DISCUSSION PAPER: DEPRIVATION OF LIBERTY, CHESHIRE WEST AND THE CRPD

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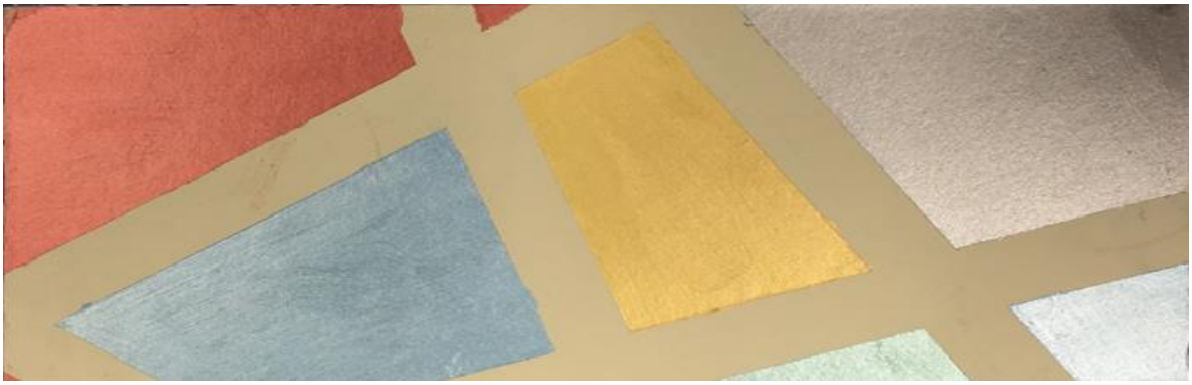

A: Introduction

1. This paper discusses whether there may be room in which to revisit *Cheshire West* to capture (in a principled fashion) what appears to be an instinctive difference between:

    a. the position of a person who is confined, cannot consent to that confinement, but where there appears to be no element of coercion or the deployment of measures against their will;

    b. the position of person who is confined, cannot consent to that confinement, but is subject to coercion.

2. One of the (possibly unanticipated) consequences of the decision in *Cheshire West* is that there is no place within the exercise of determining whether a person is deprived of their liberty[1] to ask whether there is any element of compulsion or coercion being exercised, either by State agents or private individuals. Indeed, it is a striking fact that the word "coercion" or "coercive" only appears once in the judgments of the Supreme Court justices, and only in setting out submissions made on behalf of the respondent local authorities.[2]

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The picture at the top, "*Colourful*," is by Geoffrey Files, a young man with autism. I am very grateful to him and his family for permission to use his artwork.

[1] As opposed to asking whether such deprivation of liberty is justified.

[2] See para 38.

3. This is particularly striking in light of the fact that the Strasbourg Court has always looked to the presence or absence of coercion as a factor (sometimes "an essential factor"[3]) in deciding whether a set of circumstances amount to a deprivation of liberty and, in the context of Article 5(1)(e) ECHR, has expressly equated deprivation of liberty with "*compulsory confinement*."[4] Whilst generalisation is dangerous, it is appropriate to consider that there may be settings in which individuals are less likely to be subject to coercion than others. For instance, and as a very broad generalisation, one may consider that an individual being cared for in their home (especially by family members) is less likely to be subject to coercion than an individual in an institutional placement. However, on a strict reading of *Cheshire West*, the position of such an individual is to be equated directly to that of a person (say) subject to substantial coercion in an institutional setting. This undoubtedly does represent a non-discriminatory approach to the meaning of liberty, but it is one that brings within the scope of Article 5 (for domestic purposes) a very significant cohort of individuals whom it is clear are very far removed from those the framers of the Convention had in mind. Even allowing for the fact that the Convention is a living instrument, we are entitled to consider whether "*notions currently prevailing in democratic States*"[5] compel the conclusion that this cohort of individuals be considered to be deprived of their liberty for purposes of Article 5 ECHR. At the level of principle, and reiterating that I am only addressing the position of those in respect of whom no coercion is being deployed, I would suggest that it is legitimate to consider that – all other things being equal – these "notions" do not compel this conclusion.

4. Further, the very assessment and authorisation procedure necessary so as to secure the Article 5 rights of those in the position of MIG or MEG, may be perceived by the individuals concerned as constituting an interference with their Article 8 rights.[6] They may even, on the law as it stands at present, constitute an interference with their rights under Article 1 Protocol 1 ECHR because, if they are joined as a party to any judicial authorisation procedure, they will not be eligible for non means-tested legal aid, and may therefore be compelled to pay for the privilege of protection.

5. I am also conscious that that the conclusion reached by the Supreme Court in *Cheshire West* has had the – inadvertent – consequence that, at least in some cases, incentives on public bodies to

[3] *Firat v Turkey* (Application no. 34010/06, decision of 10 September 2013) at para 35. See also, e.g. *Kasparov v Russia* [2016] ECHR 849 at para 36.

