

Chapter 3

Liberty Safeguards

Chapter 3 – Liberty Safeguards

Chapter 3 is in four sections:

- A. The human rights framework for assessing whether a person who lacks capacity is deprived of their liberty.
- B. The case law in England and under the European Convention on Human Rights (ECHR) that exposed the “Bournewood gap” and led to the development of the Deprivation of Liberty Safeguards (DoLS).
- C. Identifying the Bournewood gap in New Zealand.
- D. Options for law reform to “plug the gap” with legal safeguards for deprivations of liberty – referred to in the recommendations in this report as “liberty safeguards”.

Introduction

- 3.1 The major legal issue that emerged from reform of the English mental capacity law has been the need to provide legal protections for people who both lack capacity to consent or object to their healthcare and living arrangements, and are effectively detained. Detention that affects the liberty of people who lack capacity (referred to as “deprivations of liberty” in human rights conventions) is concerned with the fundamental human right not to be arbitrarily detained. Such liberty rights are guaranteed by the International Covenant on Civil and Political Rights 1966 (ICCPR),³⁸⁰ the United Nations Convention on the Rights of Persons with Disabilities (CRPD),³⁸¹ the European Convention on Human Rights (ECHR),³⁸² and the New Zealand Bill of Rights Act 1990 (NZBORA), as well as having long been protected by the common law.
- 3.2 People who lack capacity may face substantial restrictions on their liberty and freedom of movement, not only when they receive treatment in a secure hospital unit, but also when they live in a residential care facility or in supported living arrangements in the community. Liberty and freedom of movement are values of fundamental importance in our society, yet currently in New Zealand there is no guaranteed legal process governing this loss of liberty for people who lack capacity. There is a process for people detained in psychiatric facilities under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MH(CAT) Act), some of whom may lack capacity. However, there is no guaranteed process for reviewing the need for detention of other people who may be detained in a range of healthcare and living environments, who are not subject to involuntary treatment under the mental health legislation.

³⁸⁰ ICCPR, art 9. The NZBORA expressly affirms New Zealand’s commitment to the ICCPR and requires all statutes to be construed consistently with these rights if possible.

³⁸¹ CRPD, art 14. The main international human rights instruments to which New Zealand is a party that are relevant to mental capacity law are referred to in Chapter 2A. The key provisions of the CRPD, ICCPR and the ECHR are set out in Appendix C.

³⁸² European Convention on Human Rights (opened for signature 4 November 1950, entered into force 3 September 1953) (“European Convention” or “ECHR”), art 5.

- 3.3 The House of Lords' decision in the *Bournewood* case in 1999,³⁸³ and the decision of the European Court of Human Rights (ECtHR) in *HL v United Kingdom* in 2004,³⁸⁴ exposed a gap in the legal protections that cover the detention of compliant people who lack the capacity to object, which became known as the "Bournewood gap". In *HL v United Kingdom*, the ECtHR found that a man who had been informally admitted to a psychiatric hospital in England had been deprived of his liberty when the staff exercised complete control over his freedom of movement. This deprivation of liberty was not "lawful" and breached art 5(1) of the ECHR as there was inadequate protection against the arbitrariness of his informal admission. Article 5(4) of the ECHR therefore required that he have guaranteed access to an independent review process concerning the lawfulness of his detention.
- 3.4 In 2007, the UK Parliament responded to this decision – so closing the Bournewood gap – by amending the Mental Capacity Act 2005 to create the Deprivation of Liberty Safeguards (DoLS) regime.³⁸⁵ This was intended to create a suitable process governing such deprivations of liberty. It would only be mandatory to follow this process, however, when a person was deprived of their liberty in terms of art 5(1) of the ECHR.³⁸⁶ Then the decision of the United Kingdom Supreme Court, in *Cheshire West*³⁸⁷ in March 2014, gave a broad interpretation to the range of situations in which people were to be viewed as deprived of liberty under the MCA. This meant that the process required by DoLS would have to be applied to many more people in care homes and hospitals, as well as in community settings such as foster care placements.³⁸⁸
- 3.5 In view of these significant developments, which almost paralysed the operation of these safeguards under the mental capacity law in England, it is surprising how little attention has been given to this issue in New Zealand – in regards to detention of people who lack capacity but are not under the MH(CAT) Act.³⁸⁹ The Bournewood gap and the ongoing developments in England raise important questions for New Zealand about the positive obligations on the State to provide oversight and legal protections for those who lack capacity and are effectively detained, independent of the standard of care or quality of living arrangements provided to them. Or, to put it another way: in the absence of legal safeguards, is there a significant gap in our law to protect detained people who lack capacity, where the State is involved with the provision of their health and social care? If so, how should New Zealand fill this gap in a review of its law?
- 3.6 Many people who lack capacity to make decisions about their accommodation arrangements – either those in residential care or those who are about to be discharged from hospital and admitted into care – have made no legal provision anticipating their loss of capacity. So they do not have a legally authorised person appointed under an enduring power of attorney

³⁸³ *Bournewood*, above n 5.

³⁸⁴ *HL v United Kingdom*, above n 4.

³⁸⁵ MCA, ss 4A and 4B, Schedules 1A and A1. The new legislative scheme was inserted into the Mental Capacity Act 2005 (England and Wales) by the Mental Health Act 2007, which came into effect in 2009. See Chapter IC summary of ongoing law reform.

³⁸⁶ Section 65(4) of the Mental Capacity Act provides: "In this Act, references to deprivation of a person's liberty have the same meaning as in Article 5(1) of the Human Rights Convention".

³⁸⁷ Above n 7.

³⁸⁸ The *Bournewood* case, *Cheshire West* and the Deprivation of Liberty Safeguards are discussed in more detail below.

