HEALTH, WELFARE AND DEPRIVATION OF LIBERTY
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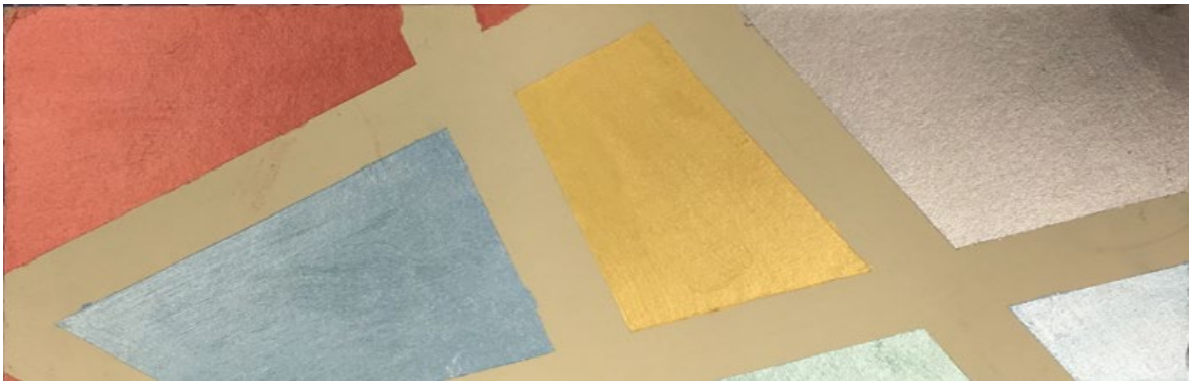

Welcome to the June 2026 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: coverage of 'year zero' as regards deprivation of liberty following the *AGNI* case;

(2) In the Property and Affairs Report: the SCCO and costs where P has died or regained capacity, and can you lie as to your own capacity;

(3) In the Practice and Procedure Report: the Court of Appeal resets transparency;

(4) In the Mental Health Matters Report: nominated persons resources and 20 years of Mental Health Law Online;

(5) In the Children's Capacity Report: overseeing consent;

(6) In the Wider Context Report: well-being and wishes, and capacity and divorce;

(7) In the Scotland Report: Scottish reactions to *AGNI*.

Nyasha Weinberg's practice having taken in a new direction, we say a farewell and thank you to her this issue; we are, however, delighted to welcome Alex Cisneros to the team.

A reminder that that whilst Chambers have launched a new and zippy version of our website which may look unfamiliar, all the content that you might need – our Reports, our case-law summaries, and our guidance notes – can still be found via here.

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

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A Reference by the Attorney General for Northern Ireland of a devolution issue under paragraph 34 of Schedule 10 to the Northern Ireland Act 1998 [2026] UKSC 16) (Supreme Court (Reed, Hodge, Lloyd-Jones, Sales, Stephens, Rose and Simler SCJJ)

Article 5 – deprivation of liberty

Summary[1]

A seven member constitution of the Supreme Court has set aside the decision of *P v Cheshire West and Chester Council* [2014] UKSC 19 ('*Cheshire West*'). In *A Reference by the Attorney General for Northern Ireland of a devolution issue under paragraph 34 of Schedule 10 to the Northern Ireland Act 1998* [2026] UKSC 16, the Supreme Court determined that:

a. The *Cheshire West* 'acid test' for identifying the objective element of deprivation of liberty was wrong and departed from Strasbourg case law;

b. A person without mental capacity to make decisions about their residence and care arrangements can give subjective consent to what would otherwise be a deprivation of liberty, so as to take their circumstances out of Article 5 ECHR.

The judgment did not involve determination of the rights of specific individuals, and thus cannot be appealed to the European Court of Human Rights as there is no relevant 'victim.'

Background and the issues in the case

The definition of deprivation of liberty in the care and treatment context set out by the Supreme Court in *Cheshire West* directly determined the scope of the (different) deprivation of liberty safeguards frameworks in both England & Wales and Northern Ireland, because both Mental Capacity Acts do not contain a statutory definition of deprivation of liberty, but cross-refer directly to Article 5 ECHR.

In 2025, the Attorney General of Northern Ireland ('the Attorney General') made a reference to the Supreme Court as to the lawfulness of a proposed revision by the Minister of Health there of the Code of Practice accompanying the deprivation of liberty provisions in the MCA (Northern Ireland) 2016. The proposed revision to the Code would guide professionals to identify that people could give subjective consent to confinement through words or conduct showing contentment with their care arrangements even if they lacked capacity to take decisions as to their residence and care. That revision did not suggest that the *Cheshire West* 'acid test' [2] to determine whether a person is confined. The

[1] Note: Arianna, Tor and Alex contributed to the summary. They have not contributed to the commentary which follows.

[2] The *Cheshire West* 'acid test' was set out by Lady Hale at paragraphs 48-49 of the judgment of the Supreme Court in 2014 (emphasis added):

Attorney General referred the proposed revision to the Code to the Supreme Court for it to determine whether the Minister of Health there would be acting incompatibly with his obligations under the ECHR if issued it. The Attorney General invited the Supreme Court to find that the Minister could lawfully issue the revision, on the basis that *Cheshire West* had taken too narrow a view of what 'valid consent' to confinement means for purposes of Article 5 ECHR. The Attorney General took the position that it was not necessary to revisit the 'acid test' to determine the reference.

The Lord Advocate (the senior Law Officer in Scotland) acted as respondent to the reference, reflecting (no doubt) the concern of Scottish Government as to the proper interpretation of Article 5 in the context of moves towards provisions relating to deprivation of liberty in Scotland. The Lord Advocate adopted a position broadly supportive of the Attorney General.

The Secretary of State for Health and Social Care ('the Secretary of State') intervened and invited the Supreme Court to conclude that the earlier decision in *Cheshire West* was wrong in identifying that there was an 'acid test' to determine whether a person was confined, In the alternative, the SSHD adopted the Attorney General's submissions as to an expansion of the understanding of the concept of valid consent, subject to a number of caveats.

Three charities (Mind, Mencap and the National Autistic Society) intervened to argue that the Supreme Court should take particular care in determining the reference in the absence of a clear factual matrix. They argued that the appropriate test to apply was whether there was a 'real risk' the outcome sought by the Attorney General would breach fundamental rights, and that such a risk existed where ECtHR caselaw supported the view that people who lack the mental capacity to consent to their particular care arrangements cannot give valid consent to them. To the extent the ECtHR caselaw allowed for a person to lack capacity and be able to provide valid consent, the charities argued that this was where the lack of capacity has been determined on a global basis, such as under a system of guardianship, not where there had been a finding of a lack of capacity with respect to the particular care arrangements. In relation to DHSC's submissions, they argued that the objective limb of Article 5 ECHR did not fall to be considered in the reference, but if it was to be considered, *Cheshire West* should be followed.