[4] See *Winterwerp v Netherlands* (1979-80) 2 EHRR 387 at para 39, in the context of analysing when deprivations of liberty may be justified for purposes of Article 5(1)(e) ECHR, where one of the criteria for detention is "*mental disorder* [of] *a kind or degree warranting compulsory confinement*."

[5] See *Guzzardi* at paragraph 95. "*The Government's reasoning* […] *demonstrates very clearly the extent of the difference between the applicant's treatment on Asinara and classic detention in prison or strict arrest imposed on a serviceman (see the above-mentioned Engel and others judgment, p. 26, par. 63). Deprivation of liberty may, however, take numerous other forms. Their variety is being increased by developments in legal standards and in attitudes; and the Convention is to be interpreted in the light of the notions currently prevailing in democratic States (see notably the Tyrer judgment of 25 April 1978, Series A no. 26, pp. 15-16, par. 31)*."

[6] They may well also be regarded as such as by family members who are also under scrutiny, but this is a secondary consideration.

take steps to reduce restrictions (or to move individuals to less restrictive environments) have been reduced because the relevant public bodies can, with some legitimacy, say that the individuals concerned will always be deprived of their liberty in any setting.[7] There may be some situations, therefore, in which individuals have lost a tool, both within and without the Court of Protection, with which to exert, legitimate, leverage over public bodies to ensure that they take steps which minimise the restrictions upon them.

6. The question this paper therefore poses is: is there any principled basis upon which these matters can be reflected which is faithful to the core conclusion underpinning the judgment of the Supreme Court in *Cheshire West*, namely that the right to liberty which must mean the same for everyone, regardless of their physical or cognitive impairments?

7. I suggest that there are two possible ways in which a positive answer to this question can be given. I emphasise, and emphasise strongly, that I only advances the two possible analyses set out below to address the matters set out in paragraphs 1-4 above. I do not do so to seek to address the fact that the systems currently in place do not afford of adequate protections for those deprived of their liberty, either because of the backlogs arising under the administrative scheme within Schedule A1, because of limitations in the legal aid system, or because of the failure of local authorities and CCGs to bring cases to court for the judicial authorisation of deprivations of liberty outside care homes and hospitals. It is a matter for the State[8] to fund adequate protections for those who are, in fact, deprived of their liberty and, in respect of those currently outside Schedule A1, to take steps to introduce administrative mechanisms to provide the necessary procedure prescribed by law if they wish to avoid the need for all such cases to come to court (whether those contained in the Law Commission's proposals or otherwise).

8. There are two variants to my analysis, a 'stronger' and a 'weaker' one, both focused on the subjective element in the 'trinity' of factors going to an Article 5 deprivation of liberty.[9] I preface my discussion of both with an analysis of the constituent components of 'valid consent' which applies to both of the possible answers I suggest.

[7] And Article 5 ECHR is not concerned with conditions of detention, save in extreme circumstances: see *NYCC & Anor v MAG & Anor* [2016] EWCOP 5, [2016] COPLR 346 at para 26.
[8] Whether central government or local government is irrelevant for these purposes.
[9] See *Cheshire West* at para 37:
"The second question, therefore, is what is the essential character of a deprivation of liberty? It is common ground that three components can be derived from *Storck* 43 EHRR 96, paras 74 and 89, confirmed in Stanev 55 ECHR 696, paras 117 and 120, as follows: (a) the objective component of confinement in a particular restricted place for a not negligible length of time; (b) the subjective component of lack of valid consent; and (c) the attribution of responsibility to the state."

B: 'Valid consent'

9. The attention of the Supreme Court in *Cheshire West* was focused solely upon the question of whether there was a confinement. Any confinement in each of the cases of P, MIG and MEG was clearly imputable to the State. Further, it was common ground before the court that because P, MIG and MEG did not have capacity to consent to the arrangements amounting to a confinement (applying the provisions of the MCA 2005) that they could not, and did not, give valid consent.

10. However, I suggest that there are, in fact, proper grounds upon which to pose the question as to whether the equation between lack of capacity to consent applying the provisions of the MCA 2005 and lack of valid consent for the purposes of Article 5 ECHR is one that is necessarily correct.