³⁸⁹ J Dawson "The Law of Emergency Psychiatric Detention" (1999) 2 New Zealand Law Review 275-303; A Douglass "Implications of the Treatment of Incompetent and Vulnerable Patients" (presentation to the Medical Law Conference, Wellington, 18 April 2011); A Martin "Who Decides in Hard Cases? The Boundaries of Competency and Consent" (presentation to HDC Medico-Legal Conference, Wellington, 18 October 2012); S Nightingale and I Reuvecamp "Regulating the Detention of Mentally Incapacitated Adults Not Subject to the Mental Health Act" in Dawson and Gledhill, above n 92 at 163.

(EPOA), or an appointed welfare guardian, who has the power to consent or object to decisions authorising their detention in relation to their living arrangements. Even if they do, or if court orders are obtained, the PPPR Act is not designed to provide ongoing oversight of their detention or restrictions on their liberty.

- 3.7 Where, in such situations, there is no-one to act on behalf of a person who lacks capacity, healthcare providers in New Zealand are often reliant upon the common law doctrine of necessity, expressed through Right 7(4) of the HDC Code, to provide a legal justification for their confinement. This justification is based on the assumption that decisions about the effective detention of a person who lacks capacity can simply be made in their best interests by healthcare professionals, without any independent oversight of those decisions being required – an assumption that has been rejected by the ECtHR.
- 3.8 The rights restricted by deprivation of liberty highlight the vulnerability of people who lack capacity and who are at risk of abuse, neglect and exploitation.³⁹⁰ There are also legal risks for those working in the health and disability sector. These concern the extent to which providers of health and disability services might breach their duty of care to people by detaining them without legal authority or, indeed, for not detaining them when it is required to provide them with adequate care (including potentially breach of statutory objectives or duties),³⁹¹ the prospect of criminal liability for insufficient care,³⁹² and the potential for breach of professional standards.³⁹³ Importantly, the lack of safeguards against deprivation of liberty poses practical and ethical challenges for people who work with this vulnerable group and recognise that the current legal framework is inadequate to best promote and protect the autonomy of those for whom they care.³⁹⁴
- 3.9 This chapter sets out the human rights framework for assessing when a person who lacks capacity has been deprived of their liberty, and for giving effect to the central guarantee that any detention should not be arbitrary. It outlines the meaning of the Bournemouth gap, the effect of the DoLS regime, and subsequent case law in England under the MCA and the ECHR. Then it identifies the existence of a similar gap within New Zealand’s legal framework and the problems encountered in practice due to the lack of adequate protections for people in these circumstances. It identifies the reasons why New Zealand should “plug the gap” and recommends the development of appropriate legal safeguards.

³⁹⁰ See for example, T Baker “Legal Protections and Remedies for Elder Abuse, Neglect and Exploitation” in Diesfeld and McIntosh, above n 228 at 477.

³⁹¹ See for example, ss 22 and 23 of the New Zealand Public Health and Disability Act 2000. The objectives and functions of DHBs include: “to promote effective care or support for those in need of personal health or disability support services” and “to promote the inclusion and participation in society and independence of people with disabilities”, and “to monitor the delivery and performance of services.”

³⁹² See for example, Crimes Act offences: s 151 - a duty in respect of vulnerable adults to provide necessities and protect from injury; s 195 - ill-treatment or neglect of child or vulnerable adult; and s 195A - a failure to protect a child or vulnerable adult.

³⁹³ This chapter highlights some of these legal risks however its focus is on the legal protection needed for people who lack capacity and is not an analysis of the civil and criminal liability of public (DHBs) and private providers (residential care facilities, for example). Chapter 1B provides an overview of the relevant laws in New Zealand.

³⁹⁴ More than any other aspect of this legal research project, the inadequacies of Right 7(4) of the HDC Code as a safeguard and the difficulties with the using the court process under the PPPR Act for the placement and living arrangements of people who lack capacity, have been raised with the writer.

3A: THE HUMAN RIGHTS FRAMEWORK

Liberty and the right not to be arbitrarily detained

- 3.10 Liberty and the right to be free from arbitrary detention is guaranteed in both New Zealand law (under legislation and the common law), as well as in the main international human rights instruments to which New Zealand is a party.³⁹⁵ Sections 21–23 of the NZBORA, art 9 of the ICCPR, and art 14 of the CRPD express the right to liberty or the right to not be arbitrarily detained (sometimes referred to as habeas corpus rights) in a very similar fashion.³⁹⁶
- 3.11 Section 22 of the NZBORA plainly says that “Everyone has the right not to be arbitrarily arrested or detained”. The purpose of this right is to ensure that no person is subject to the constraints and ill effects that are associated with detention other than in accordance with the law.³⁹⁷ There are several accompanying rights in the NZBORA,³⁹⁸ including the right to have the validity of one’s detention determined without delay by way of habeas corpus, and the right to immediate release if one’s detention is unlawful.³⁹⁹ These rights under section 3 of the NZBORA must be respected by anyone exercising a “public function”, and would include District Health Boards (DHBs) as well as private rest homes and mental health facilities that receive public funding.⁴⁰⁰
- 3.12 Article 5(1) of the ECHR is similar to the rights expressed in the NZBORA. It is also similar to art 14 of the CRPD,⁴⁰¹ which both New Zealand and the UK have ratified.⁴⁰² Therefore, the case law from the ECtHR will be influential in New Zealand. Article 14 of the CRPD provides:

³⁹⁵ The main international human rights instruments to which New Zealand is a party that are relevant to mental capacity law are set out in Chapter 2. These include the ICCPR, the ICESCR and the CRPD.

³⁹⁶ The New Zealand Bill of Rights Act 1990 (NZBORA) expressly affirms New Zealand’s commitment to the ICCPR.

³⁹⁷ A Butler, P Butler *New Zealand Bill of Rights Act: A Commentary* (LexisNexis, Wellington, 2015) at 1088.

