

Deprivation of Liberty Safeguards – guidance for doctors



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Liberty protection safeguards – an update

In July 2018, the Government introduced, via the Mental Capacity (Amendment) Bill, a new proposed statutory regime for authorising the deprivation of liberty of incapacitated adults. This scheme – the Liberty Protection Safeguards (LPS) – will replace the Deprivation of Liberty Safeguards (DoLS) in their entirety. At the time of writing it is expected that the new regime will come into force in autumn 2020. The LPS will be accompanied by a Code of Practice. Please check the BMA website for updated information.

Until the LPS come into force, this guidance is designed as a prompt to help health professionals identify factors that may be relevant when assessing whether an adult may be deprived of liberty. We also hope that it might enable health professionals to consider whether there may be less restrictive ways of providing the necessary care and treatment.

The guidance sets out our understanding of the legal position following Cheshire West and Ferreira. It looks briefly at potential deprivations of liberty in acute settings before giving more detailed guidance on deprivation of liberty in care homes and other residential settings.

Key points for health professionals

- The fact that care or treatment amounts to a deprivation of liberty does not mean that it is inappropriate. It means only that it reaches a certain threshold of restriction such that authorisation is required.
- Identifying and authorising a deprivation of liberty should not substitute for or impede the delivery of the highest standard of care.
- The focus of decision-making must remain the best interests of the patient.
- Nothing in the MCA or DoLS is designed to prevent the provision of timely and appropriate medical treatment. In an emergency, treatment must not be delayed for the purposes of identifying whether a deprivation of liberty has taken place, or seeking its subsequent authorisation.
- An authorisation for a deprivation of liberty does not provide legal authority for treatment. Treatment for adults unable to consent must be given on the basis of an assessment of their best interests or in accordance with another legal provision of the MCA.
- Authorisation for a deprivation of liberty is unlikely to be necessary where urgent or lifesaving treatment for a physical condition is being provided to a patient lacking capacity, where the treatment is necessary, in the patient's best interests and is materially the same as that which would be provided to a person with capacity to consent. This is likely to include most treatment provided in an ITU or analogous setting.

At a glance

Where an individual is being provided with care and treatment in circumstances that amount to a deprivation of liberty, that deprivation has to be authorised. Factors that indicate that an individual may be deprived of liberty include:

- That the person is confined to a restricted place for a non-negligible period of time
- That the person does not have the capacity to consent to their care and treatment in those circumstances
- That the person is subject to ‘continuous and complete supervision and control’, and
- That the person is not free to leave.

Introduction

During the provision of care and treatment to adults who may temporarily or permanently lack relevant decision-making capacity, it may be necessary to treat them in circumstances that amount to a deprivation of liberty under Article 5 of the European Convention on Human Rights. In 2009, an amendment to the Mental Capacity Act (2005) for England and Wales (MCA) came into effect which introduced the Deprivation of Liberty Safeguards (DoLS). These are designed to ensure that appropriate safeguards are in place to protect adults deprived of their liberty.

One enduring challenge for health professionals has been identifying those conditions that may amount to a deprivation of liberty, as opposed, for example, to some necessary and temporary constraints on an incapacitated individual’s liberty in their best interests.

The Supreme Court, in its judgment in *Cheshire West* set out an ‘acid test’ for the deprivation of liberty – discussed in more detail below. The Court held that, when assessing whether an individual was deprived of their liberty, the purposes of that deprivation – such as the delivery of healthcare – were not relevant. *Cheshire West* resulted in a widespread view that many more adults were being deprived of their liberty in health care settings than had been thought. This led to a considerable increase in the use of DoLS and raised questions about whether incapacitated adults who were being treated in settings where issues concerning deprivation of liberty had seldom arisen, such as in ITUs, required authorisation under the safeguards.

The Court of Appeal addressed some of these concerns in the subsequent case of *Ferreira*. Put very simply, the Court held that where an incapacitated adult was receiving urgent or emergency treatment and the treatment was materially similar to that which would be provided to a person with capacity, then there was no deprivation of liberty under Article 5. Any loss of liberty arose from the individual’s physical condition, not from restrictions imposed by those providing care or treatment. Following *Ferreira* it is now generally accepted that there will ordinarily be no deprivation of liberty where an individual is being treated in ITU.