11. As a starting point, the Strasbourg court has, on occasion, sought to investigate the nature of the person's purported agreement. This was very clear, for instance, in the decision in *David v Moldova*.[10] It was, here common ground that an individual (whose mental capacity was not examined) agreed initially to be a hospitalised in a psychiatric hospital, and that after hospitalisation he was not free to leave although he expressed a wish to return home. The ECtHR held (at para 35) that:

> *"In so far as the Government can be considered as claiming that, by agreeing to be hospitalised, the applicant waived his right to liberty, the Court reiterates that the fact that a person initially agreed to enter an institution does not prevent him or her from relying on Article 5 if he or she subsequently wishes to leave (see De Wilde, Ooms and Versyp v. Belgium, judgment of 18 June 1971, Series A no. 12, § 65). Accordingly, the Court considers that the applicant/s continued detention from the moment he expressed his wish to leave the hospital amounted to a "deprivation of liberty" within the meaning of Article 5 § 1 of the Convention."*

12. Agreement appears to have been a factor in the decision in *HM v Switzerland*[11] where the court found that there was no deprivation of liberty in the placement of an elderly woman in a care home. As Lady Hale noted in *Cheshire West*, the case is a "difficult" one (para 27), which has been treated by the Strasbourg court differently in subsequent cases, but at least on occasion as a case which turned upon the fact that the subjective test was not met.[12]

13. Importantly, the Strasbourg court has not limited itself to verbal expressions of wishes when identifying whether an individual is deprived of their liberty. For instance, in *Červenka v the Czech Republic*, the ECtHR rejected an argument that a "fully incapacitated" (under Czech law) person was not deprived of his liberty at a private care home placed there on the basis of an agreement signed by a state appointed guardian, the ECtHR noting that: "[w]*hile he did not show clear*

[10] [2008] ECHR 987.
[11] *HM v Switzerland* (2004) 38 EHRR 17.
[12] See the summary at para 61 of *Cheshire West*.

disagreement on the day of his admission to the social care home or shortly beforehand, from his subsequent conduct it was obvious that he had not consented to his placement there."[13]

14. *Cervenka*, a 2016 decision, sits in a line of authorities relating to confinement following 'incapacitation' at the hands of a guardian in the former Soviet Union. These earlier authorities were summarised thus by Lady Hale in *Cheshire West*:

> *31. […] In Shtukaturov v Russia (2012) 54 EHRR 27, decided in 2008, the applicant had been placed in a psychiatric hospital at the request of his legal guardian, which in Russian law was regarded as a "voluntary" admission. Although he lacked the de jure legal capacity to decide for himself, this did not necessarily mean that he was de facto unable to understand his situation (para 108). Indeed, he had evinced his objections. The subjective element of lack of consent was made out (para 109). The court took the same view in DD (para 150) and in Kedzior (para 58). Thus it appeared to give some weight to the objections of a person who lacked legal capacity when deciding that the subjective element was made out despite the consent of the person's legal guardian.*[14]

15. However, and importantly, the ECtHR identified in *Mihailovs v Latvia*[15] that a person who may *de jure* lack the capacity to consent to arrangements amounting to a confinement – in that case in care homes – might nonetheless *de facto* have the ability to understand their position and, in turn (it appears) to give valid consent.[16] The court in that case in distinguishing between two different care homes in which Mr Mihailovs was confined identified that he was deprived of his liberty in one, to which he objected, and was not in the other, to which he gave his "*tacit agreement*."[17]

16. The fuller passage from the judgment where the court outlines the principles applied is instructive as regards the precise language used:

> *134. The Court next turns to the "subjective" element, which is also disputed between the parties. The Court reiterates that the fact that the applicant lacked de jure legal capacity to decide matters for himself does not necessarily mean that he was de facto unable to understand his situation (see Shtukaturov, cited above, § 108). Whilst accepting that there are situations where the wishes of a person with impaired mental faculties may validly be replaced by those of another person acting in the context of a protective measure, and that it is sometimes difficult to ascertain the true wishes or preferences of the person concerned (see Stanev, cited above, § 130), the Court finds that this was not the applicant's case. The documents presented to the Court indicate that the applicant subjectively perceived his compulsory admission to the Īle Centre as a deprivation of liberty. Contrary to what the*

[13] *Červenka v the Czech Republic* (Application no. 62507/12, decision of 13 October 2016 at para 103.
[14] *DD* is a reference to *DD v Lithuania* [2012] ECHR 254 and *Kedzior* to *Kedzior v Poland* [2012] ECHR 1809.
[15] Identified by Lady Hale in *Cheshire West* as "seem[ing] *to go further*" (para 31).
[16] *Mihailovs v Latvia* [2013] ECHR 65 at paragraph 134.
[17] See paras 135 and 139.

> *Government suggested, he has never regarded his admission to the institution as consensual, and has objected to it during his stay there. (emphases added).*

17. The decision in *Mihailovs* could be read as the Strasbourg court, in essence, undertaking its own assessment of the applicant's functional mental capacity and concluding that Mr Mihailovs had capacity to consent to the arrangements and was withholding it.[18]

18. However – and perhaps because the United Nations Convention on the Rights of Persons with Disabilities had been cited to it[19] – the actual language used was rather closer to that of Article 12 CRPD.[20] I return to this below, but suggest that, on a proper reading of *Mihailovs*, the critical questions that the court asked itself were whether it was possible (a) to ascertain the person's true wishes and preferences; and (b) whether it was possible on the basis of those wishes and preferences to identify the individual's subjective perception of the confinement.