> *48. So is there an acid test for the deprivation of liberty in these cases? I entirely sympathise with the desire of Munby LJ to produce such a test and thus to avoid the minute examination of the living arrangements of each mentally incapacitated person for whom the state makes arrangements which might otherwise be required. Ms Richards is right to say that the Guzzardi test is repeated in all the cases, irrespective of context. If any of these cases went to Strasbourg, we could confidently predict that it would be repeated once more. But these cases are not about the distinction between a restriction on freedom of movement and the deprivation of liberty. P, MIG and MEG are, for perfectly understandable reasons, not free to go anywhere without permission and close supervision. So what are the particular features of their "concrete situation" on which we need to focus?*
>
> *49. The answer, as it seems to me, lies in those features which have consistently been regarded as "key" in the jurisprudence which started with HL v United Kingdom 40 EHRR 761: **that the person concerned "was under continuous supervision and control and was not free to leave"…***

The Official Solicitor to the Senior Courts in England & Wales intervened in particular to raise concerns about departing from the decision in *Cheshire West*. The Mental Welfare Commission for Scotland intervened in (broad) support of a wider concept of valid consent.

The Supreme Court's judgment

The Supreme Court in its decision did not fully adopt the submissions of any of the parties, but was most strongly influenced by the positions of the Secretary of State and the Attorney General (as well as the observations of the Mental Welfare Commission for Scotland relating to the weight that could be placed on the views of those with impaired decision-making capacity).

In a unanimous decision (authored by Lord Sales and Lady Simler), the Supreme Court determined that in considering whether a person is deprived of their liberty, there is an overlap between the objective and subjective elements,[3] and it was necessary to consider both parts to determine the reference. The Supreme Court also determined it was appropriate to apply the House of Lords' *1966 Practice Statement (Judicial Precedent)* ([1966] 1 WLR 1234 and overrule *Cheshire West* on the basis that it was wrong, had given rise to practical difficulties and unjust costs and was impeding proper development of the law due to an anticipated divergence between Strasbourg law and domestic law which could not be corrected given that public authorities have no right of appeal to the ECtHR.

Deprivation of liberty – a multi-factorial approach

The Supreme Court considered that the test for determining whether a person is deprived of liberty was found in *Guzzardi v Italy* (1981) 3 EHRR 333. The *Guzzardi* judgment takes into account the concrete situation and totality of the restrictions on the individual, including their type, duration, effects and manner of the restrictions on the person, with no single factor being determinative.

The Supreme Court accepted that part of the *Cheshire West* 'acid test' was found in *Guzzardi* (see paragraph 184),but considered that *Guzzardi* required consideration going beyond the factors of being subject to continuous supervision and control, and not being free to leave the place of detention. Whilst the Supreme Court had some sympathy with the desire with the earlier court in *Cheshire West* to establish a universally applicable bright-line test to assist decision makers, they noted that such a test had the negative feature of "*failing to be appropriately responsive to the justice of particular situations arising across the whole field of its application* (paragraph 183). And, whilst it was understandable in its context, the Supreme Court considered that underlying policy concern of the majority in *Cheshire West* – that it is only by treating the vulnerable individual as being deprived of their liberty that one can be confident that there will be regular reviews of the suitability of their placement and an independent person appointed with a duty to pursue the individual's best interests – was not a good reason for extending the definition of deprivation of liberty (paragraph 183).

[3] The third element, state imputability, was only touched on in passing in the judgment, the Supreme Court noting at paragraph 116 that, although the Strasbourg jurisprudence on article 5 makes it clear that a state party to the Convention is only responsible for a deprivation of liberty if there is a relevant element of state responsibility in relation to the situation, in the care context it is relatively easy to identify factors giving rise to such responsibility, including where public officials are on notice that an individual is subject to a deprivation of liberty at the hands of a private party.

The Supreme Court considered that "[t]*he paradigm case of deprivation of liberty is detention in a cell, but so far as article 5(1)(e) is concerned, this has extended to include detention in psychiatric hospitals and certain social care institutions*" (paragraph 5). The Supreme Court considered that to determine whether a deprivation of liberty existed, consideration should be given to "*how close the [restriction] in question is to the paradigm of deprivation of liberty, which is confinement in a prison cell* (paragraph 119).

Before we turn to set out how the Supreme Court addressed the objective and subjective elements of liberty, it is important perhaps to make clear their approach to the concept of 'liberty' as (although set out late in the judgment), it underpinned their judgment. Relying in significant part upon the (extra-judicial) writings of former District Judge Anselm Eldergill, they held that "[l]*iberty means the same thing for everyone. As explained in Engel, it means physical liberty, including the freedom to go where one pleases. For those 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, they are not being prevented by a third party from doing something and are not being deprived of anything. The state may in some circumstances be subject to positive obligations (as the Secretary of State accepts) to take reasonable steps to prevent a deprivation of liberty, by, for example, providing a wheelchair or other aid to enable the individual to leave. But that is a wholly different point*" (paragraph 198).[4] They considered that this did not give rise to discrimination, because "[t]*he non-disabled person is in a fundamentally different position from persons who are unconscious, or in a minimally conscious state, or profoundly mentally and physically disabled. The former is capable of leaving but prevented from doing so. The latter are simply, by reason of their condition, not capable of leaving. It follows that there is no less favourable treatment of people in a materially similar position*" (paragraph 198).

Deprivation of liberty – the objective element

Although the Supreme Court emphasised that it was not always easy to split out the objective and subjective elements of the test for deprivation of liberty, it did nonetheless set out in different places considerations it considered relevant specifically to determining whether the objective limb of Article 5 had been satisfied:[5]

- The degree of supervision and control over the person's movements, the possibility for them to leave the restricted area, the extent of isolation and the availability of social contacts (paragraph 121);

- The effect of the restrictions on the individual. The Supreme Court considered that restrictions which were 'fairly limited' and therefore unlikely to suggest the objective element was satisfied included "*locking the doors of a care home to stop individuals who are not capable of looking after themselves from wandering into the streets*" (paragraph 136(iv). "*Where restrictions become progressively more intrusive, it will be relevant to consider whether they are imposed in response to an*

[4] At paragraph 196, the Supreme Court also noted that *"[d]ifficult issues could arise regarding the possibility that a state (under the Convention) or a public authority (under the Human Rights Act) might owe a physically disabled but mentally alert individual a positive duty under any of articles 3, 5 and 8 of the Convention to assist them to be physically mobile, but we do not seek to address them in this judgment."*

[5] Note, we have not always these references out in the order that they appear in the (very wide-ranging) judgment, as, at times, discussions of similar themes appear in quite widely spread out points.

increase in the need in a particular case to protect the individual and/or the interests of others…the subjective experience of the individual affected is relevant. If they do not experience a restriction as a major intrusion in their life, that tends to indicate a classification as a restriction on liberty of movement rather than as a deprivation of liberty" (paragraph 136(iv);

- The duration of the restrictions.[6] It was noted while the duration of restrictions in the context of people who lack capacity and live in care settings was likely to be long in many cases, "*it is significant that they are specifically taken in the individual's own interests, to care for them and to keep them well and safe (consistently with safeguarding others against harm they might cause, if that is an issue)*…[I]*t is important to recognise that individuals in care enjoy a range of personal protections under the regimes applicable to them, including rights to independent external reviews and audits by qualified professionals* […] *and to express their own views and preferences and have them taken into account. This helps ensure that the measure is applied only for as long as necessary*." (paragraph 136(iii).