Commenting on *Ferreira* in a subsequent case at the Supreme Court¹, Lady Arden stated:

For the reasons which the Court of Appeal (McFarlane LJ, Sir Ross Cranston and myself) gave in...Ferreira... the situation where a person is taken into (in that case) an intensive care unit for the purpose of life-saving treatment and is unable to give their consent to their consequent loss of liberty, does not result in a deprivation of liberty for article 5 purposes so long as the loss of liberty is due to the need to provide care for them on an urgent basis because of their serious medical condition, is necessary and unavoidable, and results from circumstances beyond the state’s control. (Emphasis in bold added).

Although the law in this area is not absolutely settled, in the BMA’s view it would be reasonable to assume that, where incapacitated adults are being provided with short-term treatment for physical conditions in analogous settings, such as A&E departments, and any loss of liberty arises primarily from the patient’s physical condition, rather than constraints or coercion applied by carers, authorisation is unlikely to be required. In cases of doubt, legal advice should be sought. We particularly recommend that advice is sought where care or treatment of an

incapacitated adult involves a significant degree of coercion, or restrictions of liberty are likely to extend over longer periods of time.

What this guidance does not cover

This guidance does not address the specific question of deprivation of liberty in psychiatric settings. Professionals working in these settings tend to be more familiar with, and more sensitive to, the need at times to detain people and to seek legal authority as appropriate. The complex interplay of mental health and mental capacity legislation, along with provisions for the care of informal patients, make this a complex area of law and clinical practice and separate guidance is required.

In addition, given the current state of legal uncertainty, this guidance does not address questions relating to the deprivation of the liberty of a person in his or her own home. Where health professionals identify adults with impaired capacity who they have reason to believe may be being deprived of their liberty in their own home, they should discuss the matter with an appropriate adult safeguarding lead. This guidance refers solely to those aged 18 and over.

This guidance is designed to assist health professionals identify where an individual may lawfully be deprived of liberty. Detailed separate guidance is available, listed at the end, to address the procedures for authorising that deprivation.

Deprivation of liberty and the provision of treatment

Some health professionals may feel the legal concept of deprivation of liberty sits uncomfortably with their ordinary obligations to promote the best interests of their patients. It is important to emphasise that even if care or treatment amounts to a deprivation of liberty it does not follow that the care or treatment is inappropriate. It means only that it reaches a certain threshold of restriction such that authorisation is required.

Nothing in the MCA or DoLS is designed to prevent the provision of timely and appropriate medical treatment. In an emergency, treatment must not be delayed for the purposes of identifying whether a deprivation of liberty has taken place, or seeking its subsequent authorisation.

Deprivation of liberty – the legal position

The MCA provides health professionals with protection from liability where they may have to restrict the liberty of incapacitated adults and the restriction is both necessary to protect the adult from harm, and proportionate to the risk of harm. Appropriate use of restraint in these circumstances is lawful under the MCA. The protection from liability does not extend to depriving incapacitated adults of their liberty. The difficulty is identifying the point at which the intensity and duration of restraint amounts to a deprivation of liberty. The MCA does not contain a definition of what constitutes a deprivation of liberty. It refers instead to Article 5 of the European Human Rights Convention, the right to liberty and security of person.

The European Court of Human Rights has identified three elements that all need to be met before a particular set of circumstances will amount to a deprivation of liberty under Article 5:

- The objective element: that the person is confined to a particular restricted place for a non-negligible period of time
- The subjective element: that the person either does not or cannot consent
- Imputable to the state: that deprivation is one for which the state can be said to be responsible.

Cheshire West (P v Cheshire West and Chester Council; P and Q v Surrey County Council) – an outline of the cases

These cases concerned the criteria for judging whether the living arrangements made for a mentally incapacitated person amount to a deprivation of liberty. P and Q (known as MIG and MEG) are sisters who were the subject of care proceedings in 2007 when they were respectively 16 and 15. Both have learning disabilities. MIG was placed with a foster mother to whom she was devoted and went to a daily education unit. She never tried to leave the foster home alone but would have been prevented from doing so had she tried. MEG was moved from foster care to a residential home for learning disabled adolescents with complex needs. She sometimes required physical restraint and received tranquilising medication.