³⁹⁸ The following rights in the NZBORA are also relevant to placement of people into care or detention and their deprivation of liberty: s 11 the right to refuse to undergo medical treatment; s 17 freedom of association; s 18 freedom of movement and residence; s 19 - freedom from discrimination; s 23 associated procedural rights. For a review of applicable rights under the MH(CAT) Act, see K Gledhill, “A “Rights” Audit of the Mental Health Act”, in Dawson and Gledhill, above n 92 at 285.

³⁹⁹ NZBORA, s 23(1)(c). The NZBORA rights are subject to reasonable and justifiable limitations, including those prescribed by law: NZBORA, s 5. Whenever legislation can be given a meaning that is consistent with the rights and freedoms contained in the NZBORA, that meaning is to be preferred: NZBORA, s 6.

⁴⁰⁰ NZBORA s 3(a) confirms the Rights in the Act apply only to acts done by the State, or 3(b) “by any person or body in the performance of any public function, power, or duty conferred or imposed on that person or body”. The Crown Entities Act 2004, s 7 includes DHBs in its schedule of public entities. Added to this, Right 4 of the HDC Code requires health and disability services to be of an “appropriate standard of care”, in a manner appropriate to a person’s needs, that optimises their quality of life and with cooperation between providers.

⁴⁰¹ Article 5(1)(e) of the European Convention specifically allows detention for those of “unsound mind”, provided it is lawful and there is a necessity test based on adequate evidence of mental disorder: *Winterwerp v The Netherlands* (1979) 2 EHRR 387. These same criteria are not present in Article 14(1)(b) of the CRPD so to this extent art 5(1)(e) is inconsistent with art 14 of the CRPD: Gledhill, above n 398 at 292. See also P Fennel and U Khaliq, “Conflicting or complementary obligations? The UN Disability Rights Convention on Human Rights and English law” (2011) *Eur Hum Rights Rev*.

⁴⁰² New Zealand also has in common with the UK that it is a party to both the ICCPR, as expressly recognised in the New Zealand Bill of Rights Act 1990 (NZBORA), and the CRPD. See discussion on applicable international human rights treaties in Chapter 2 Supported Decision-making.

Article 14 – Liberty and security of the person

1. States Parties shall ensure that persons with disabilities, on an equal basis with others:
 - (a) Enjoy the right to liberty and security of person;
 - (b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.
2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation.⁴⁰³

3.13 Article 14 of the CRPD is specifically concerned with liberty rights. In addition, art 19 provides the right to live independently and be included in the community. The UN Committee has identified the detention of people with disabilities without their consent (or with the consent of a substitute decision-maker) as a form of “arbitrary deprivation of liberty” that violates articles 12 and 14 of the CRPD, requiring State parties to refrain from such practices and to establish a mechanism to review existing cases.⁴⁰⁴

3.14 A prevailing theme in all of these human rights instruments is that any limit on liberty should be the least restrictive to achieve its purpose.⁴⁰⁵ Statutes and common law rights that protect liberty should therefore be read with these rights in mind.

3.15 Statutes can also authorise deprivations of liberty of people with impaired capacity in the health and disability setting in situations where the detention is “prescribed by law”. The MH(CAT) Act for example, provides for involuntary treatment and detention of some people with a mental disorder, and the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act) also authorises detention of people with intellectual disability who commit criminal offences.⁴⁰⁶ The significance of these laws is that they have accompanying procedural safeguards to protect the interests of people subject to them. However, there are many people with impaired capacity who may be detained in similar health and disability settings – for example, “informal” patients on psychiatric wards – who are not subject to those laws and therefore do not have the benefit of those procedural safeguards.

⁴⁰³ The concept of “reasonable accommodation” means that modifications are to be made to achieve equal protection unless they impose a disproportionate burden. K Gledhill “The Filling of the Bournemouth gap” in McSherry and Freckleton, above n 102 at 115.

⁴⁰⁴ UN Committee, above n 242 at [40]. In this respect, the UN Committee is particularly concerned with involuntary detention in psychiatric institutions and does not appear to contemplate detention of people with impaired capacity living in supported living arrangements in the community.

⁴⁰⁵ The least restrictive intervention is also one of the primary objectives of the PPPR Act, s 8(a).

⁴⁰⁶ See Chapter 1B for an overview of the MH(CAT) Act and the IDCCR Act. A summary of the MH(CAT) Act safeguards are set out below.

Common law – habeas corpus and false imprisonment

- 3.16 The right to review the lawfulness of any deprivation of liberty has long been recognised under the common law.⁴⁰⁷ Both an application for a writ of habeas corpus and the action for false imprisonment allow people to test the lawfulness of their confinement and they provide remedies when a person is unlawfully deprived of their liberty.
- 3.17 Habeas corpus has traditionally been available to secure the release of a person confined by any person or statutory body. Recently, habeas corpus applications in the High Court have been based on allegations that people subject to care and welfare orders under the PPPR Act have been unlawfully deprived of their liberty by their appointed welfare guardian.⁴⁰⁸ While the Family Court, not the High Court, is the proper forum for these cases, they may indicate that there is not an adequate process under the PPPR Act itself to identify and monitor such deprivations of liberty.⁴⁰⁹
- 3.18 The habeas corpus procedure is designed for clear cases of unlawful detention and is less suitable for cases requiring detailed legal or factual analysis due to the swiftness of its procedure.⁴¹⁰ In these cases, proceedings in false imprisonment, or an application for judicial review (where those involved are performing a public function) would be more suitable.⁴¹¹ Habeas corpus is also not available where the detained person has appeal rights that have not been exhausted.⁴¹²
- 3.19 The tort of false imprisonment, a civil wrong, is committed when one person is detained or imprisoned by another person acting without lawful justification.⁴¹³ There must be total and intentional restraint by physical means, or by other means (such as coercion, threats, or claims of authority) that cause the person to submit to deprivation of their liberty.⁴¹⁴
- 3.20 A person falsely imprisoned can seek a declaration that their detention is unlawful, or seek damages from the person or body responsible, and such proceedings can be brought against private individuals, not only against public bodies.⁴¹⁵ In *ZH v Commissioner of Police for the Metropolis*,⁴¹⁶ the English Court of Appeal upheld a decision to award damages for psychological trauma where the police – without lawful authority – forcibly removed a young man with severe autism and learning disabilities from a swimming pool and subsequently