- The presence or absence of objection if the person is "*capable of objecting or giving tacit agreement*" [7] (paragraph 53(iv)). The incapacitous person's "*subjective attitude, as so expressed, carries significant, indeed usually decisive weight, according to the criteria set out in Storck. Conversely, if such a person manifests a view that they do not accept that situation, that opinion should also be respected and will usually lead to the conclusion (if the objective circumstances indicate that they are detained) that they are subject to a deprivation of liberty*" (paragraph 151). Coercion is a "necessary element" in defining a deprivation of liberty (paragraph 187). "*The* […] *stress for the individual in having their objections overruled may lead to suffering and result in the use of physical force or physical restraint. These features of the individual's concrete situation are likely to be clear indicators that they are being confined, in the sense of suffering a deprivation of liberty*" (paragraph 187). "[I]*f 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*" (paragraph 189). In the regard, the Supreme Court also noted that the presence or absence of sedative medications will be relevant where they are capable of suppressing objections (paragraph 188).

- The 'relative normality' of the placement: "*if an individual is living in their own home, in accordance with their wishes and feelings, it makes it less likely that the individual is being subject to a deprivation of liberty within the meaning of article 5. Put another way, the restrictions imposed would need to be more severe or extensive to amount to such a deprivation, such as, for example, a combination of restraint, medication, and seclusion* (paragraph 193).

- Where measures are far from confinement in a prison cell, the purpose of the measures. The judgment considered that therapeutic purpose may make it less likely that a

[6] There was no specific discussion of the issue of what constitutes a 'non-negligible' period of time, an issue which has featured quite often in post-*Cheshire West* discussions.

[7] See further the section on the subjective element below.

measure is a deprivation of liberty, as is the proportionality of the restriction to achieving the relevant purpose (see paragraphs 130, 132 and 134).

- Other relevant rights in play, particularly Articles 2, 3 and 8; the Supreme Court noted the potential for intrusive assessments to have to be carried out in the context of determining whether any deprivation of liberty is justified (see paragraph 141).

Deprivation of liberty – the subjective element

The Supreme Court considered that the ability to give subjective consent to what would otherwise be a deprivation of liberty was an 'autonomous concept' for the purposes of Article 5 ECHR which was untethered to domestic test for decision-making capacity, or tests for waivers of ECHR rights (which must be free and fully informed, and the individual would need to have legal capacity to make such a decision (paragraph 126).

The Supreme Court found that the test for whether a person is able to give subjective consent to an Article 5 deprivation of liberty was lower than the test for capacity under the Mental Capacity Act 2005, with a person being able to give consent if they are *"conscious of their environment and has a basic understanding of their living circumstances in a secure care environment, so that they can in some suitable way express their view about their situation, who manifests their acceptance of that situation."* (paragraph 53(ii)). In reaching this conclusion, the Supreme Court observed that *"[t]he argument that, because some adults will find it difficult to communicate and express views and feelings about their placement, the views of no adults should be capable of vouching consent creates an arbitrary threshold and may lead to unnecessary and intrusive interference with the private lives of those adults with impaired mental capacity who are able to express views and feelings."* (emphasis in the original) (paragraph 192).

In defining the 'autonomous concept' of consent for the purposes of Article 5 ECHR, the Supreme Court further considered that *"mental capability recognised under the Convention…focuses on the individual's de facto ability to express their own view*" (paragraph 158), rather than an ability to make an informed decision. The Supreme Court further considered that "*if an individual is placed in a secure care home, has de facto understanding of their situation and does not express or manifest any objection to staying there despite having a realistic opportunity to do so, they can be taken to have given tacit consent sufficient to negative the subjective element required for a finding that there has been a deprivation of liberty*" (paragraph 172).

The judgment described what was required for consent in a number of different places:

- "*Where an individual lacks full mental awareness (in a factual sense) in relation to their circumstances, so that they cannot be regarded as someone with full ability to decide how they wish to be treated for all purposes, they may nonetheless be sufficiently aware of the circumstances in which they are maintained in confinement as to be able to register whether they are happy or unhappy with those circumstances and to enter protests against their treatment if they are unhappy with them*[…] *They may have impaired understanding of many things and may lack capacity in a full legal sense, but they may nevertheless have a fundamental understanding of whether they are broadly happy or unhappy about something so basic, and their understanding of and choices regarding that should be accorded respect*" (paragraph 135).

- Subjective consent for the purposes of Article 5 ECHR is "*concerned with a person's de facto understanding of their situation and how they experience it*" (paragraph 201).

- If a person has "*a basic level of awareness and consciousness of their living arrangements that is sufficient to enable them to know and communicate whether they are happy or unhappy with them, they may be treated as able to give or withhold valid consent to confinement by an expression of their wishes and feelings* (paragraph 201).

- Compliance or acquiescence may carry less weight "*if it is accompanied by the administration of sedative medication which is capable of suppressing objections*" (paragraph 188).

- A "*tacit positive indication of wishes and feelings showing contentment with the arrangements*" may be sufficient to show consent (paragraph 191).

- The approach taken to whether a person has given this consent should be "*practical and realistic*" (paragraph 127). Where there is 'serious doubt' as to the incapacitous person's "*attitude*" "*no inference should be drawn*" (paragraph 192).

Although no party to the reference suggested that it was possible for another to give substitute consent for an adult with impaired decision-making capacity, the Supreme Court appeared to leave the door open for this at paragraph 164, where it noted that "*the mere fact that the individual concerned is incapable of expressing any view does not lead to the conclusion that the subjective element of a deprivation of liberty is made out. On the contrary, in an appropriate case it may lead to the conclusion that the subjective element is assessed by reference to the view of the person with authority to make decisions for the individual, in their best interests.*"

Who is or is not deprived of their liberty

The judgment offered some specific examples of people who were or were not deprived of their liberty, some of which drew on existing case law:

- A person cared for in hospital (or probably, in any other setting) in a minimally conscious state is not deprived of their liberty (paragraph 116). "*The non-disabled person is in a fundamentally different position from persons who are unconscious, or in a minimally conscious state, or profoundly mentally and physically disabled. The former is capable of leaving but prevented from doing so. The latter are simply, by reason of their condition, not capable of leaving. It follows that there is no less favourable treatment of people in a materially similar position*" (paragraph 199).

- A person experiencing catatonia (eg due to severe dementia or in the aftermath of suffering a stroke or traumatic head injury) and *"unable to express any view at all about what should happen to them, whether verbally or by physical manifestations of contentment or discontent*" cannot be deprived of their liberty as they lack control over their body (paragraph 142). The Supreme Court found that such individuals do not "*have any bodily, physical liberty to exercise, irrespective of the circumstances in which they are being cared for. Also, since there is no possibility of anyone contradicting their will in that regard, it cannot sensibly be said that anyone is subjecting them to treatment which constitutes a "deprivation" in relation to their physical or bodily liberty*" (paragraph 142).

- The temporarily unconscious may experience a deprivation of liberty even if they are not immediately aware of it, if they would be prevented from leaving when they regain consciousness (the examples given being a prisoner, or a person already subject to detention under mental health legislation) (paragraph 143).

