1335; and the Social Services and Well-being (Wales) Act, Part 3 Code of Practice (assessing the needs of individuals), Part 4 Code of Practice (Meeting Needs) and Part 10 Code of Practice (Advocacy) ("Welsh Codes").

circumstances change duty to review the plan (s.27(4)(a)), and take all reasonable steps to reach agreement with the adult concerned (s.27(5)). CA Guidance: §13.31 reviews should be every 12 months.

8. *Safeguarding and adult protections* (s.42-47):[2] duties apply where the local authority has "*reasonable cause to suspect*" that an adult in its area (a) has need for care and support, (b) is experiencing, or is at risk of abuse or neglect, and (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. Includes a duty of enquiry s.42(2) to decide whether any action should be taken, if so what, and by whom. Duty to establish a safeguarding adult board: s.43. see also CA Guidance (Chapter 14).
9. *Independent advocacy* (s.67-68): local authority must arrange independent advocate to be available to represent and support the individual for the purpose of facilitating their involvement in various matters, including the needs assessment, care and support planning and reviews. Duty arises, where person would experience substantial difficulties in understanding, retaining, weighing or using that information and communicating their wishes and feelings: s.67(4)[3]. See also IMCAs (above): MCA, ss.35-41[4]; MCA Code of Practice (Chapter 10)[5].
10. *Guidance*: duty to act under general guidance of the Secretary of State: s.78 (see Chapters 1 (promoting well-being), 6 (assessment and eligibility), 7 (independent advocacy), 10 (care and support planning), 11 (review of care and support plans), 14 (safeguarding)[6] of the CA Guidance.

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[2] See also s.73 CA 2014 on the extension of Convention protections under the HRA to those receiving care and support from registered care providers. The MHB (see below §12) will also extend protections under the HRA to others under clause 52.

[3] See further requirements in the Care and Support (Independent Advocacy Support) (No 2) Regulations 2014, SI 2014/2889.

[4] The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006, SI 2006/1832, regs. 5-7.

[5] See also in Wales, *Welsh Codes, Part 10 Codes of Practice (Advocacy).*

[6] See in Wales s.145-147 of the SSW(W)A 2014, placing a duty on local authorities to act in accordance with any relevant requirements contained in a code of practice, and have regard to any relevant guidelines contained in it. see Welsh Codes, *Part 2 Code of Practice, Wellbeing and overarching duties* §10-35, *Part 3 Code of Practice (assessing the needs of individuals)* on assessment generally and on reviews §§92-100, *Part 10 Code of Practice (Advocacy)*, and *Part 7, Working Together to Safeguard People Volume I – Introduction and Overview.*

Mental Health Act 1983

11. *Section 117 (after-care) - care planning, reviews and independent advocacy*: community mental health framework[7], regular review at agreed intervals (at least every 12 months); see also role of different types of independent advocates[8]. Where local authority is providing accommodation under s.117(2) and the person expresses a preference for particular accommodation, and certain conditions are met (including that the accommodation is suitable to meet the person's needs): Care and Support and After-care (Choice of Accommodation) Regulations 2014, SI 2014/2670, reg. 4.

12. Informal patients: under the *MHA Code of Practice*: informal patients should have their legal position and rights explained to them (§4.49), including their right to leave (§4.51), access to an Independent Mental Health Advocates ("IMHA") in certain circumstances (§6.10). The Code advises against a blanket locked door policy (§8:10). See also §26.106 regarding seclusion, and in relation to children (§§19.49-19.72). Under the Mental Health Bill 2024 ("MHB"), which has completed its passage through the House of Lords and is at the Report Stage in the House of Commons, clause 40 and schedule 3, will provide for informal patients to qualify for help from IMHA.[9]

NHS Continuing Healthcare: National Health Service Act 2006

13. *Care Planning, Reviews and independent advocacy:* person-centred approach, having due regard to wishes and preferred outcomes; reviews at 3 months and 12 months as minimum (some will require more frequent review in line with clinical judgement and changing needs), see also role of different types of independent advocates[10].

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[7] See guidance, The Community Mental Health Framework for Adults and Older Adults (2019).

[8] Defined in s.117(6); see Chapter 33-34 of the *Mental Health Act 1983 Code of Practice*; see also Statutory Guidance, *Discharge from mental health inpatient settings,* Principle 1. Safeguarding obligations under CA 2014 apply to aftercare provision. Section 117 applies in Wales. However, Wales has its own *Mental Health Act 1983 Code of Practice for Wales* (see Chapter 33 and 34), as well as the devolved Mental Health (Wales) Measure 2010. Safeguarding obligations under the SSW(W)A 2014 apply to aftercare provision in Wales.

[9] In Wales s.130E of the MHA provides for the appointment of an IMHA, including informal patients in certain circumstances. The Mental Health (Independent Mental Health Advocates) Wales Regulations 2011, SI 2011/ 2501 (W. 273) make provision as to the requirements for independent mental health advocates, including requirements as to their independence. *Part 10 Code of Practice (advocacy)* Annex 4.