⁴⁰⁷ *Chief Executive of the Department of Labour v Yadegary* [2001] 2 NZLR 495 (CA) at [44]. New Zealand Courts have recognised the presumption in law in favour of liberty - *in favorem libertatis*. In the Supreme Court decision: *Zaoui v Attorney General* [2005] 1 NZLR 577 at 650 [52] “And it is of prime importance that any powers of detention be approached in light of the fundamental right, long recognised under the common law, of liberty for all persons subject only to such limits as are imposed by law.”

⁴⁰⁸ *E v E*, above n 63. See also *JDEB & ors v JAB & RHB and MAB*, above n 63, following an unsuccessful writ of habeas corpus in the High Court.

⁴⁰⁹ There has been a successful habeas corpus case in Victoria, Australia. In *Antunovic v Dawson* [2010] VSC 377, it was held that Mrs Antunovic had been unlawfully restrained and the Court ordered her release, even though she had not been subject to any physical restraint. The Court accepted her evidence that she felt that she was unable to leave the premises at which she was residing without the permission of her psychiatrist.

⁴¹⁰ *N and N v CEO of CMDHB* [2016] NZHC 277, Thomas J at [18].

⁴¹¹ Habeas Corpus Act 2001, s 14(1A)(b). *Manuel v Superintendent Hawkes Bay Prison* [2005] 1 NZLR 16 (CA).

⁴¹² *E v E*, above n 63 at [48] and *T v Regional Intellectual Care Agency* [2007] NZCA 208.

⁴¹³ S Todd and J Hughes *The Law of Torts in New Zealand* (5th ed, Brookers/Thomson Reuters, Wellington, 2009) Chapter 4 Trespass to person.

⁴¹⁴ JG Fleming *The Law of Torts* (9th ed, LBC Information Services North Ryde NSW, 1998) at 33–37.

⁴¹⁵ Law Society *Identifying a Deprivation of Liberty: a practical guide* (2015) <http://www.lawsociety.org.uk> at 23.

⁴¹⁶ [2012] EWHC 604 (Admin), upheld in the English Court of Appeal, [2013] EWCA Civ 69.

physically restrained him and detained him in a police van. The police did so without consulting his carers, informing themselves of the nature of his disabilities, or considering less restrictive options.⁴¹⁷

3.21 However, in the *Bournemouth* case, discussed below, the ECtHR rejected the idea that the common law actions of habeas corpus and false imprisonment – that have to be initiated by or on behalf of a disabled person – provided adequate remedies (or an adequate review process) for deprivations of liberty under the ECHR. A more accessible review process was required.

Arbitrary detention – legal principles

3.22 A common set of legal principles concerning the meaning of “arbitrary detention” can be drawn from cases interpreting these liberty rights in both domestic and international courts and tribunals. In particular, extensive case law on the interpretation of Article 5(1) of the ECHR has been developed by the ECtHR. This establishes very similar principles to those expounded by the New Zealand courts interpreting the NZBORA.⁴¹⁸

3.23 In summary, the key elements of the right not to be arbitrarily detained are:

- a distinction is made between mere “restrictions” on liberty and “deprivations” of liberty that reach the threshold of “detention”: the difference between the two is one of intensity;⁴¹⁹
- any detention must clearly be authorised or justified by law;⁴²⁰ the concept of arbitrariness is broader than unlawfulness;⁴²¹ and “arbitrary” has been defined as “inappropriate, unpredictable or disproportionate”;⁴²²
- although lawful at the outset the detention may become unreasonable and arbitrary by virtue of indefinite or prolonged duration or disproportionate consequences;⁴²³
- the aim is to *prevent* arbitrary detention occurring, so legal safeguards against deprivation of liberty should operate prospectively, not retrospectively;⁴²⁴
- laws authorising detention must be written so as to provide meaningful standards by which a person can know whether their detention is lawful; and

⁴¹⁷ The Court awarded £28,000 in damages and held that the provisions of the MCA and use of restraint under s 6, are specifically designed to provide specified express pre-conditions for those dealing with people who lack capacity. Section 6 of the MCA imposes two important limitations on the acts which can be carried out with protection from liability under s 5. Firstly, the person using it must reasonably believe that it is necessary to do the act in order to prevent harm to the person lacking capacity; and secondly, the restraint used must be a proportionate response both to the likelihood of a person suffering harm and the seriousness of the harm.

⁴¹⁸ Butler and Butler, above n 397 at 1088.

⁴¹⁹ *Austin v United Kingdom* (2012) 55 EHRR 14 (ECtHR,GC) at [57]. The approach under the NZBORA is similar to that adopted by the ECtHR, which considers a range of factors relating to the alleged detention, and then evaluates whether there has been a mere “restriction” on liberty or a “deprivation” that reaches the threshold of “detention”: Butler and Butler, above n 397 at 1091.

⁴²⁰ In a case involving interpretation of the Mental Health Act 1969, the High Court held that the Act must be interpreted in accordance with s 22 NZBORA; when a person is detained otherwise than in accordance with the law or principles which the law regards as appropriate for regulating a discretion, that detention will be deemed arbitrary: *Re M* [1992] NZLR 29 Gallen J.