P is an adult with cerebral palsy and Down's syndrome. He requires 24-hour care. Until he was 37, he lived with his mother but when her health deteriorated the local social services authority obtained orders from the Court of Protection that it was in P's best interests to live in accommodation arranged by the authority. Since November 2009 he has lived in a staff bungalow with other residents near his home and has one-to-one support. Intervention is sometimes required when he exhibits challenging behaviour.

The Supreme Court held, unanimously in the case of P, and by a majority of 4 to 3 in the case of MIG and MEG that they had been deprived of their liberty. The Court made several points including:

- *It was important not to confuse the benign purposes of the care arrangements with the question of whether a person was deprived of liberty.*
- *What would be a deprivation of liberty for a non-disabled person is also a deprivation for a disabled person.*
- *The key feature is whether the person concerned is under continuous supervision and is not free to leave.*
- *The person's compliance or lack of objection, the purpose of the placement or its relative normality are immaterial.*

The objective element

Decisions about whether a person has been deprived of their liberty, will always depend upon the circumstances of the case, including factors such as the type, duration, intensity, effects and implementation of the restrictive measures, operating either alone or in combination. Case law indicates that what amounts to a 'non-negligible period of time' will vary according to factors including the intensity of the restrictions imposed.

The subjective element

Where the person in question gives valid consent to the confinement in question, no deprivation of liberty will take place under Article 5.

Imputable to the state

There are two relevant ways in which the state has responsibility to protect people from unlawful deprivations of liberty. The first is to prevent direct unlawful deprivations by the state – its 'negative' obligation. The second is its 'positive' obligation: to intervene to protect people from deprivation of liberty by private persons or organisations, such as, in our context, private providers of care as well as family and friends. To reiterate, although state imputability is clearly engaged by all NHS providers and those contracted by the NHS, it also extends to those providing care in private care homes and hospitals.

Cheshire West

The decision in Cheshire West is complex but a number of useful points can be drawn from it. The first is what Lady Hale described as the ‘acid test’ for a deprivation of liberty. According to Lady Hale the important question, the ‘acid test’, was whether, in the circumstances of the case, the individual ‘was subject to continuous or complete supervision and control and was not free to leave’. Lady Hale also stated that because of the extreme vulnerability of many people with impaired capacity, decision-makers ‘should err on the side of caution in deciding what constitutes a deprivation of liberty.’

What does ‘continuous or complete supervision and control’ mean?

The phrase ‘continuous and complete supervision and control’ may suggest confinement in a locked room or ward with continuous visual monitoring by health or care staff. While there is little doubt that these circumstances would amount to a deprivation of liberty, later case law has established that deprivation of liberty can take place in circumstances that are markedly less restrictive than this. The Courts have, for example, found an individual to be deprived of his liberty when he was in an open ward with regular unescorted access to open hospital grounds.

One approach that may be helpful when assessing whether an individual is subject to continuous or complete supervision or control is to ask whether those responsible for looking after the individual have a plan of care that means that they are likely to be aware at any time:

- Where the individual is
- What the individual will be doing, and
- What steps they will take if at any time they cannot establish the above.

What does ‘not free to leave’ mean?

The courts have made it clear that when deciding whether an individual is free to leave, they must set aside the question of whether they are actually able to leave or whether they are making any attempt at leaving. In law, a person can still be objectively deprived of their liberty even where they lack the physical ability to leave, or are entirely compliant with their circumstances.

In determining whether someone is free to leave it can be helpful to ask: what would happen if they did try to leave? If the answer is that reasonable steps would be taken to assist them to leave, then this limb of the test is unlikely to be met. If steps would be taken to prevent them from leaving, even where those steps would be manifestly in their best interests, then this would suggest that they are not free to leave. The question is not therefore whether doors are locked. The question is how staff would respond if a patient sought to unlock the door and leave.

The following questions may be helpful when assessing whether an individual is ‘free to leave’:

- Is the person free to come and go as they wish or do they need permission?
- Are they able to leave and live somewhere else or would they require permission?
- If they leave and try to relocate somewhere else, will steps be taken to return them?

If they need permission to leave or to move and if they would be returned should they leave, then this suggests that they are not free to leave and this limb of the deprivation of liberty test is likely to be satisfied.

What if someone is unable to express any wish or desire to leave?