- Certain hospital inpatients: *"In ordinary circumstances, an individual in hospital to receive treatment (and who, for their own protection, would be prevented from leaving while, say, confused and unable to think because of medication) would not be regarded as suffering a deprivation of liberty within the meaning of article 5. Ordinary expectations and the ordinary conduct of life play a significant role in the assessment whether there is a deprivation of liberty* […] *The presumption is that a person who is unconscious and kept in care to have medical treatment administered does not suffer a deprivation of liberty, unless there is evidence that they are in fact in detention or there is an established pattern of behaviour to show that they clearly do (or would) object to being cared for in this way* (paragraph 145).[8]

- 'MIG' in *Cheshire West* (who lived in a Shared Lives placement) was not deprived of her liberty as "*there were sufficient indications of her being happy with her living arrangements to amount to valid consent*" and "*[h]er living arrangements were as close to normal as possible and such minimal element of confinement as existed was for her benefit and protection*" (paragraph 203). The Supreme Court considered that neither the subjective nor objective elements were met, as "*her situation was very far removed from the paradigm case of confinement in a prison cell*" (paragraph 203).

- 'MEG' in Cheshire *West* (who lived in a small residential children's home run by the NHS) was not considered to be deprived of her liberty. The subjective element was not met because she was *"happy living in the NHS facility where she was placed as to amount to valid consent to being there. She showed no wish to leave the facility or go out on her own. Although she received tranquillising medication, that was not administered with a view to disabling her from forming a view about her living circumstances and does not seem to have had such an effect*" (paragraph 204). MEG's having 'outbursts' were not considered to undermine this consent. The Supreme Court also considered that the objective element was not met either because her *"living arrangements were as normal as possible in the circumstances, and the continuous supervision and control to which she was subject were directed to meeting her care needs rather than to making her a prisoner. Although she was physically restrained on occasion, that was done for her own protection or for the protection of others, and not with a view to punishing her. Overall, again, her situation was far removed from the paradigm case of confinement in a prison cell* (paragraph 204).

- The Supreme Court reserved its opinion on whether 'P' in *Cheshire West* was deprived of his liberty and appear not to have set aside this aspect of the judgment, though

[8] Note that, whilst agreeing with the conclusion of the Court of Appeal in *Ferreira*, which 'carved out' those in receipt of life-sustaining medical treatment in hospital where the arrangements for their treatment were not out of the ordinary, the Supreme Court reached it for different reasons. One matter which will need considering in due course is where the person is subject to mental health legislation but transferred to another (acute) hospital for physical health treatment.

expressed some features of the situation "*tend to indicate that he was not subject to a deprivation of liberty*" (paragraph 205).

- The Supreme Court endorsed the finding of Lieven J in *Re SM (Deprivation of Liberty; Severely Disabled Child)* [2024] EWHC 493 (Fam) that no deprivation of liberty existed for a 12-year-old with "*profound cognitive and physical disabilities, who responded like a child of a few months old) was under constant supervision and control, but this was because her condition was such as to require this by way of care, not to prevent her from leaving her placement. In fact, SM was wholly incapable of leaving, both because of physical inability and because she was unable to form any desire or intention to leave. In our view, the judge was right to conclude that this situation did not involve a deprivation of liberty within the meaning of article 5*" paragraph 196.[9]

What does the judgment mean?

Narrowly, the outcome of the case means that the Health Minister in Northern Ireland can issue a revised Code (albeit, as the Supreme Court identified, the version before the court will require further modification in light of the judgment).

More broadly, the MCA 2005 expressly ties the application of DoLS to the definition of deprivation of liberty in Article 5, and requirements to seek community deprivation of liberty authorisations also stem from Article 5. Who is (and is not) deprived of their liberty for purposes both of DoLS and community authorisation of deprivation of liberty is now as set out by the Supreme Court in *AGNI*. The same also applies in relation to situations where the question is whether authorisation of deprivation of liberty may be required in respect of admission and treatment under the MHA 1983.

Comment[10]

The Dawn of Article 8?

It will take time for the dust to settle, but the Article 5 ramifications of the judgment are clear as health and social care start embarking on a return to the pre-*Cheshire West* era. Although the DoLS numbers are very unlikely to suddenly drop from the 365,000 requests last year to anywhere near the original impact assessment estimate of 21,000, there will of course be a significant reduction over time. Current low and medium priority DoLS requests will be triaged against the new test, Part 8 reviews will keep best interests assessors very busy, and a cautionary approach in borderline cases seems likely to be adopted.

The Supreme Court's interpretation of confinement is now arguably more aligned with that of the Strasbourg Court, which has a Council of Europe-wide meaning, although some may academically question whether its 'Guzzardi-add-ons', coupled with its approach to valid consent, has interpreted the concept too narrowly. Article 5 concerns physical liberty and the prison cell paradigm (originating from Article 5(1)(a) and (b) contexts) has since *HL* and *Stanev* long been recognised by Strasbourg in hospital and care home scenarios respectively for the purposes of Article 5(1)(e). Neither before nor since *Cheshire West* has Strasbourg found a deprivation of liberty in other care contexts.

[9] The Supreme Court did not appear to reach this conclusion on the basis that SM was a child per se as opposed to by reference to the nature of SM's physical and cognitive disabilities. The Supreme Court did not address the judgment in *Re D* or the role of parental authorisation of situations which would otherwise amount to a deprivation of liberty.

[10] For a rapid reaction webinar held on the day the judgment was handed down, see here.

The practical advantage of the *Cheshire West* acid test was its simplicity. Arguments about the borderline between restricting movement and depriving liberty were rendered largely otiose. A multifactorial approach with no factor being decisive will inevitably lead to new case law as judges at first instance are asked to apply it to specific factual scenarios. Chapter 2 of the DoLS Code of Practice, which was out of date for over a decade, is now very much back in fashion.

Before analysing the judgment, it is important to make an obvious point that is often overlooked. Regardless of whether someone's liberty is restricted or deprived, the underlying legal basis under the MCA 2005 is the same: (i) inability to decide, (ii) best interests, (iii) necessity and (iv) proportionality. The only difference is that the defence to liability derives solely from ss.5-6 MCA 2005 rather than from an authorisation by a local authority, Local Health Board, or Court of Protection judge. The judgment does however mean that fewer people will have (i) representation, be it lay and/or legal, (2) access to non-means tested legal aid, and (iii) an independent assessment of best interests.

1. The multifactorial approach to confinement

A deprivation of liberty concerns compulsory confinement, directly or indirectly attributable to the State, and the Supreme Court's endorsement of the *Guzzardi* multifactorial approach reflects what it has considered to be the European approach. Factors including the type, duration, effect and manner of implementation of the measures in question are key. What the judgment highlights is what *Winterwerp* has always said: "*the mental disorder must be of a kind or degree warranting compulsory confinement*." If confinement was not compulsory, why would compulsory confinement ever need to be justified for Article 5(1)(e) purposes?

The controversial part of *Cheshire West* was, for some, the irrelevance given to objections. It reduced a test of *compulsory* confinement to confinement alone, which meant that the 'effect' factor was rendered meaningless. The 'type' and 'manner of implementation' of restrictions means having regard to the specific context and circumstances surrounding them. The possibility of leaving, the degree of supervision and control, the extent of isolation and the availability of social contacts form part of that context. However, the forthcoming first instance arguments are likely to concentrate on the weight to be given to the issues of relative normality and purpose, and how to interpret 'valid consent' in the real world.