⁴²¹ *Manga v Attorney-General* [2002] NZLR 65 at [44], Hammond J at [40].

⁴²² *Zaoui* above n 407 at [100].

⁴²³ *Zaoui* above n 407 at [175].

⁴²⁴ In this sense, the law is prophylactic: Butler and Butler, above n 397 at 1088.

- there must be speedy access to a court or tribunal (or other suitable process) that is sufficiently independent of the organisation responsible for the person's detention and is capable of directing the person's release.⁴²⁵

3.24 A key question is, therefore, whether New Zealand law currently meets these standards where the person detained lacks capacity. Before considering that question further, it is appropriate to consider the case law under the MCA, developed in light of the European Convention, and the steps taken in England to provide procedural safeguards for detained people who lack capacity, under the DoLS regime. As a result of these developments under the MCA, there is much greater clarity regarding situations in which there is a deprivation of liberty, and the kind of legal safeguards required.

3B: THE BOURNEWOOD GAP

The *Bournewood* case in the House of Lords

3.25 The *Bournewood* case arose in 1997, after HL, a 48-year-old man, was informally admitted to and detained at Bournewood Hospital in England. HL had suffered from autism and significant learning disabilities since birth, and he lacked capacity to consent or object to his medical treatment. Some years earlier, after 32 years living in Bournewood Hospital, he had been discharged to live with paid carers (or a paid foster family), with whom he lived for three years. Following an incident in which he became agitated at a day-care centre, HL was sedated and taken back to the Bournewood Hospital. No statutory authority was invoked for HL's "informal" admission to the hospital at this time, because the practice was not to use statutory powers when a person in his position was not resisting the arrangements.⁴²⁶ HL's former carers, who disagreed with the arrangements made for him at Bournewood Hospital, filed a claim on his behalf for a writ of habeas corpus and damages for false imprisonment.

3.26 In the High Court the claim was unsuccessful; however, the decision was overturned in the Court of Appeal.⁴²⁷ On further appeal, in a unanimous decision by the House of Lords, it was held that any actions taken by the hospital staff to detain HL that might otherwise have constituted an invasion of his rights, were justified on the basis of the common law doctrine of necessity.⁴²⁸ Moreover, a majority of three of the five Law Lords held that HL had not been detained at all during the later stages of his treatment at the hospital, when he had stayed on an unlocked ward and had made no attempt to leave.

3.27 Lord Goff, for the majority, held that any question of detention of HL during the later stages of his treatment would have arisen only if he had attempted to leave the hospital and been prevented from doing so, which he did not do. The two Law Lords in the minority considered, however, that HL had been detained, because: he was sedated both to get him to the hospital

⁴²⁵ European Convention on Human Rights, art 5(4); New Zealand Bill of Rights Act 1990, s 23(1)(c).

⁴²⁶ Section 131(1) of the Mental Health Act 1983 (UK) preserved the common law principle of necessity as a justification for informally receiving in hospital or mental nursing homes compliant incapacitated patients.

⁴²⁷ *Bournewood* above n 5; [1998] 2 WLR 764, CA. On the day of its decision HL was then "sectioned" under the Mental Health Act. He was released to his carers five weeks later and formally discharged a week after that. Meanwhile the hospital appealed to the House of Lords.

⁴²⁸ *R v Bournewood Community and Mental Health NHS Trust, Ex p. L* [1998] All ER 289 at 299, Lord Goff. The common law power to detain and restrain patients who lack capacity to decide where to live where detention is necessary and in their own best interests: *Re F* [1990] 1 AC 2 applied.

and while he was there; he would have been “sectioned” under the MHA if he had tried to leave; his carers were at first prohibited from visiting him in case he wanted to leave with them; and the hospital was not prepared to release him back into the care of his carers until they thought him ready to leave. This amounted to complete and effective control by the staff over his freedom of movement, and was therefore “detention”.

- 3.28 Despite the Law Lords’ unanimous decision that, even if HL had been detained, this would have been justified under the common law doctrine of necessity, Lord Steyn identified the existence of a lacuna in the law. This has come to be known as “the Bournemouth gap”:⁴²⁹

The common law principle of necessity is a useful concept but it contains none of the safeguards of the 1983 Act. It places effective and unqualified control in the hands of hospital psychiatrists. ... [N]either habeas corpus nor judicial review are sufficient safeguards against misjudgements and professional lapses in the case of compliant incapacitated patients. ... The result would be an *indefensible gap* in our mental health law. ... The suggestion that HL was free to go is a fairytale. [Emphasis added]

- 3.29 It is therefore the absence of *procedural* “safeguards”, rather than the absence of any *criteria* governing the person’s effective detention, that is the feature of the “gap”. The criteria for lawful detention were provided by the common law principle of necessity, but there was no readily accessible procedure for reviewing that detention.

- 3.30 An application was then lodged on HL’s behalf with the European Court of Human Rights (ECtHR) effectively challenging the decision of the majority of House of Lords that HL was not detained in these circumstances, and challenging the notion that his detention would be lawful – under the doctrine of necessity – when no adequate process existed for its independent review.

European Court of Human Rights decision – *HL v United Kingdom*

- 3.31 In *HL v United Kingdom*,⁴³⁰ the ECtHR then held that during the later stages of his admission to Bournemouth Hospital, HL was deprived of his liberty (as the European Convention puts it), and his subsequent detention was a violation of Article 5(1) of the ECHR as it was not “in accordance with a procedure prescribed by law”.⁴³¹ The Court held that the use of the common law doctrine of necessity to detain compliant people who lacked capacity to object to their detention, rather than using the Mental Health Act 1983, was not adequate to protect people against the risk of arbitrary detention. The relevant parts of art 5(1) provide that:

Everyone has the right to liberty and security of person. No one should be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law.