19. Is there any bar to an analysis which seeks to 'domesticate' the approach identified in *Mihailovs* to the identification of whether an individual is validly consenting to a confinement? For the reasons set out below, I suggest that that the answer is 'no.'

20. Although the Supreme Court in *Cheshire West* were not invited to consider questions of the requirements for valid consent, the focus of their attention being solely on the objective element, Lady Hale noted that the element of the case that she found the most difficult was why it could not be said in light of *Mihailovs* that P, MIG and MEG were also giving tacit consent to their

[18] In this regard, the court will note the description given in the case itself of Mr Mihailovs' impairments. He was said (para 27) to have had a diagnosis of epileptic dementia (F02.8), and focal symptomatic epilepsy with secondarily generalised seizures. Outlining a psychiatric opinion provided after the application had been communicated to the Government the court noted (para 46): "*The psychiatrist had ticked the following boxes in the form to describe the applicant's state of health: inpatient neuropsychological treatment; outpatient treatment with a psychiatrist; unable to organise daily routine independently; orientates in time; is capable of being outside the house alone in a known environment or route; unclear, inadequate speech; frequent mood swings; inadequate emotions; no perception disorders; unstable and restricted attention and concentration abilities; difficulties in switching attention; "other" (unspecified) reasoning disorders; noticeably deteriorated memory; adequate behaviour; non-critical attitude towards his illness; smoking addiction; no comprehension regarding the need for the use of medication; behaviour dependent on the regular use of medication; assistance necessary for the use of medication; assistance necessary to perform household tasks, to use medication, to move outside the house, to perform operations with money; periodic surveillance necessary. She concluded with a recommendation that the applicant needed to live in a social care institution for people with serious mental disorders*." It is, of course, impossible to apply s.2 MCA 2005 to Mr Mihailovs' case, but many of these matters would regularly be cited in a determination that an individual satisfied the capacity requirement under Schedule A1 to the MCA 2005.

[19] By the European Disability Forum, the International Disability Alliance and the World Network of Users and Survivors of Psychiatry, who intervened in the proceedings (see para 4).

[20] Which provides for the recognition of legal capacity for those with disability on an equal basis with others in all aspects of life (Article 12(2)) and that (in Article 12(4)) that "measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person […]."

placements in circumstances where it appeared that they were manifesting contentment.[21] I suggest – respectfully – that Lady Hale essentially then avoided the question, instead acknowledging that none of the distinctions between that of *Mihailovs* and MIG and MEG were very satisfactory.[22] Lord Neuberger also recognised that there might be "rare" cases in which a person lacking capacity to make a particular decision according to the provisions of the MCA 2005 could be said to have done more than comply with a situation and give some form of consent.[23] Neither Lords Kerr nor Lord Sumption (the other members of the majority) addressed the question of what might constitute valid consent.

21. What was not before the Supreme Court in *Cheshire West* was Article 12 of the UNCPRD. Lady Hale in *Cheshire West* had regard to Article 14 of the UNCRPD, which provides that those with disabilities enjoy the right not to be deprived of their liberty on the same basis as others; she did not have regard to Article 12 of the same Convention. This may, perhaps, have been because there was not at the time that the case was heard quite the focus on Article 12 as there now is following the publication by the UN Committee on the Rights of Persons with Disabilities General Comment No. 1 upon Article 12 in April 2014, the month after the *Cheshire West* decision was handed down.[24]

22. Article 12 of the UNCRPD provides for the universal right to legal capacity. In General Comment No. 1 upon Article 12, the UN Committee on the Rights of Persons with Disabilities emphasised the crucial importance of ensuring that steps are taken to support individuals to exercise their legal capacity, including by means of supported decision-making.[25] There are – at present – extensive debates as to the extent to which the Committee has sought to go beyond the requirements imposed upon States by the CRPD.[26] However, for present purposes, it seems to me that the courts can revisit the proper construction of "valid consent" through the prism of Article 12 CRPD and the obligation to secure the necessary support to persons with disabilities to exercise their legal capacity, here, to be recognised as agreeing to what objectively amount to confinements. This leads either to a 'strong' analysis, or a somewhat 'weaker' analysis – the strength or weakness being a mark of: (1) the extent that the analysis requires a reconsideration of the conventional legal