If a person entirely lacks the capacity to form or express any desire to leave he or she may still, in law, be deprived of liberty. In these circumstances it can be helpful to ask what the relevant decision makers would say if somebody, such as a family member, with a proper interest in the incapacitated person's welfare, wished to move them somewhere different.

Both limbs of the test must be satisfied

In *Cheshire West* the court stated that both parts of the 'acid test' had to be satisfied. A person must be under continuous supervision and control and not be free to leave. Some uncertainty has arisen here as it would seem reasonable to suggest that a person could be deprived of liberty by being kept in a locked room but not be subject to any supervision. In our view, decision makers should exercise caution in these circumstances. If a person is kept in confinement and is therefore clearly unable to leave, we recommend that a proper assessment of their circumstances be made and consideration given to seeking authorisation for a deprivation of liberty.

Factors that are not relevant to assessing whether an individual is deprived of liberty.

In *Cheshire West* the court listed a number of factors that are not relevant to the assessment of whether a person is objectively deprived of their liberty. These are:

- The person's compliance or lack of objection
- The relative normality of the placement
- The reason or purpose behind the placement

A non-negligible period of time

As discussed earlier, case law from the European Court of Human Rights (ECtHR) has made it clear that a deprivation of liberty will involve confinement in a particular place for a 'non-negligible' period of time. The ECtHR did not indicate how long such a period would be. Subsequent case law suggests that the relevant length of time will vary depending upon the nature and intensity of the particular circumstances. In one instance the complete and 'intense' restraint by police officers of an autistic boy for 40 minutes was held to amount to a deprivation of his liberty. Separately it was held that someone required to remain in hospital during the application for admission under s.136 of the Mental Health Act for up to 8 hours would not 'ordinarily' be deprived of their liberty.

When considering whether the period of time someone is confined amounts to 'non-negligible' for the purposes of assessing whether a deprivation of liberty has taken place, the following factors are likely to be relevant:

- The intensity of the measures of constraint
- The extent to which the individual resents or resists the constraints.

Factors to consider when assessing whether an individual may be deprived of liberty

Have the three Article 5 elements been satisfied?

- The objective element: is the person confined to a particular restricted place for a non-negligible period of time?
- The subjective element: does the person refuse to consent or are they unable to consent?
- State imputability: is the deprivation of liberty directly or indirectly the responsibility of the state?
- (This element will always be satisfied where the care is either delivered directly or commissioned by an NHS body. It will also apply where care is provided privately in a hospital or care home.)
- Do the circumstances satisfy the ‘acid test’: is the individual subject to complete or continuous supervision and control and is not free to leave? Useful questions to ask here will include the following:
 - Is the person free to come and go as they wish or do they need permission?
 - Are they able to leave and live somewhere else or would they require permission?
 - If they leave and try to relocate somewhere else, will steps be taken to return them?
 - How intense are the measures of constraint?
 - To what extent does the individual resent or resist the constraints?

Distinguishing Cheshire West – Ferreira and treatment provided in an ITU

Maria Ferreira, who had Down’s Syndrome and learning disabilities, died in ITU after dislodging a tube with her mittened hand. Although an inquest was to be held, the question of whether a jury was required depended on the legal question of whether, under the Coroner’s and Justice Act 2009, she had died ‘in state detention’. It became important therefore to establish the ‘overlapping’ question of whether she had been deprived of her liberty by the state under Art 5(1) ECHR. Whether the Coroner should sit with a jury broadened into the wider question of whether a person being treated in ITU who could not consent to that treatment was deprived of liberty and required a DoLS authorisation.

The Court of Appeal held that, for the following reasons, Ms Ferreira was not deprived of her liberty while she was being treated in ITU:

- She was being treated for a physical illness and materially similar treatment would be provided to a person who did not have her mental impairment.
- Her loss of liberty resulted from her physical condition, not from restrictions imposed by the hospital
- Any deprivation of liberty resulting from the administration of life-saving treatment does not engage Article 5(1) so long as it is unavoidable, is necessary to avert a real risk of serious injury and is kept to the minimum required for the purpose.

The Supreme Court refused permission to appeal the case and the judgement effectively establishes that DoLS applications will not usually need to be made for patients who lack capacity and are being appropriately treated in an ITU.