- 3.32 One of “the following cases” encompassed by art 5(1), covers – and permits – “the lawful detention ... of persons of unsound mind”.⁴³² To be lawful, under the Convention, however, such detention must also be “in accordance with a procedure prescribed by law”.⁴³³ Overall,

⁴²⁹ Bournemouth, above n 5 at 493 and 495.

⁴³⁰ Above n 4.

⁴³¹ European Convention on Human Rights, art 5(1).

⁴³² European Convention on Human Rights, art 5(1)(e). In *Winterwerp v the Netherlands* (1979) 2 EHRR 387, the ECtHR held that the need for “lawful” detention imports the need for both substantive and procedural safeguards.

⁴³³ European Convention, art 5(1).

therefore, in determining if HL had been unlawfully deprived of his liberty, the ECtHR had to consider three issues: Was HL detained? Was he of unsound mind? And was his detention unlawful because it was not “in accordance with a procedure prescribed by law”?

- 3.33 The ECtHR found that HL was detained because the healthcare professionals treating and managing him “exercised complete and effective control over his care and movements”.⁴³⁴ In effect, they agreed on this matter with the minority judges in the House of Lords. They said HL “was under continuous supervision and control and was not free to leave”. The Court accepted, however, that HL was “of unsound mind”. His detention could therefore be authorised by law.
- 3.34 So the remaining question was whether his detention was lawful. The ECtHR emphasised that the essential objective of art 5(1) was “to prevent individuals being deprived of their liberty in an arbitrary fashion”.⁴³⁵ This required the “existence in domestic law of adequate legal protections” and “fair and proper procedures”.⁴³⁶ English law did not provide this and so HL’s detention was unlawful – in effect, because English law provided insufficient procedural safeguards against arbitrary detention of a person in his situation.⁴³⁷
- 3.35 The ECtHR also held that there had been a breach of HL’s art 5(4) right to a speedy review of the lawfulness of his detention. Article 5(4) provides that:
- Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.
- 3.36 The requirements of art 5(4) were not satisfied merely by the availability of habeas corpus or judicial review proceedings. They would have to be triggered by some person on HL’s behalf, and were reactive and not readily accessible.⁴³⁸

Response to the “Bournewood gap” under the Mental Capacity Act

- 3.37 This decision of the ECtHR in *HL v United Kingdom* was highly significant in 2004 and remains so.⁴³⁹ Around the same time, the UK Parliament was poised to enact the MCA, which would address a wide range of legal arrangements for people who lacked capacity. The ECtHR’s decision in *HL v United Kingdom* did not prevent the passage of this legislation but, as originally passed in 2005, the MCA contained no provisions to close the “Bournewood gap”. The *HL* decision of the ECtHR meant, however, that, in the absence of adequate legal provisions, there was now a large group of people in England who were being deprived of their liberty contrary to art 5(1) of the European Convention.⁴⁴⁰

⁴³⁴ *HL v United Kingdom*, above n 4 at 799.

⁴³⁵ *Ibid.*

⁴³⁶ *Ibid.*

⁴³⁷ The ECtHR emphasised the lack of fixed rules for the admission and detention of compliant people and the strong contrast with the extensive network of safeguards for involuntary patients under the Mental Health Act 1983 (UK), *HL v United Kingdom*, above n 4 at 770.

⁴³⁸ *HL v United Kingdom* above n 4 at 804.

⁴³⁹ As early as 1985 the Mental Health Act Commission in England recognised this problem and asked for its remit to be extended to what would also be called “de facto detained patients”, G Richardson “*R v Bournewood Community and Mental Health Trust, ex parte L [1999]: Bournewood 15 Years On*” in J Herring and J Wall *Landmark Cases in Medical Law* (Hart Publishing, Oxford, 2015) at 129.

⁴⁴⁰ In a submission to the House of Lords, the Mental Health Act Commission estimated there were at that time, 48,000 “informal” admissions to hospital each year of people who lacked capacity and had

3.38 The UK Government was therefore forced to respond. It previously had no “Plan B” as it was confident of winning the case in the ECtHR and that the Court would find there had been no deprivation of liberty.⁴⁴¹ The ECtHR’s conclusion, that detention under the common law principle of necessity failed to meet the requirements of art 5(1) due to the absence of adequate review process, therefore required the Government to make fairly radical reforms to the law, for which it was unprepared.⁴⁴²

Deprivation of Liberty Safeguards (DoLS)

3.39 In its original form, the MCA gave all kinds of carers a general authority to act in the best interests of an incapacitated person, but that authority did not extend to depriving a person of their liberty.⁴⁴³ The response of the UK Government to the *HL* decision was to enact a 2007 amendment to the MCA, combined with a supplementary Code of Practice that came into force in April 2009.⁴⁴⁴ These reforms introduced the Deprivation of Liberty Safeguards, otherwise known as DoLS, to remedy the breaches of the European Convention.⁴⁴⁵

3.40 The DoLS seek to ensure the identification and better protection of people who lack capacity and are, or may be, deprived of their liberty in a hospital or care home. They require the decision to deprive the person of liberty to be externally reviewed and authorised, even if the person is not actively seeking to leave their care arrangements.⁴⁴⁶ They apply on the whole to older people and people with disabilities who lack capacity. They require a hospital or care home⁴⁴⁷ to apply to the local authority⁴⁴⁸ for express authorisation of a deprivation of liberty.⁴⁴⁹ If a person’s right to liberty needs to be infringed in other settings, authorisation must be sought from the COP.

3.41 Once a potential deprivation of liberty is identified, health and care professionals are required to conduct no less than six assessments, involving a minimum of two assessors (including a best interests assessor and a mental health assessor), to see if each of the six “qualifying requirements” under the DoLS regime are met.⁴⁵⁰ In very broad terms, these assessors must

restriction on their liberty. They also estimated that in anyone day there were 22,000 informal patients who lacked capacity compared to 13,000 patient detained under the MHA. Richardson, above n 439 at 130-131.