[21] *Cheshire West* at para 55.
[22] *Cheshire West* at para 56.
[23] This is implicit from his conclusion at para 68 that there will be "*rare circumstances where the absence of objection can be said to amount to consent, as in Mihailovs v Latvia, paras 138-139*."
[24] The General Comment being adopted on 11 April 2014.
[25] In other words, a process of decision-making which requires support to be given to a person to make their own decisions, and where such is not possible, for any decision to be taken on the basis of the best interpretation of an individual's known will and preferences in respect of that decision.
[26] These are summarised most neatly in the two reports by the Essex Autonomy Project examining the compatibility of the MCA 2005 with the CRPD (the 2014 report) and the wider compatibility of the legislation in England & Wales, Scotland and Northern Ireland with the CRPD (the 2016 report). See also the decision of the European Court of Human Rights in *AM-V v Finland* (Application No. 53251/13, decision of 23 March 2017), in which the Strasbourg court rejected a materially similar contention framed through the prism of Article 8 ECHR as a challenge to a Finnish judicial decision which had the effect of enabling a person's (mentally) incapacitous desire to move to another part of the country to be overridden in their interests.

position; (2) the consequent number of those who would 'benefit' from the analysis (in the sense of being recognised of being able to give valid consent).

C: Strong analysis: valid consent can be constructed even in the absence of an individual's ability to give capacitous consent applying s.2 MCA 2005

23. Interpreting Article 5 through the prism of Article 12 CRPD, I suggest it is possible legitimately to reach the conclusion that a person can give the requisite valid consent to a confinement even if they are not able – applying the provisions of s.2 MCA 2005 – capacitously to give that consent at the point of assessment.[27]

24. Put another way, in circumstances where it is clear that a person seeks through their words or actions to manifest their wish to be in a particular place and to receive care and treatment under the regime in place for them there, then it would be both appropriate and entirely in keeping with the spirit of Article 12 CRPD to interpret that desire as representing their valid consent for purposes of Article 5 ECHR. This would be so whether or not, applying the test set down by s.2 MCA 2005, they have the capacity to consent to those arrangements. This would also apply in a situation where a person is not currently able to express or manifest any wish but from what is known of them from those close to them they would have expressed such a wish had they been capable of doing so. This latter analysis could not apply to a person who has a life-long severe cognitive impairment, but would in respect of people who had capacity to make decisions as to their residence and living arrangements (including marrying and forming families) but, either because of illness or accident, no longer do.

25. This analysis would be non-discriminatory, and therefore complies with the edict of Lady Hale in *Cheshire West* because liberty has the same objective meaning for all. It would also eliminate the arguable discrimination that is inherent in an approach that, at present, denies the ability of a person to manifest their consent to a set of arrangements with which they agree (or would agree) if they do not satisfy the test under s.2 MCA 2005, and requires them to undergo additional (and sometimes burdensome) scrutiny so as to protect their Article 5 rights.

26. This approach, further, would give a principled answer to the rhetorical question posed by two of the judges in the minority in *Cheshire West*[28] as to why HL might properly be considered not to be deprived of his liberty when he left that hospital even if subject (functionally) to the same form of restrictions at the hands of his carers. If HL manifests the requisite wish to stay with his carers then such would represent the giving of the requisite valid consent for purposes of Article 5 ECHR,

[27] This is separate to the issue of whether an individual may be able to give advance consent prior to the onset of incapacity to a specific set of arrangements which would amount to a confinement. There are arguments (rehearsed in the Law Commission's *Mental Capacity and Deprivation of Liberty* report, at paras 15.2 to 15.9), and drawing on the analogy with the position relating to advance decisions to refuse medical treatment) that such consent can survive the loss of capacity and take the situation out of Article 5 ECHR.
[28] See paragraph 100 (Lords Carnwath and Hodge).

and so there would be no deprivation of his liberty, even if, objectively, he remains – necessarily – subject to continuous supervision and control and prevented from leaving in his own interests. I note, further, that it appears Steven Neary is considered by the London Borough of Hillingdon to be deprived of his liberty by his father,[29] in circumstances where all the evidence recorded in the judgments upon the case indicated strongly, to the extent he is capable of expressing wishes and feelings, Steven's core desire is to live at home with his father. Steven, therefore, might well be seen as a person who should be considered to be giving such valid consent, even if (as appears likely) he lacks capacity to do so applying the provisions of s.2 MCA 2005.