The question inevitably arises as to what extent *Ferreira* applies outside of an intensive care setting. In the BMA's view it is reasonable to assume, following Lady Arden's comments in *D (A Child)* discussed above, that the judgment will apply to individuals similarly situated who are being provided with short-term treatment for physical conditions in analogous settings, such as A&E departments, provided any loss of liberty arises primarily from the patient's physical condition, rather than constraints or coercion applied by carers. As *Ferreira* states:

'In general there is no need in the case of physical illness for a person of unsound mind to have the benefit of safeguards against the deprivation of liberty where the treatment is 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'

This is not, however, a completely settled area of law and in cases of doubt, legal advice should be sought. We particularly recommend that advice is sought where care or treatment of an incapacitated adult involves a significant degree of coercion, or restrictions of liberty are likely to extend over longer periods of time.

Deprivation of liberty in hospitals

Where the care and treatment of an adult is provided in an NHS hospital, delivered by an independent health care provider or is arranged or commissioned privately or by a Clinical Commissioning Group (CCG), it is necessary to consider whether that care or treatment may amount to a deprivation of liberty.

We have seen that, in the case of *Ferreira*, authorisation for a deprivation of liberty is unlikely to be required where patients are being treated for a physical condition in ITU. In the BMA's view, it is reasonable to extrapolate to clearly analogous cases such as urgently necessary treatment in an A&E department.

There may however be circumstances where treatment in acute hospitals amounts to a deprivation of liberty. In *Ferreira* the Court referred to the case of a woman 'of unsound mind' who was provided with obstetric treatment against her wishes. The anticipatory treatment plan included the possibility of preventing her leaving and the administration of invasive treatment for a caesarean section. The Court held that, because the treatment would have been 'materially different' from that offered to a patient 'of sound mind', authorisation for any deprivation of liberty would be required.

Conveyance by ambulance

In the majority of cases the conveyance of adults lacking the capacity to consent to hospitals and care homes in an emergency is unlikely to amount to a deprivation of liberty. Ordinarily it will be lawful under the MCA provided that the treatment in hospital, or residence in the care home, is in the adult's best interests. The Deprivation of Liberty Safeguards Code indicates that there may be some exceptional circumstances in which conveying a person to hospital may amount to a deprivation of liberty. These may include:

- Where the police or other statutory service may be involved in order to gain entry to the person's home and assist in their removal and conveyance
- Where it may be necessary to do more than try and persuade or briefly restrain the individual
- Where the person may need to be sedated to facilitate transportation
- Where the journey is exceptionally long.

Treatment in an acute ward

Large numbers of patients who lack capacity to consent to their care and treatment are treated in acute wards. Although the overwhelming majority of these will not be deprived of their liberty, there may be occasions where some restriction of liberty is required. The MCA permits a restriction of liberty where it is necessary to protect the person from harm and the restrictions are a proportionate response to the risk of harm, always keeping in mind the obligation to identify options that are less restrictive of an individual's liberty. Care needs to be taken to identify where such restrictions, either individually or cumulatively, may amount to a deprivation of liberty. Measures that can restrict individual liberty in these settings include:

- Physical restraint
- Baffle-locks on doors
- Methods of restraint to prevent people removing catheters, tubes or drips
- Raised bed-rails
- Patients being placed in chairs from which they cannot get up without help
- Being unable to leave the ward.

Sadly, Ferreira did not address itself to potential deprivations of liberty in the provision of non-emergency treatment in acute hospital settings. As such, it is important to keep in mind *Cheshire West*: the key issue is whether the individual is under continuous supervision and control and is not free to leave. As discussed earlier, particular care needs to be taken where the treatment or care involves a considerable degree of coercion, or restrictions are applied with particular intensity or are likely to be in place for any length of time. In cases of doubt, legal advice should be sought as a matter of urgency.

Case example: treatment in an acute ward likely to amount to a deprivation of liberty

Mrs Lockyer has been living on her own since her husband died two years previously. Until fairly recently she has been managing quite well but her neighbours have become concerned about her increasingly erratic behaviour and her spells of dizziness. One evening a neighbour notices that her front door is open. He goes inside and finds her passed out in the hall. He calls an ambulance and she is admitted to an acute ward. Neurological investigation identifies that she has had a stroke. On recovering consciousness her capacity is impaired. She is adamant that she wants to return home but the treating team considers it to be in her best interests to remain in hospital for further assessment.