⁴⁴¹ Richardson, above n 439 at 135.

⁴⁴² Had the non-compliance been restricted to art 5(4), the introduction of an adequate mechanism for review might have been sufficient, but the decision found the entire process of admission to be unlawful. Richardson, above n 439 at 134.

⁴⁴³ Under the MCA, the common law doctrine of necessity was codified under s 5 and authority for the use of restraint in s 6.

⁴⁴⁴ *Mental Capacity Act 2005: Code of Practice*, above n 164.

⁴⁴⁵ Sections 5 and 6 of the MCA were insufficient as they provided a defence to battery rather than prescribed a procedure and therefore did not meet the requirements of Article 5(1)(e) of the Act. Section 4A of the MCA prohibits the deprivation of liberty of a person under the Act other than where the court has made an order under s 16(2)(a); where it is authorised for a life sustaining or emergency treatment: s 4B; or where the deprivation is authorised under the procedure set out in Schedules A1 and 1A, otherwise known as DoLS.

⁴⁴⁶ The DoLS fall into two categories - those that operate during the process for the issue of authorisation, and those that apply once an authorisation is in place.

⁴⁴⁷ The managing authority of hospitals and care homes is usually the NHS body responsible for the running of the hospital in which the relevant person is, or is to be, a resident.

⁴⁴⁸ The supervisory body of hospitals and care homes is a Primary Care trust, or a local authority.

⁴⁴⁹ There is a duty on the managing authority of the hospital and care home to apply for a standard authorisation from its supervisory body to detain the person. *Mental Capacity Act 2005*, c 9 Sch A1 [13] – [20]. The duty also applies if a standard authorisation is in force and there is to be a change in the place of detention: at [25].

⁴⁵⁰ The six qualifying requirements are: age (18 or older), mental health (mental disorder under MHA), mental capacity, (person lacks capacity) best interests (assessment includes needs and care plan, views

ascertain if a person lacks capacity to make decisions about their accommodation and whether it is in their best interests to be deprived of their liberty.⁴⁵¹

- 3.42 When, following those procedures, a standard⁴⁵² (or urgent)⁴⁵³ authorisation is then issued by a local authority, the decision can still be challenged through an administrative review procedure or in the COP.

Cheshire West – broadening the circumstances in which the procedural safeguards are required

- 3.43 Subsequently, in March 2014, the UK Supreme Court delivered its judgment in two cases known as *Cheshire West*.⁴⁵⁴ There were two appeals: one called *P v Cheshire West and Cheshire Council*, the other *P and Q v Surrey County Council*, though the composite decision is usually referred to as *Cheshire West*. This decision gave an expanded interpretation to the concept of deprivation of liberty under the MCA, so that it covered many more people in care homes and hospitals, as well as in community settings such as foster care placements, than had previously been understood. The legal test the Court applied – for when safeguards are needed – is referred to as the “acid test”.⁴⁵⁵ This test is met when an individual is under the continuous supervision and control of those caring for them *and* is not free to leave. In these circumstances they are deprived of their liberty in terms of art 5(1) of the ECHR.
- 3.44 The *Surrey* arm of the appeal concerned P and Q (otherwise known as MIG and MEG). They are sisters with learning disabilities. MIG was placed with a foster mother to whom she was devoted. She never attempted to leave the foster home by herself but would have been restrained from doing so had she tried. MEG lived in a residential home for learning disabled adolescents with complex needs.
- 3.45 The *Cheshire* arm of the appeal concerned P who has cerebral palsy and Down syndrome and requires 24-hour care. Until P was 37 years old he had lived with his mother, but when her health deteriorated, the local authority obtained orders from the COP that it was in his best interests to live in accommodation arranged by it. They placed him in a situation of one-to-one support that enables him to leave the house where he lives with other residents, but forcible intervention is sometimes required when he exhibits challenging behaviour.
- 3.46 In a decision by the majority, the Supreme Court held that all three of these people – MIG, MEG and P – were deprived of their liberty, in their respective settings.⁴⁵⁶ Their circumstances met the “acid test”. The fact that the living arrangements were comfortable and made their lives enjoyable made no difference – “a gilded cage is still a cage”.⁴⁵⁷

of managing authority and interested persons), eligibility (potential status under the MHA) and no refusal: Mental Capacity Act 2005, s 9 Sch A1 [13] – [20].

⁴⁵¹ The standard by which a person’s best interests is to be assessed is set out in s4 of the MCA. See Chapter 5 Best Interests – a standard for decision-making.

⁴⁵² A standard authorisation required if it appears likely that there will be a deprivation of liberty within the next 28 days.

⁴⁵³ An urgent authorisation is used where deprivation of liberty is for a maximum of 14 days.

⁴⁵⁴ Above n 7.

⁴⁵⁵ In *Cheshire West*, Lady Hale, at [48] began her analysis by asking “[s]o is there an acid test for the deprivation of liberty in these cases?”

⁴⁵⁶ In the case of MIG and MEG, three of the Justices dissented. They considered that the degree of intrusion was relevant to the concept of deprivation of liberty, and noted that the care regimes were no more intrusive or confining than required for the protection and well-being of the persons concerned.

⁴⁵⁷ *Cheshire West*, above n 7 Lady Hale at [46] - [49].