27. Finally, the analysis set out above would also potentially help solve a further conundrum. The Committee on the Rights of Persons with Disabilities takes the view that deprivation of liberty on the basis of disability is contrary to Article 14 and represents arbitrary detention. Whilst the approach set out here would not entirely eliminate the clash between Article 5(1)(e) ECHR and Article 14 CRPD, it would substantially limit it. It is clear that the Committee on the Rights of Persons with Disabilities views deprivation of liberty as a state of affairs which relates primarily to coercive institutional care (see General Comment 5 (2017) on Article 19 on the right to independent living at para 48, outlining the "obligation to release all individuals who are confined against their will in mental health services or other disability-specific forms of deprivation of liberty." Again, this appears to speak to a contrast as far as the Committee are concerned between detention and the circumstances of, say, MIG, and it is legitimate to consider that they would not wish to advance an interpretation of Article 14 CRPD which (on their analysis) would render it impossible for the current arrangements for MIG to continue. It would, arguably, be possible to square the circle, at least as regards MIG, by recognising that she is seeking to give valid consent to the confinement to which she is subject.[30]

28. In practical terms, therefore, this would mandate an assessment of any one who is confined in circumstances such as those of P, MIG and MEG to determine whether it could be said that they validly consent to that confinement. Such an assessment would be carried out for a different purpose, but have a strong functional resemblance, to the approach to determining best interests under the MCA 2005 identified by Lady Hale in *Aintree* at paragraph 45 as the proper application of ss.4(4), (6) and (7) MCA 2005. Where the person is unconscious or otherwise unable to express any views, this would require the same exercise of consultation with others properly interested in their welfare as mandated by s.4(7) MCA 2005 (see also in this regard *Aintree* at paragraph 39); it would also require consideration of their known wishes, feelings, beliefs and values, including any written statements made whilst they had capacity (see s.4(6) MCA 2005). In some ways, it would also resemble the 'holistic' exercise mandated by Baker J in *Re RD & Ors* [2016] EWCOP 49 to determine whether an individual would wish their RPR to challenge under s.21A the authorisation

[29] https://markneary1dotcom1.wordpress.com/2017/03/23/lady-hale-comes-to-cowley/.
[30] It might be thought – in passing – particularly frustrating that the Committee in its concluding observations on the UK in August 2017 did not address the position of MIG and MEG as they had been invited to do.

under Schedule A1 to which they are subject,[31] although I stress that the purpose of the exercise would not be to determine whether there is an absence of an objection, but rather a positive wish to remain in the relevant place and receive care there under the regime in place for them.

29. I need to emphasise four points here:

a. first: I am not seeking, by the back door, to argue that *Cheshire West* was necessarily wrongly decided (such a submission not, in any event, being one that could dictate a different outcome before the lower courts). However, because the questions posed immediately above were not asked, we simply do not know whether or not it could be said that P, MIG or MEG were, in fact, validly consenting;

b. second: this analysis would not provide any route through where there is any suggestion that the person is: (1) merely acquiescing to a situation; or (2) simply compliant. I am acutely aware that acquiescence and/or compliance can 'mask' a real wish to be elsewhere, and I would not suggest – for instance – that HL could have been said on the facts of the reported case to be giving any form of valid consent to his stay in Bournewood hospital in the seminal decision of the European Court of Human Rights. In other words, and to reiterate, valid consent could only be constructed on the basis of suitable and sufficient evidence of a positive wish to remain in in the relevant place and receive care there under the regime in place for them. Absence of objection would not suffice;

c. third: this analysis would only represent a sufficient protection for the rights of the individuals concerned were it to operate on the basis that wherever a person is subject to a confinement then the burden will lie upon the State body responsible for that confinement[32] to establish that they do, indeed, validly consent to it. In other words, the default position should be that anyone who meets the acid test (and whose circumstances are imputable to the State) should be considered to be deprived of their liberty until and unless it is proved that they are not because they validly consenting to the arrangements. Such would give effect to the positive obligations imposed by Article 5 ECHR and ensure that it is effective in relation to vulnerable individuals;

d. fourth, I am aware that this analysis is not confined to 'domestic' settings, and that the court will need to have in mind other settings, in particular admission to psychiatric institution. The Strasbourg court is particularly (and understandably) concerned in the case of such admission to identify whether any confinement can truly be said to be consensual, and to err on the side of caution. This can be seen from *HL v United Kingdom* itself where the court did not rely upon

[31] See para 86.
[32] Either directly, or via the route identified in *SRK* to state imputability where the state is aware of a confinement at the hands of private individuals.

HL's apparent compliance as giving the requisite valid consent,[33] and also from *Atudorei v Romania*.[34] A similar approach has also been taken domestically to the question of whether a person can ever validly consent to confinements arising under the aegis of the Mental Health Act 1983 by the Court of Appeal's decision in *The Secretary of State for Justice v MM*.[35] In this case the Court of Appeal held – in the context of considering the argument that a person can consent to conditions on discharge imposed by a Mental Health Tribunal amounting to a confinement – that "*where conditions amounting to a deprivation of liberty are compulsorily imposed by law, the agreement of an individual cannot prevent that compulsory confinement from constituting a deprivation of liberty*." [36] In the circumstances, I would suggest that (a) a considerably higher threshold is required before it can be shown that the individual has in fact validly consented to an admission as an informal patient to a psychiatric institution;[37] and (b) it is, as matters stand,[38] not possible as a matter of law for anyone to consent to a confinement imposed by operation of the MHA 1983.