2. Relative normality

The judgment states that "*liberty means the same for everyone*" (at paragraph 198) but also refers to the "*relative normality of the placement*" as being a relevant factor. Strasbourg has never used a relative *disabled*-normality approach; it focuses on how distant the arrangements are from the paradigm. Whether the Supreme Court intended such an approach is not immediately obvious. The 'type' of measures could incorporate relative normality but one needs to be clear: relative to what? If it is relative to the paradigm which applies regardless of disability, which bears in mind the ordinary universal restrictions of modern life that everyone endures, that could be uncontroversial ('universal-normality'). But if it involves comparing one disabled person with the normal life of another disabled person, that would be a real concern ('disabled-normality').

One could argue that whether anyone is confined against their will must be benchmarked against universal-normality. If someone with a disability is supported to go out in the community if they wish, to engage in daily living activities, is not prevented from having contact with loved ones

etc, that is relatively normal compared to those *without* disability. Relying on others to help or support in the pursuit of one's will and preferences is not supervision and control. It *enables* physical liberty, not deprives. If one needs someone to go out with them to avoid a significant impact to their well-being, that must be provided. Indeed, the positive obligations of Article 5 to take reasonable steps to prevent a deprivation of liberty "*by, for example providing a wheelchair or other aid to enable the individual to leave*" (paragraph 198), now assume much greater prominence. Failing to promote physical liberty will now be a more meaningful argument to deploy.

3. Purpose

Whether the purpose of a measure is relevant to establishing a deprivation of liberty (Article 5(1)), or only at a later stage when examining its justification (Article 5(1)(e)), has always been hotly debated. It has arisen at the initial stage in the context of whether someone's *residual* liberty has been deprived, and in circumstances where Article 5 would provide *no* lawful basis for detention. But whether the borderline between restricting and depriving liberty should vary according to the particular interests served by the restrictions is contentious. It is therefore important to note that the judgment says that purpose is relevant (but not decisive) in "*more marginal or borderline"* cases.

4. Valid consent

This is the part of the judgment which many will find the most challenging. Article 5 is an autonomous European concept, so valid consent to confinement does not mean valid consent under the Mental Capacity Act 2005. Under domestic law, if someone lacks capacity to decide a matter, consent cannot be inferred or implied and a best interests decision is required. None of that is affected by this judgment.

All of the relevant European case law on this issue concerns scenarios where someone has been deprived *globally* of legal capacity. In the Strasbourg context, this is generally because a guardian has been appointed by a court to make decisions for them. Much of the debate about valid consent has therefore focused on whether the guardian can give valid consent or whether the person can validly consent *despite* what may be a contrary view held by their guardian.

Strasbourg sees legal capacity as a status test, whereas the MCA 2005 focuses on the functional test of mental capacity. Mental and legal capacity are not synonymous, and debate may follow as to the precise circumstances in which someone unable to functionally decide on their arrangements can still validly consent to something as serious as being in confinement. *Stankov* at paragraph 90 provides:

> [A] *person's consent to admission to a mental health institution for treatment can only be considered valid under the Convention if there is sufficient and credible evidence suggesting that the capacity to consent, and to understand the consequences of that act, have been established in a fair and appropriate procedure, and that all necessary information concerning the placement and the proposed treatment has been adequately provided to the interested party … The court considers that this principle is also applicable when it comes to obtaining consent for the placement in a social care home of a person whose legal capacity is impaired due to their mental health, as in the present case.*

But the Supreme Court interprets this in the context of whether *Stankov* had waived his rights to victim status, rather than as an explanation of the valid consent requirement. There will no doubt be an academic focus on whether this is the correct interpretation, for when Strasbourg

says in *Stanev and Shtukaturov* that "*the fact that a person lacks legal capacity does not necessarily mean that he is unable to comprehend his situation*", it is correcting the bluntness of plenary guardianship or incapacitation proceedings so as to empower the person. For now, there are three features in play:

1. Mental capacity: the functional, matter-specific test of whether a person can understand, retain, use, weigh and communicate the decision.

2. Legal capacity: the status of being able to hold and exercise rights and make legally effective decisions.

3. Factual ability: being sufficiently aware of the circumstances in which they are maintained in confinement as to be able to register whether they are happy or unhappy with those circumstances and to enter protests against their treatment if they are unhappy with them.

The Supreme Court was not pointed to any Strasbourg decision suggesting that a person lacking legal capacity, invalidly placed by a guardian, is outside the protection of Article 5 merely because they appear content. Every guardian-placement before it has been identified as a deprivation of liberty. Whereas those cases of valid consent involved either the person retaining legal capacity or factually accepting the placement, as opposed to merely appearing content with it. *HM* was legally capable; *Mihailovs* was "*well aware of his situation*" and tacitly agreed to staying in the open institution at Lielbērze which he left voluntarily on occasions.

Those with mental capacity to decide either way who agree to the arrangements will be providing valid consent in both domestic and European terms. Those with such mental capacity who do not consent will not. The Supreme Court held at (paragraph 191) that, *"If the individual is capable of expressing a view and there is serious doubt about their attitude, no inference should be drawn"*. But what if they are incapable of expressing a view? Those who lack such mental capacity cannot give 'domestic consent' and it is anticipated that a cautionary approach may be taken to 'European consent' to confinement, particularly in borderline or marginal cases. And it would be no surprise if a longitudinal approach to 'happiness' is adopted to ensure this is applied narrowly. Indeed, the relationship between the judgment and *HL v UK* may well come under further judicial scrutiny in due course.

5. Consent from others

The courts will need to grapple with the remit of paragraph 164 that says:

> *… the mere fact that the individual concerned is incapable of expressing any view does not lead to the conclusion that the subjective element of a deprivation of liberty is made out. On the contrary, in an appropriate case it may lead to the conclusion that the subjective element is assessed by reference to the view of the person with authority to make decisions for the individual, in their best interests. The court's analysis of the Nielsen judgment confirms this.*

Is this only applicable if the individual is incapable of expressing *any* view? Is the appropriate case those under 16 without a care order whose parents can consent, or are there others? Nothing in the judgment appears to disturb the rules regarding the limits of parental responsibility in the confinement context. But where does this leave health and welfare LPAs and deputies? What about others "*with authority to make decisions for this individual, in their best interests*"? Does the s.5 MCA 2005 defence provide such 'authority'?! Surely the Supreme Court did not intend for health and social care

practitioners making best interests decisions to have the authority to take people outside Article 5 protection? For that would be completely contrary to *HL v UK*.

6. Community cases

On the face of it, there seems likely to be a significant drop in the need for *Re X* authorisations. By their very nature, they typically relate to people in their own tenancy or home without any 'triggers' for an oral hearing who are far less likely now to be seen as deprived. Of course, as paragraph 193 recognises, living in your own home could still engage Article 5, but "*the restrictions imposed would need to be more severe or extensive… such as, for example, a combination of restraint, medication and seclusion*". Those sorts of combined measures would not have gone down the streamlined *Re X* process in the first place and a welfare application would still seem likely given – at the very least – the significant Article 8 issues, discussed below.