[10] See the *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care* (England, 2022), §§191-197, 201-209, 330-332, PG9, PG57; see also Local Government and Public Involvement

Health and Social Care Act 2008 (Regulation by Care Quality Commission)[11]:

14. *Functions:* registration of health or social care providers and managers (Chapter 2).
15. *Regulation for service providers and managers:* Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (SI 2014/2936), including regs. 9 (person centred care), 10 (dignity and respect), 12 (safe care and treatment), 13 (safeguarding).
16. *Reviews and investigations:* CQC conducts reviews of regulated activities by registered service providers, assess performance of service providers, and publish a report (s.46 and see also s.48)[12]; assessment carried out in accordance with Single Assessment Framework[13] (includes safe, effective, caring, responsive, well-led, with focus on safeguarding, rights under MCA, Equality Act and HRA). From 1 July 2022 CQC registered providers required to ensure staff receive specific training on learning disabilities and autism appropriate to their role (see also *Oliver McGowan code of practice*, (19 June 2025) on new requirements for training re learning disabilities, and autistic people).[14]
17. *Inspections of local authorities and ICS:* inspection powers extended to include reviews of regulated care functions by local authorities and integrated care systems, assess performance and publish a report: ss.46A, 46B[15] and in relation to local authorities

in Health Act 2007 (2007 c 28)s.223A (local authority must make such arrangements as it considers appropriate for the provision of independent advocacy services in relation to its area); for the position in Wales, see the NHS (Wales) Act 2006 and the Continuing NHS Healthcare: the National Framework for Implementation in Wales (2022), §§2.83-2.86, 3.29.

[11] Equivalent regulators in Wales are the Healthcare Inspectorate Wales ("HIW") for health services and Care Inspectorate Wales ("CIW") for social care services. HIW inspects NHS services, and regulates independent healthcare providers, as well as Community Mental Health Teams in Wales (see: Care Standards Act 2000 and Independent Health Care (Wales) Regulations 2011 (SI 2011/734). See also the *National Minimum Standards for Independent Healthcare Services in Wales* (2011 no.16). The HIW, alongside the CIW, monitors the use of the MHA 1983, the MCA and the requirements of the DOLS. CIW inspects and regulates social care providers under the Regulation and Inspection of Social Care (Wales) Act 2016, chapter 3; see also the Regulated Services (Service Providers and Responsible Individuals)(Wales) Regulations 2017; SSW(W)A s.161-161C, Code of Practice for Review of Local Authority Social Services and Cafcass Cymru (27 November 2024).

[12]The Care Quality Commission (Reviews and Performance Assessments) Regulations 2018, SI 2018/54.

[13] CQC Assessment Guidance, Section 2 Assessment Framework.

[14] Health and Care Act 2022 s.181.

[15] Health and Social Care Act 2008, amended by Health and Social Care Act 2022. The review duties on the CQC in relation to local authorities and ICSs are distinct.

Health and Social Care Act 2008 (Regulated Care Functions) Regulations 2023 (SI 2023/238) reg. 2).[16] See CQC *Assessment framework for local authority assurance*, (November 2023), Theme 3 includes "Safeguarding". New default powers to Secretary of State to act if satisfied local authority failing or has failed to discharge CA 2014 functions to acceptable standard[17].

Civil Law

18. Battery, false imprisonment, negligence and trespass against a person (if outside MCA/no authorisation).

Criminal Law

19. General offences (assault, false imprisonment); also specific offences of ill treatment or wilful neglect in relation to mental health patients and those who lack capacity respectively (MHA 1983, s.127 and MCA 2005, s.44.); regulatory offences (2008 Act, s.33-37), and s.20-25 Criminal Justice and the Courts Act 2015).

Children (Children Act 1989)[18]

20. *Child Protection:* Part IV (care and supervision orders) and V (protection of children)
21. *Looked after children:* Part III of 1989 Act (duty to safeguard and promote the welfare of children, provision of services for children in need, duty to accommodate (s.17 and 20), provision of accommodation (s.22C); duty to ensure visits to, and contact with, looked after children (s.23ZA).
22. *Care planning:* Care Planning, Placement and Case Review (England) Regulations 2010 ("2010 Regulations"), reg 4-5, Part 3 and 4; see also Part 5 (visits by local authority representative).

[16] See in relation to Wales: SSW(W)A s.161-161C

[17] SSW(W)A s.150-157

[18] See SSW(W)A, ss.21-23 (assessing children), 32-34, 37-39 (meeting care and support needs of children), and Part 6 of the SSW(W)A (looked after and accommodated children), and the regulations and Code of Practice made thereunder: SSW(W)A s.178, entitlements of looked after children, and to other children specified within section 178, to advocacy. Local authorities must have regard to their overarching duties to have due regard to Part 1 of the United Nations Convention on the Rights of the Child as set out in section 7 of the SSW(W)A. Care Planning, Placement and Care Review (Wales) Regulations 2015 (No. 1818 (W. 261)). *Part 6 Code of Practice (Looked After and Accommodated Children)*. *Part 10 Code of Practice (Advocacy)* §§89-90.