D: Weak analysis: the test for capacity to consent to a confinement will vary depending upon its nature, in particular the presence or absence of coercion in the confinement

30. Alternatively, if the view is taken that – domestically – having capacity to consent to a confinement applying the test under the MCA 2005 is a necessary (but not sufficient[39]) requirement to give valid consent for purposes of Article 5 ECHR, I suggest that the court should refine the test for capacity to consent to a confinement to take account of the extent to which the confinement can be said to be coercive. This is a 'weak' analysis because, whilst it stays within the four walls of the MCA 2005, it will, for the reasons set out below, apply to a more limited category of people than those considered immediately above.

[33] Although note that *HL* was decided before *Storck*, in which the reference to 'subjective element' was first crystallised.
[34] [2014] ECHR 947, where the court noted at para 137 that, "*according to the medical evidence in the case-file, during her hospitalisation the applicant lacked insight and therefore did not have the ability to recognise the need for her hospitalisation and treatment* […] *Consequently, notwithstanding the parties' arguments to the contrary and the fact that she does not appear to have lodged complaints or attempted to escape from the institution, it does not appear that the applicant ever regarded her admission to the facility or her treatment as consensual*."
[35] [2017] EWCA 194.
[36] Para 28.
[37] An informal admission is, by definition, one where the individual is not subject to any confinement imposed by operation of the MHA 1983 – indeed, it was the very fact that the formal procedures of the Act were not invoked which founded the Strasbourg court's conclusion that HL was arbitrarily deprived of his liberty.
[38] Although note that at the time of writing (December 2017) permission to appeal this decision has been sought from the Supreme Court.
[39] Because such consent must not just be capacitous, but also voluntary.

31. The test for capacity to consent to confinement has been the subject of consideration in a number of domestic cases but never from the perspective of coercion.[40] It is also an oddity of the case-law, stemming, most likely from the way in which the capacity requirement in Schedule A1 is framed,[41] that it has usually concentrated on the question of whether P has the capacity to make decisions as to their residence and care arrangements, without specific reference to the (logically separate) question of whether they have capacity to consent to confinement to which they are subject at the relevant placement.

32. A partial exception was the decision in *LDV*, in which Baker J was concerned with the question of whether a woman with learning disabilities could consent to admission to a psychiatric hospital in circumstances of confinement. At paragraph 66, he held that "*although the court is not, strictly speaking, bound by the provisions of Schedule A1 when deciding whether or not to make an order depriving a person of his liberty, I accept the submission made on behalf of the Official Solicitor by Mr Ruck Keene that the appropriate course in these circumstances is for the court to approach the question as if it was considering the "mental capacity requirement" under paragraph 15*." Baker J then went on to outline what – on the facts of LDV's case – was the salient information relevant to that decision, holding at paragraphs 39 and 40:

> *39 I consider that on the facts of this case, the clinicians and the court should ask whether L has the capacity to understand, retain, use and weigh the following information:*
>
> *(1) that she is in hospital to receive care and treatment for a mental disorder;*
>
> *(2) that the care and treatment will include varying levels of supervision (including supervision in the community), use of physical restraint and the prescription and administration of medication to control her mood;*

[40] The reported or publicly available cases (the majority having been decided by Baker J) being: *PH v A Local Authority* [2011] EWHC 1704 (Fam), [2012] COPLR 128; *CC v KK* [2012] EWHC 2136 (COP), [2012] COPLR 627; *A Primary Care Trust v LDV* [2013] EWHC 272 (Fam) [2013] COPLR 204; *RB v Brighton & Hove City Council* [2014] EWCA Civ 561; [2014] COPLR 629; *X v A Local Authority & Anor* [2014] EWCOP 29; and *P v Kent County Council* [2015] EWCOP 89.

[41] There is a prospect that the statutory test will be changed in due course in any replacement of Schedule A1. See the Law Commission's Mental Capacity and Deprivation of Liberty report at para 9.7 "*We consider that the Liberty Protection Safeguards should continue to have a mental capacity requirement in order to translate into domestic terms the Article 5(1) requirement of an absence of valid consent. However, we are concerned by the evidence from consultation suggesting that the current requirement is poorly understood and implemented. In part, this confusion may be due to the existing wording (that the person must lack capacity in relation to whether they should be accommodated in the relevant hospital or care home for the purpose of being given the relevant care or treatment); this does not, in our view, get to the heart of the issue under Article 5. It is not the fact of a placement in itself, but the arrangements made for the person at the placement – including the elements of supervision, control and lack of freedom to leave identified by Lady Hale in Cheshire West – that give rise to the deprivation of liberty. We therefore consider it more accurate, and more closely aligned to Article 5, to provide that the person must lack capacity to consent to the care or treatment arrangements which would give rise to a deprivation of that person's liberty*" (see also the proposed new para 1(2)(b) of Sch AA1 to the Mental Capacity Act).