Factors indicating that Mrs Lockyer may be deprived of her liberty include the following:

- She is subject to continuous supervision
- The treating team will not let her return home
- She is likely to have to remain on the ward for a substantial time.

Deprivation of liberty in care homes

Broadly speaking, care homes are designed to provide residential care and support, either on a short- term basis for respite care or for a longer term. Care homes cater for people with a wide range of needs including older people with dementia, the learning disabled and those with long-term mental health conditions. Although generalising here can be difficult, the fact that care homes often involve decisions about residence and may require the monitoring of residents' movements, means that questions about possible deprivations of liberty are likely to arise with some frequency.

Nothing in the terms of provision of supported care by itself confers authority on the providers to deprive residents of their liberty. Some care home residents will have the capacity to consent to the arrangements for their care. In addition there are a number of legal measures with different effects that may make lawful some constraints on the liberty of residents. These include:

- A welfare order made by the Court of Protection
- Leave granted to a mental health patient under the Mental Health Act (MHA)
- A guardianship order under the MHA
- A Community Treatment Order (CTO) under the MHA.

In the absence of any other relevant legal authority, any deprivation of liberty in a care home of an adult lacking the relevant capacity to consent to it requires authorisation under DoLS.

The following are examples of measures that may be applied in residential care homes that may restrict an individual's liberty:

- Locks or keypad entry systems
- Observation and monitoring
- A care plan that requires an escort when the person leaves the home
- Restrictions on access to open spaces and activities (including where they result from staff shortages)
- Restrictions on visitors and/or contact with family or friends
- Mechanical or chemical restraints
- Requirements, on behalf of residents with enduring mental health problems, to take part in specified programmes or to receive certain treatments
- Curfews

Case example: provision of care to an elderly man with dementia that may amount to a deprivation of liberty in a care home

Mr Rughoo is 85 with some cognitive impairment associated with the early stages of dementia. Following the death of his wife he found living at home increasingly challenging. After a dangerous fall he agreed to move into a local care home and had the capacity to agree to the arrangements for his care. Recently Mr Rughoo's dementia has progressed. He has been enjoying an early evening trip to a local pub, but is now required to inform staff of his movements before he is allowed to leave. On one occasion he did not return from the pub at the agreed time and the police were informed and they returned him.

Factors indicating that Mr Rughoo may be deprived of his liberty include the following:

- He no longer has capacity to consent to the altered terms of his care
- He is not free to leave the home
- He is subject to a high degree of supervision and control in the home.

Case example: provision of care to an adult with learning disability that may amount to a deprivation of liberty in a care home

Peter is 21 with a severe learning disability and attention deficit hyperactivity disorder. He lives in a specialist learning disability residential care home. Peter is frequently agitated and distressed, particularly at night time when he can become difficult to manage. There are fewer staff available at night time and on several occasions they have had to restrain him. Following restraint he has been confined to a 'quiet room' for periods of time. His parents have asked that he be permitted to stay with them at the weekend but the request has been refused.

Factors indicating that Peter is likely to have been deprived of his liberty include the following:

- The use of restraint
- Periods of confinement in the ‘quiet room’
- The refusal of his parents’ request that he reside with them.

Deprivation of liberty in circumstances requiring authorisation by the Court of Protection: supported living services, shared lives schemes and extra care housing

Care provided to adults in supported living services, shared lives schemes – formerly known as adult placements – and extra care housing that involves a deprivation of liberty cannot be authorised under the DoLS regime and will need to be referred to the Court of Protection for authorisation.

Supported living services

‘Supported living’ is a form of care whereby a local authority arranges a package of care and accommodation for a disabled, elderly or ill person. The individual lives in their own, usually rented, home and typically receives a package of care or support to enable them to live as independently as possible. Although the purposes of supported living are to maintain the person’s autonomy, some forms of supported living will involve the provision of direct nursing or personal care, and these may have an impact on the supported person’s liberty. There are a number of measures that may be put in place in supported living arrangements that may restrict a person’s liberty. These include:

- Decisions on where to live being taken by others
- Doors locked for security reasons to prevent the individual leaving
- Access to the community being restricted by staff availability
- Use of physical or chemical restraint
- Restricted access to friends and family
- Use of rigid timetables with which the individual is expected to comply.