23. *Reviews and Independent Reviewing Officer*: s.25A-30A (role and functions of IRO, monitor performance of authority functions, participate in reviews, ensure wishes and feelings of the child are considered by authority, if appropriate, refer to CAFCAS); see reg 6 and Part 6 of 2010 Regulations (keep care plan under review, reg 33 sets out timing reqs); reg. 36 and Part 8 (role of the IRO), Schedule 7 (considerations on review).
24. *Safeguarding*: s.47 (duty to make enquiries where reasonable cause to suspect child suffering, or likely to suffer, significant harm); *Working Together to Safeguard Children* (statutory framework)[19] and substantive statutory guidance[20]; s.10-11 Children Act 2004 (cooperation need to safeguard and promote welfare of children); Child Safeguarding Practice Review Panel (s.16A-P).[21]

NHS: NHS Continuing care for children

25. Where children have very complex health needs these needs may be met by an additional package of care known as continuing care (see: *National Framework for Children and Young People's Continuing Care,* 2016, assessment includes considering the preferences of the child and their family (§§7, 21, 32-34). Commissioners will keep the package under regular review (§13)[22].
26. Since September 1 2014, under s.26 of the Children and Families Act 2014, a new framework for children and young people (up to age 25) with SEND applied in England, with the right to request an assessment (s.36), and if eligible needs right to an integrated Education, Health and Care plan (EHC plan) (s.37), with decisions appealed to the First Tier Tribunal by the child's parent or young person (s.51).[23] An

[19] *Working Together to Safeguard Children, Statutory framework: legislation relevant to safeguarding and promoting the welfare of children* (December 2023).

[20] *Working Together to Safeguard Children 2023, A guide to multi-agency working to help, protect and promote the welfare of children* (December 2023).

[21] In Wales duties under ss.128 and 130 SSW(W)A to report adults at risk and children at risk and the duties to enquire under s.126 of the Act and section 47 of the Children Act 1989. See also guidance, *Social Services and Well-being (Wales) Act 2014 Working Together to Safeguard People Volume I – Introduction and Overview.*

[22] See equivalent in Wales, the *Children and Young People's Continuing Care Guidance* (2020) at §3.55 (package reviewed three months after commencing and annually thereafter or when circumstances have changed, or on request).

[23] See guidance, *SEND code of practice: 0 to 25 years* (September 2024). In Wales, the position is governed by the Additional Learning Needs and Education Tribunal (Wales) Act 2018

EHCP must be reviewed at least annually (s.44). See s.80 for treatment of young people lacking capacity.

Care Standards Act 2000: Regulation by Ofsted[24]

27. *Functions:* registration of person carrying on, or managing children's homes, domiciliary care providers, fostering agencies, supported accommodation (Part 2 of CSA).
28. *Regulation of person who carries on or manages establishment:* s.22-23 CSA, requirements imposed in regulations, and guidance. Examples include Children's Homes (England) Regulations 2015 and Supported Accommodation (England) Regulations 2023, setting out quality standards for relevant provision. Includes quality and purpose of care standard (reg. 6), children's wishes and feelings standard (reg. 7), protection of children standard (reg 12)[25]; The Fostering Services (England) Regulations 2011 include arrangements for the protection of children (reg. 12).
29. *Inspections:* inspections carried out under s.31 CSA, in accordance with relevant social care common inspection framework for each type of provision[26] and guidance.[27]
30. *Inspections of local authorities*: inspection of local authority children's services, using the Inspection of Local Authority Children's Services (ILACS) framework[28], will evaluate experiences of children and young people including those receiving social work services because there are significant concerns about their safety and welfare, and looked after children.

[24] In Wales, these functions are carried out by the Care Inspectorate Wales: Regulation and Inspection of Social Care (Wales) Act 2016, and the regulations Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017, see also guidance *The Regulation and Inspection of Social Care (Wales) Act 2016 Statutory Guidance* (Version 3 – March 2024).

[25] See for example, *Guide to the Children's Homes Regulations including the quality standards* (April 2015).

[26] See for example, *Social care common inspection framework (SCCIF): children's homes* (4 April 2025).

[27] *Guidance Social care common inspection framework (SCCIF): children's homes* (4 April 2025) which includes assessing staff understanding of and support for children's communication, and whether children have access to, and are actively encouraged to involve, a suitably skilled and experienced independent advocate and, where appropriate, an independent visitor under the heading "*The overall experiences and progress of children*".

[28] See guidance *Inspecting local authority children's services* (13 August 2025).