> *(3) that staff at the hospital will be entitled to carry out property and personal searches;*
>
> *(4) that she must seek permission of the nursing staff to leave the hospital, and, until the staff at the hospital decide otherwise, will only be allowed to leave under supervision;*
>
> *(5) that if she left the hospital without permission and without supervision, the staff would take steps to find and return her, including contacting the police.*
>
> *40 Whilst I accept Mr. Mant's submission that the specific consent under consideration is to the 'deprivation of liberty' and not to the care or treatment as such, it seems to me that the information which must be understood, retained, used and weighed extends to some information about the context in which the deprivation is being imposed.*

33. Baker J's approach in *LDV*, therefore, secured consideration of the material factors going to the confinement at the placement in question through the prism of the salient information. Almost by definition, I would suggest, a person who is confined in circumstances of coercion – i.e. against their will – will be subject to more rigorous regime of control and supervision, together with more 'high-end' steps to ensure that they do not leave the control of those providing them with care. A person will therefore have to be able to understand, retain, use and weigh more information about the circumstances of that confinement than a person who may, technically, be confined, but wishes to be in the place(s) where they are confined and to receive care there, and in respect of whom the arrangements will be very much lighter-touch.

34. Another way of putting this is to hold that that the bar to establishing that a person has capacity to consent to a confinement in circumstances where they do not perceive themselves to be confined (i.e. there is no suggestion of actions being taken against their will) is lower than the bar for finding a person has capacity to consent to confinement in circumstances of coercion.[42] Whilst the MCA does not, itself, contain any form of "sliding scale," the courts have, in practice, varied the bar: examples being capacity to marry[43] and capacity to consent to sexual relations.[44]

35. I would suggest therefore that it would be possible – and proper – to conclude that the decision whether to be accommodated and cared for in circumstances of (objective) confinement with which the person is content is an inherently simpler decision than a decision whether to be accommodated in circumstances of coercion. If it is an inherently simpler decision, then it stands

[42] Technically, of course, and bearing in mind the wording of s.1(2) MCA 2005, this proposition should be stated that the presumption that the person has capacity to consent to a confinement in circumstances of confinement should be easier to displace. However, given the way in which the question arises, and because the burden is on the body doing the detaining to establish that the relevant individual is, in fact, consenting so as to avoid a challenge that they are unlawfully depriving them of their liberty, it is arguably better to talk in terms of the bar being lower.
[43] See *A* Local *Authority v AK & Ors* [2012] EWCOP B29, [2013] COPLR 163 at para 15.
[44] *IM v LM & Ors* [2014] EWCA Civ 37, [2015] 1 Fam 61 at paras 80 to 82.

to reason that it should be easier to establish that the individual in question has in fact capacitously consented.

36. I have been careful to characterise matters by reference to the presence or absence of coercion, rather than by reference to whether or not the person is to be confined, for two reasons. The first is that it is entirely possible that a person may be subject to coercion in any setting (for instance) their own home; the second is that making the location the touchstone test runs the risk of introducing both complexity and potential arbitrariness into any test.[45] In practice, and as regards the home environment, the overlap between being cared for in what one perceives to be one's own home and not being subject to coercion is likely to be high, but I suggest that we should, if at all possible, not introduce any further elements into the consideration of whether Article 5 is engaged than those included in the article itself. As set out above, coercion is at the heart of Article 5, and its presence or absence therefore provides the appropriate guiding principle.

37. I note that, if the courts were to adopt this analysis, which sits squarely within the MCA, then there would be some who might, on the 'stronger' analysis set out above, be considered to be manifesting valid consent, but could not properly be said to have the capacity to consent even applying the low 'non-coercive' bar. Further, a person who is now profoundly impaired following an accident or as a result of progressive illness would in principle be able to 'benefit' from the 'strong' analysis because it would potentially be possible to construct their consent from their pre-existing wishes, feelings, beliefs and values; they would not be able to benefit from the 'weak' analysis.

Conclusion

38. It is important to emphasise that neither of the analyses set out above (yet) have judicial endorsement; those applying the law on the ground as it stand must therefore proceed on the basis that a lack of MCA capacity to consent to the confinement means that that (if the confinement is imputable to the state) the person is deprived of their liberty for purposes of Article 5(1)(e). But it is just possible that the route outlined above may prove to be a fruitful avenue to pursue in future to seek to hold true to the principle of non-discrimination in a way that, at the same time, does enable 'calibration' to identify those who are truly confined.

Alex Ruck Keene

[45] This is why, with respect, the approach taken by the Court of Appeal in Ferreira to seeking to create a general "carve out" of the urgent/acute hospital setting from Article 5 is problematic.

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