7. Medical treatment

Strasbourg has never found medical treatment *per se* to deprive liberty and in its re-alignment the Supreme Court approves the approach adopted in cases like *Ferreira* and *Briggs*. Moreover, at paragraph 145 it held, "*in ordinary circumstances, an individual in hospital to receive treatment (and who, for their own protection, would be prevented from leaving while, say, confused and unable to thing because of medication) would not be regarded as suffering a deprivation of liberty within the meaning of article 5.*"

However, emphasis was put at paragraph 141 on the other ECHR rights which meant those in care "*cannot be left unprotected and without appropriate review of their interests on a continuing basis*". It is anticipated that Article 8 may feature more heavily in future, perhaps by extending the *Neary* principle so that significant healthcare issues (eg Article 8 interferences with bodily integrity against the person's will) that cannot be resolved by discussion must be placed before the Court of Protection. That would also accord with *X v Finland* (Application no. 34806/04; 3 July 2012) at paragraph 220 which, in the context of forced administration of medication, held that "*this represents a serious interference with a person's physical integrity and must accordingly be based on a "law" that guarantees proper safeguards against arbitrariness.*" It would also accord with the clear line of authority from Strasbourg that, whilst there are no express procedural safeguards contained in Article 8, there are implicit safeguards aimed at giving a person a degree of involvement in decisions affecting their private and family life that is sufficient to protect their interests, the requisite degree of involvement being calibrated to the circumstances of the case, and the seriousness of the interference with the rights that the article protect (see, for instance, *Shtukaturov v Russia* [2012] EHRR 27 (App No 44009/05) at paragraphs 88 to 89.

8. Not negligible or significant?

The judgment's summary at [53](ii) that refers to "*confinement in a restricted space for a significant period"* seems out of kilter with the "*not negligible period*" adopted by Strasbourg. There is a big difference between the two, and the issue could be important for example in A&E scenarios were risks are high but inpatient beds awaited. How long can ss.5-6 MCA 2005 be relied upon before a deprivation of liberty arises? The conventional European rule of thumb was that, depending on the circumstances, beyond 72 hours was more than negligible but is that "*a significant period*"?

9. Other rights and safeguards

Identifying the (domestic) restrictions first before considering (European) happiness is crucial because a happiness-first approach risks overlooking the restrictions and therefore risks a breach of s.6 MCA 2005, as a result of which there would be no s.5 defence to liability. Even if cases are miles away from the paradigm, s.6 demands that any *intended* restriction of movement, whether or not the person resists, is only lawful if it is both necessary and proportionate to the risk of harm. Unless and until those domestic law requirements are identified and analysed, the person's European happiness is not relevant.

Advocacy will also continue to play a key role. For those lacking capacity to decide who are unbefriended, an IMCA at 28 days of hospital admission or 8 weeks of residential care is mandatory. Advocacy under the Care Act 2014 and Social Services Well-being (Wales) Act 2014 are mandatory where the conditions are satisfied. Under the former's statutory guidance at para 13.32, "*It is the expectation that authorities should conduct a review of the plan no later than every 12 months*". At least annual care reviews provide professional oversight in social care.

It might also be thought particularly important that DHSC is held to the promise that it could be taken to have made to the court (reflected in paragraphs 10 and 141) that there are sufficient safeguards in domestic law to secure the wider rights of those with impaired decision-making capacity that everything did not need to be hung off Article 5.

The contact constraints on the Court of Protection

Re PB (Appeal: Best Interests: Restrictions on Contact in a Care Home) [2026] EWCOP 21 (T2) (HHJ Burrows)

Article 8 – contact

Summary

The issue of visiting in care homes is a distinctly hot topic. Linked, it appears, to high profile media coverage, DHSC has announced a review of Regulation 9A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, itself introduced in the wake of the pandemic. Regulation 9A does not, however, apply to judges making decisions in the Court of Protection. The media coverage noted above was focused primarily on the role of the Court of Protection. Whilst it does not expressly refer to that coverage, it does not require too much reading between the lines to see the careful and comprehensive judgment of HHJ Burrows in *Re PB (Appeal: Best Interests: Restrictions on Contact in a Care Home)* [2026] EWCOP 21 (T2) as drafted, in part, to explain why the Court of Protection takes the approach that it does.

The case itself took the form of an appeal against a decision of a district judge that it was in the best interests of a lady in her late 80s, PB, to remain at the care home, and that contact between her and her daughter, SB, should continue to be supervised and limited. As HHJ Burrows noted:

> *14 The history leading to these proceedings is properly summarised in the Local Authority's position statement for the hearing before the DJ, as follows:*
>
> *(9) PB bought the property she lives in with her late husband and it is understood that PB is the sole beneficiary and owner of the property. SB is believed to have moved into the property with PB in November 2017.*
>
> *(10). The local authority had previously commissioned the agency to provide a package of care three times per day to PB in her home and the agency had been*

providing this care for [around] two years; prior to that, eight different care agencies had [been] commissioned but then ceased involvement, citing issues in the working relationship with SB.

(11). The court will note the exhibits provided from the previous care provider, the agency, which detail incidents and difficulties in work conditions allegedly due to SB's behaviour over a near two year period. No one has sought for the previous provider to give evidence; nor is it considered necessary for the court to determine the detail of what went on prior to PB's move to the care home. It is an accepted fact that the relationship with the agency became difficult, but SB's case is that the agency remain willing to resume the care package and that she will work with them. She has provided evidence from the agency, most recently in November 2025, confirming that they would resume the package.

15. Pausing there, the foregoing history is not unusual in Court of Protection cases. There are often fallings out between professional care givers and the families of those to whom they provide care, both in the setting of their own home, or in the institutional setting of a care home. Sometimes these are the almost inevitable result of differences of opinion as to what sort of care P should receive. Sometimes it is to do with concerns on the part of P's family as to the standard of care P is being provided by the care giver. Sometimes there are serious problems that arise out of the behaviour of one party or another.

16. In most cases, the relationship continues, and the care giver and the family simply learn to cooperate and place the interests of P above their own. Sometimes, however, that proves impossible and the relationship breaks down. When care is provided in P's home, this results in the care giver withdrawing. When the care is provided in a residential setting operated by the care giver, it can result either in restrictions on, or the total suspension of, visits by P's family members or friends, or at least some of them. Sometimes, the management of the home simply gives notice to P that they will have to leave the home and find somewhere else.

17. That last option can be highly disruptive for P, and it can result in it being very difficult, maybe even impossible to find any appropriate alternative provision. When one is found, it may be inconveniently far away for the family or for P. It may be more expensive, perhaps prohibitively so. The history of rancour oftens follows P and can lead to the new care provider imposing restrictions on the family as a condition precedent for P's residence at the new home. This is a difficult situation for the families, the providers, the public authorities with responsibility for P's care, and for P, whose interests are often adversely affected by all this.

18. It is also a great problem for the Court of Protection. As I will explain later, the Court's limited legal powers over care providers often leaves it in the position the DJ found herself in this case. Any power the Court has over the care provider to modify their approach towards P, for instance by imposing conditions on a standard authorisation, must be used sparingly if, by their use, all that happens is that the "nuclear option" of the termination of the placement will ensue.