Case example: provision of care in a supported living service likely to amount to a deprivation of liberty

Martin is 20 years old and has autism and cerebral palsy. He lives in a one-bedroomed flat with one-to-one staffing at all times. The front door is locked for his safety and he cannot unlock it himself. He cannot stand unaided requiring a wheelchair when outside. Due to his restlessness, physical agitation and impulsive movements, he is strapped to his wheelchair when in the community.

Factors indicating that Martin is likely to have been deprived of his liberty include the following:

- He is under continuous supervision and control
- He is unable to leave the flat by himself
- He is subject to restraint.

Shared Lives schemes

Shared Lives schemes are sometimes referred to as adult fostering and involve an adult being placed for varying periods of time in the family home of a paid Shared Lives carer. The majority of placements involve adults with learning disabilities, mental health problems or drug or alcohol dependency. Although designed to promote independent living, liberty-restricting measures in these settings can include:

- Preventing people leaving unaccompanied for their own safety
- Continuous high levels of supervision and control
- Addressing challenging behaviour
- Assisting with medication including where it has a sedative effect.

Extra care housing

Extra care housing usually involves 24-hour domiciliary care in purpose built, self-contained properties. Unlike those in residential care, those in extra care housing usually rent, buy or share the ownership of an apartment or bungalow as part of a complex or village. Some individuals will have a domiciliary carer and a warden will usually be on-site to check on the welfare of residents. Measures used in extra care housing that may restrict people's liberty include:

- Location devices
- Door and movement sensors
- Doors with handles located out of reach
- Physical interventions including restraint
- Restrictions on access to the community
- Use of CCTV.

Case example: provision of care likely to amount to a deprivation of liberty in extra care housing

Cynthia has learning disabilities and severe mobility problems. Although lacking capacity to consent to the arrangements, she is living in a one-bed apartment as part of a scheme of extra care housing. For twelve hours a day she has a carer to help her get out of bed, dress and see to her daily needs. She has pressure sensors around the bed to alert staff should she fall at night. Cynthia can only leave the accommodation with a carer.

Factors indicating that Cynthia is likely to have been deprived of her liberty:

- That she is subject to twelve hours of continuous supervision and control each day
- That she is not free to leave on her own.

Deprivation of liberty check-list

In its guidance on deprivation of liberty, the Law Society has drawn up a check-list for front-line practitioners to help establish whether an individual may be deprived of liberty. This has been reproduced below.

During the ordinary care and treatment of people lacking capacity, it may be necessary, at times, to place restraints on their liberty. Many necessary restraints placed on incapacitated adults will not, by themselves, amount to a deprivation of liberty. In combination, or where they are applied with particular intensity or for sustained periods, they may do.

We give below a check-list of questions that health professionals and carers should consider when deciding whether or not someone in their care may be deprived of liberty. Incapacitated adults are vulnerable and where there is doubt, we recommend that health professionals err on the side of caution. Ultimately, the question of whether a person is deprived of liberty is a legal one. If in doubt, health professionals should seek legal advice.

- What liberty-restricting measures are being taken?
- When are they required?
- For how long will they be required?
- What are the effects of any restraint or restrictions?
- Why are they necessary?
- What are the views of the person or any family, friends or carers?
- How will the constraints or restrictions be applied?
- Is force or restraint, including sedation, being used?
- Are there any less-restrictive options available?
- Is the patient prevented from leaving by distraction, locked doors, restraint, or because they are led to believe they would be prevented from leaving if they tried?
- Is access to the patient by relatives or carers being severely restricted?
- Is the decision to admit the patient being opposed by relatives or carers who live with the patient?
- Has a relative or carer asked for the person to be discharged to their care, but the request is being denied?
- Are the patient's movements restricted within the care setting?
- Are family, friends or carers prevented from moving the patient to another care setting or prevented from taking them out at all?
- Is the patient prevented from going outside (escorted or otherwise) even though it would be possible for them to do so?
- Are the patient's behaviour and movements being controlled through the regular use of medication or, for example, seating from which they cannot get up or by bed rails that prevent them from leaving their bed?
- Do staff exercise complete control of the care and movement of the person for a significant period?
- Is the patient constantly monitored and observed throughout the day and night?

Endnotes

1 In the matter of D (A Child) [2019] UKSC 42

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