As HHJ Burrows identified:

19. In this case, both these issues feature. Not only had there been a

> *breakdown in agency provision whilst PB was at home, but there were restrictions on SB's visits at the care home, along with the threat that termination would follow any attempts to interfere with the home's exercising of its powers over contact.*
>
> *20. This is an important issue in this case because it has a direct impact on PB's best interests in two interrelated ways. Firstly, PB and SB are close, and it maybe in PB's best interests for her to have extensive contact, as and when she wishes, with her daughter. Or, to put it another way, it may upset her and injure her best interests for that contact to be restricted. Secondly, however, the breakdown in relations between the caregivers and SB is also relevant to PB's best interests. That is because it makes her tenure at the care home less secure, for the reasons I have already explained.*

On the facts of the case (but, again, not unusually) the question of whether it was necessary to hold a fact-finding hearing to identify the cause of the breakdown arose. The district judge had considered that it was not necessary, a decision HHJ Burrows entirely agreed with:

> *24. I think it is clear that the DJ decided a fact-finding hearing concerned with the history of SB's relations with care providers over a period of years, and at the present care home would have involved a considerable amount of court time. That is not always the end of the story. Sometimes there is a need for a prolonged fact finding, where, for instance, neglect or abuse are live and decisive issues in the case. However, that is only when the outcome of the fact finding will have an impact on the decision the Court has to make. This is similar to the position in the Family Court. It is a matter best determined by the judge with management of the case applying the principles enunciated by Mr Justice McFarlane (as he then was) in A County Council v DP [2005] EWHC 1593 (usually referred to as the Oxfordshire case) and most recently G (a child: scope of fact finding) [2025] EWCA Civ 1044 and as distilled into the issues before the Court of Protection by Re H-D-H [2021] EWCA Civ 1912.*

HHJ Burrows further concluded that the judge had been entitled to proceed on the basis that this was a situation where the court had to look forward, rather than backwards. He also concluded that she had not placed determinative reliance on a Decision Support Tool assessment (designed to inform decisions about CHC funding) in reaching her conclusions as to PB's care needs, and, overall, that her decision about PB's best interests as regards her continued residence in the care home was one she was entitled to reach.

HHJ Burrows then turned to the question of contact, identifying that "[r]estrictions on contact between a vulnerable adult and close family members, plainly engage Article 8 of the European Convention on Human Rights (ECHR), and the court, as a public authority itself, must ensure that any interference is necessary and proportionate." He accepted the contention that the care home was to be seen (via ss.73(1) and (2) Care Act 2014) as performing functions of a public nature, so as to be bound, directly, by the ECHR. He then turned to the operation of Regulation 9A (a matter he had raised of his own motion before the parties), identifying that

> *40. The importance of these regulations is that a registered person, such as the managers of the care home, must comply with them in carrying out a regulated activity, i.e. running the care home (see Regulation 8). A failure to do*

so leaves the care home and its managers open to regulatory action by the regulator, the Care Quality Commission (CQC). This could lead to sanctions, and even the cancellation of their registration and the likely closure of the home.

41. In other words, there is an incentive for those who operate care homes to ensure they enable their residents to receive visits at the home, and to leave the home in order to pay visits. A failure to do so is a serious matter, with perilous consequences.

*42. However, the wording of Regulation 9A, along with the general obligation under Article 8 (via s. 73 Care Act) is necessarily subject to qualifications. So, although the wording in Regulation 9A(2) provides that those staying in care homes "**must** be facilitated to receive visits" unless there are "exceptional circumstances", paragraph (3), whilst purporting not to limit that right, immediately qualifies it. The visits must be "received in a way that is **appropriate**". That visit must meet "the service user's **needs**" and "so far as **reasonably practicable** reflect their preferences" (All emphasis added). Each of the emphasised provisions requires a judgment on the part of the service provider, having first consulted with the relevant parties.*

*43. Then comes another significant provision (my emphasis, once again). In order to comply with the provision enabling visits, the care home owner **must** take action, "or put in place such precautions, as is **necessary and proportionate** to ensure that service users may receive visits to be accompanied **safely**". In determining those "precautions" regard must be given to any care or treatment plan for the service user".*

HHJ Burrows then set out what happened in PB's case, noting that it was:

44. […] not only typical of relationship breakdown between families and care providers, but also how Regulation 9A is used in such situations. Without going into detail, there were a number of allegations of incidents involving SB at the care home. These culminated in a letter on 26 November 2025. I will repeat the letter verbatim (literally), not just so as to underline its relevance to this case, but to emphasise its relative normality in this context. It said:

> *Following yesterdays incidents with SB, at the home and after careful consideration of SB ongoing challenging , and detrimental behaviours towards PB, staff, residents, and relatives within the home. e.g.*
>
> *1. Affecting staff morale, and their mental health, due to being rude, condescending, doesn't listen to staff, talks over staff, or walks away from staff whilst they are talking to her, also interrupts staff, and disrupts care by trying to tell staff how to do their jobs by telephone and in person, or threatens them with solicitors, the staff are afraid of SB and this impacts on PB, other residents, staff, and visitors who witness her behaviour's.*
>
> *2. Has demonstrated with yesterdays 2 incidents that she has put PB at a high risk of harm due to bringing food into the home for PB from an unknown source, modification, quantity, how has this been stored, when / where cooked purchased from? Which makes this food untraceable in the event of salmonella etc. SB knows as discussed in the*

schedule of expectations that she should not be here at mealtimes, and that the care home provides meals for PB in line with SALT assessment and guidelines for PB, due to high choke risk, and noncompliance with recommended IDDSI levels which are prescribed by SALT on assessment. SB has had a copy of the assessment from SALT, and the care home, and SALT team and I have discussed this in great depth With SB on many occasions. SB is not permitted to feed her mum due to the above, also SB refused to tell staff what she had fed/how much to PB so staff were unable to record PB intake at teatime yesterday.

SB also put her mum at high risk by tampering with and repositioning PB bed leaving her in a flat position which is a choke risk, despite the maintenance team at the home asking SB not to touch the bed as the hand Set wasn't working properly, and he left the room to get a replacement, when he arrived back SB had put the bed up to the highest position of the headboard and in doing so damaged the bed, and bent the frame.

This resulted in PB spending a long period out of bed in a chair whilst a replacement bed and mattress could be built/ set up and the other bed and mattress removed, compromising PB pressure relief and distressing PB.

Also, staff were away from caring for PB and other residents due to having to source/dismantle and rebuild the bed and set up the mattress, also resulted in staff not getting off shift on time due to this situation.

The business owners and management team must consider the wellbeing and safety of all residents and staff first and foremost, managing SB behaviours is no longer sustainable, especially as we approach the festive period which SB has already delayed the home in decorating the home for Christmas due to yesterday's incidents. Therefore we have only 2 choices available to us,

1. We serve PB 4 weeks' notice to leave the home as per contract, or

2. We take legal advice about barring SB from the home completely. The home feels the 2nd option would better serve PB, staff, and residents, and we are currently awaiting a call back from the care homes legal team.

As soon as I have an update, I will notify you of the decision. I'm sorry we have had to come to this, but we feel all other avenues have been taken and failed.

In an important passage, subtitled "*Choice, Regulation and the limits of the Court's Power*," HHJ Burrows set out how:

> *53. This case illustrates a recurring difficulty in Court of Protection proceedings, which is not always made explicit when welfare decisions are considered on a case-by-case basis. It concerns the interaction between the limits of the court's welfare jurisdiction, the contractual and regulatory position of private care home providers, and the practical consequences for decisions about residence and contact.*

54. It is now well established that, when determining best interests under the Mental Capacity Act 2005, the Court of Protection must choose only between options that are legally and practically available. The court does not have a free-standing power to require public authorities, or private providers, to create services, placements or arrangements that do not exist or which they are unwilling to offer. That principle was authoritatively confirmed by the Supreme Court in N v ACCG [2017] UKSC 22 and has since been consistently applied in cases where the range of options is narrow or severely constrained.

55. That principle does not reflect judicial passivity. It reflects the legal limits of the court's welfare jurisdiction. Dissatisfaction with the options that are in fact available to P may, in an appropriate case, give rise to public-law or regulatory challenge. It does not entitle this court to distort the welfare evaluation by treating unavailable options as if they were realistic contenders.

56. The point assumes particular significance where, as here, the court is faced in substance with a binary choice: either maintaining a single existing placement or risking its loss in circumstances where no alternative satisfactory placement has been identified or secured. In such cases the court is entitled, and in my judgment often required, to give decisive weight to the preservation of a stable placement, even where that stability is accompanied by restrictions that engage Article 8 rights.

57. That approach does not involve subordinating P's welfare to institutional convenience. It reflects the reality that the maintenance of stability is itself a core welfare consideration, and that the loss of a placement may have consequences which are materially more harmful than the continuation, for the time being, of arrangements which are less than ideal.

58. The analysis cannot, however, stop there. Care homes are, almost invariably, privately owned and operated pursuant to contractual arrangements. Those arrangements ordinarily confer on the provider a right to terminate the resident's occupation in defined circumstances. The Court of Protection has no jurisdiction to rewrite those contracts, nor to prevent a lawful termination pursued through the county court.

59. At the same time, care home providers performing regulated activities do not operate in a purely private sphere. By virtue of section 73 of the Care Act 2014, they are to be treated as public authorities for the purposes of section 6 of the Human Rights Act 1998. Restrictions on contact between a resident and her family therefore engage Article 8 of the Convention.

60. In addition, Regulation 9A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 imposes a positive obligation on providers, save in exceptional circumstances, to facilitate visits and to adopt the least restrictive measures that are necessary and proportionate to address identified risks. Compliance with that obligation is a matter subject to regulatory oversight by the Care Quality Commission.

61. A failure to comply with those obligations may expose a provider to regulatory action, including warning notices, conditions on registration and, in serious cases, suspension or cancellation of registration. The imposition of restrictions on contact, or

the use of the threat of eviction as a means of regulating the behaviour of family members, may therefore have significant regulatory consequences.

62. However, regulatory accountability does not equate to immediate unavailability of the placement. Unless and until regulatory action is taken, the placement remains either available or withdrawn as a matter of practical fact. The Court of Protection cannot assume future enforcement, nor can it compel a provider to continue a placement against its will on the basis that the regulator might intervene.

63. The court is therefore required to decide the case before it on the basis of present realities. In doing so, it is entitled to take into account evidence that insisting upon greater or differently-structured contact, contrary to the provider's stated position, would be likely to precipitate termination of the placement altogether.

64. That does not involve an abdication of the court's responsibility to scrutinise the proportionality of contact restrictions. Rather, it reflects an acknowledgement that the welfare jurisdiction operates within a wider legal and practical framework over which the court does not have direct control.

65. Nor does it render contact arrangements static or immune from future challenge. The court's tolerance of restrictive arrangements in circumstances of constrained choice is necessarily fact-sensitive and time-limited. Any diminution of contact beyond that authorised by the court, or any failure by the local authority to keep contact arrangements under active and meaningful review, would require careful scrutiny in future proceedings.

66. Equally, any material change in circumstances, whether a shift in the provider's position, the emergence of a realistic alternative placement, or the taking of regulatory action, may require the welfare balance to be revisited.

Applying that approach, HHJ Burrows found that the district judge was entitled to reach the conclusion that she did:

67. I do not accept that the judge abdicated her responsibility. She was clearly troubled by the limitations on contact and expressly encouraged the local authority to work towards increasing it, potentially with third-party supervision. She weighed the interference with family life against the real risk that imposing greater contact against the provider's position could destabilise PB's only available placement.

68. The District Judge did not disregard the Article 8 obligations. She was faced with evidence that, unless contact was restricted and supervised, the care home was likely to terminate PB's placement. The judge was entitled to treat that risk as real, whether or not the allegations underpinning it were disputed.

69. In those circumstances, the judge was required to choose between legally and practically available options. The Court of Protection has no power to compel a private provider to continue a placement against its will, nor to rewrite contractual arrangements. That limitation is well established.

70. The judge balanced:

- *the importance of contact between PB and SB;*
- *the interference with family life occasioned by supervision and limitation; and*

- *the materially greater harm that would likely result from the sudden loss of PB's only available placement.*

71. While the proportionality analysis could have been more fully articulated, it is apparent from the judgment read as a whole that the correct approach was applied. The restriction on contact was not treated as an end in itself, but as a contingent and time-limited measure adopted to preserve PB's residential stability. This Court will not intervene simply because a judgment might have been expressed differently. The question is whether the outcome was one the judge was entitled to reach.

72. In the circumstances of this case, where no alternative placement was available and the court was faced with a binary choice, I am satisfied that the judge was entitled to conclude that the maintenance of a stable placement was, for the time being, in PB's best interests, even at the cost of restricted contact.

73. That said, I emphasise that contact arrangements are not static. Section 21A reviews require ongoing vigilance. Any diminution of contact beyond that authorised by the court, or any failure by the local authority to keep contact under active review, would require careful scrutiny in future proceedings.

HHJ Burrows therefore granted permission – given the importance of the issue raised – but refused the appeal, although "*strongly enourag*[ing] *the local authority and the care provider to continue exploring ways of facilitating meaningful and dignified contact between PB and SB, consistent with PB's welfare and safety.*"

Comment

As set out at the outset, this decision serves as a very useful primer for those who are wanting to understand how and why the Court of Protection considers questions of contact in the care home context – and, in particular, the (distinctly depressing) extent to which it can find itself navigating a set of very constrained options, especially where private providers are involved. A 'full-spectrum' response to the issues raised in the media coverage [11] would therefore – ironically – have to include giving the Court of Protection more power.

11 In referring to this coverage, we should make clear that we are not saying that all of the situations identified there fall into the same category as that of PB's case. It is also the case that stress on families seeking to secure care can very easily and very quickly give rise to breakdowns of trust where that care is not (for whatever reason) available.

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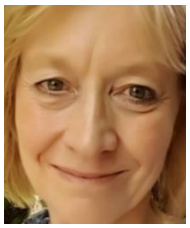

Jill Stavert: j.stavert@napier.ac.uk

Jill Stavert is Professor of Law, Director of the Centre for Mental Health and Capacity Law and Director of Research, The Business School, Edinburgh Napier University. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee. She has undertaken work for the Mental Welfare Commission for Scotland (including its 2015 updated guidance on Deprivation of Liberty). To view full CV click here.

Conferences

Members of the Court of Protection team regularly present at seminars and webinars arranged both by Chambers and by others.

Alex also does a regular series of 'shedinars,' including capacity fundamentals and 'in conversation with' those who can bring light to bear upon capacity in practice. They can be found on his website.

Advertising conferences and training events

If you would like your conference or training event to be included in this section in a subsequent issue, please contact one of the editors. Save for those conferences or training events that are run by non-profit bodies, we would invite a donation of £200 to be made to the dementia charity My Life Films in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Our next edition will be out in July. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

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