- 3.47 Speaking extra-judicially, in a speech in October 2014, Lady Hale summarised the judgment of the Supreme Court:⁴⁵⁸

We all held that the man had been deprived of his liberty, but three members of the Court held that the sisters had not been deprived of their liberty, while the majority held that they had. The acid test was whether they were under the complete control and supervision of the staff and not free to leave. Their situation had to be compared, not with the situation of someone with their disabilities, but with the situation of an ordinary, normal person of their age. This is because the right to liberty is the same for everyone. The whole point about human rights is their universal quality, based as they are upon the ringing declaration in Article 1 of the Universal Declaration of Human Rights that ‘all human beings are born free and equal in dignity and rights’.

- 3.48 The effect of *Cheshire West* has therefore been to clarify the position of people confined within a hospital or institutional care, and also to expand the reach of art 5 of the ECHR governing “deprivations of liberty” to cover living arrangements in a domestic setting, such as living in a foster home (provided the state has some significant involvement in the arrangements for the person’s care). In these situations compliance or a lack of objection by the person concerned is irrelevant to the application of the acid test.
- 3.49 The concept of deprivation of liberty also applies to 16 and 17 year olds, irrespective of their capacity to consent to their treatment or their living arrangements. Parental consent therefore cannot authorise the confinement of a child who has attained the age of 16, even if the confinement is “purely a private affair”, as such consent falls outside the scope of parental responsibility.⁴⁵⁹ Such “private affairs” are considered the responsibility of the State because it must ensure that all mentally disabled people, including young persons, have the benefit of safeguards and reviews, to ensure their living arrangements are in their best interests.

Replacement of the DoLS by the Law Commission

- 3.50 As a result of the 2014 House of Lords report and the Supreme Court judgment in *Cheshire West*, the operation and adequacy of this DoLS regime is subject to further review by the Law Commission of England and Wales (Law Commission).⁴⁶⁰ Among several criticisms outlined by the Law Commission is the “disconnect” that exists between the DoLS, which are regarded as having a “strong flavour” of mental health legislation, and the wider provisions of the mental capacity legislation, which are based on principles of autonomy and empowerment.⁴⁶¹ The DoLS are also complex and have a narrow focus on compliance with art 5 of the ECHR. Increasingly, there is greater recognition of the need to balance this right with art 8 of the ECHR, and the right to respect private and family life. Article 5 of the ECHR is said to distract

⁴⁵⁸ B Hale “Psychiatry and the Law: An enduring interest for Lord Rodger” (Lord Rodger Memorial Lecture, 31 October 2014) at 24, <http://www.supremecourt.uk/docs/speech-141031.pdf>.

⁴⁵⁹ *Birmingham City Council v D* [2016] EWCOP 8 Keehan J at [134]. D, aged 16 and who has Asperger syndrome, lacked capacity to consent to his residence and care arrangements where he lived on the hospital grounds and attended school in a locked unit. This case is the partner of a similar judgment, where the same child was 15 at the time and different rules apply to children under 16 years – referred to as *Gillick* competence: *Trust A v X and a Local Authority* [2015] EWHC 922(Fam).

⁴⁶⁰ See Chapter 1C Overview of ongoing law reform of the MCA and the DoLS regime. The Law Commission’s project was commissioned by the Department of Health. Its consultation paper was issued in July 2015. The final report and draft legislation will be published before the end of 2016.

⁴⁶¹ Law Commission, above n 199 at 11. The House of Lords Report also emphasised that the DoLS did not have the same ethos of the MCA.

attention from the underlying issue of where it is best for the person to live, which is described by Mr Justice Jackson in the COP as the “nub of the matter”.⁴⁶²

- 3.51 In *Cheshire West*, Lord Neuberger observed that some people may be surprised to learn that those living in a domestic setting could complain of deprivation of liberty under art 5.⁴⁶³ Nevertheless, the Law Commission has suggested that the right to personal liberty and art 5 safeguards are too important to be determined solely by reference to the home-like quality (or otherwise) of the setting.
- 3.52 Following extensive public consultation, the Law Commission has issued an interim statement indicating that they will be recommending a more “straightforward, streamlined and flexible” scheme for authorising a deprivation of liberty in any setting, which will not seek to go as widely as initially proposed under the “protective care” scheme.⁴⁶⁴ The responsibility for establishing the case for a deprivation of liberty will be shifted to the commissioning body (such as the NHS or local authority) that is arranging the relevant care and treatment, and away from the care provider. In an effort to have a proportionate and affordable response to the vast numbers of people now considered to be deprived of their liberty following *Cheshire West*, some people will receive independent oversight of their deprivation of liberty by an official – referred to as an “Approved Mental Capacity Professional” – whose role would be to agree or not agree to the proposed deprivation of liberty. The simplified proposal continues to recommend comprehensive rights to advocacy as a feature of the replacement scheme, with right of access to challenge restrictive treatment and care decisions in either a specialist tribunal or the COP.
- 3.53 The ongoing development of the DoLS regime under the MCA and the associated case law has therefore helped clarified two aspects of the law: firstly, how to identify a “deprivation of liberty”, and, secondly, the positive obligations on the State to take preventative measures to avoid deprivations of liberty and provide an accessible review process.

⁴⁶² *London Borough of Hillingdon v Neary* [2011] EWHC 1377 (COP), [2011] 4 All ER 584 at [151] to [152]. A young man with autism and severe learning disability was in respite care but subsequently prevented from returning home to live with his father and kept in a facility for nearly a year. The COP held that he was unlawfully deprived of his liberty and there was a subsequent damages award.

⁴⁶³ *Cheshire West*, above n 7 at [71].

⁴⁶⁴ Law Commission, *Mental Capacity and Deprivation of Liberty*, Interim Statement 25 May 2016 at 8. www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty. Initially the Law Commission proposed a “protective care” scheme with a separate scheme of safeguards for those accommodated in hospital settings and palliative care as well as those people deprived of liberty in family homes or other domestic settings. The Law Commission is also of the view that there should not be parallel legal regimes for detaining people for mental health assessment and treatment in psychiatric and other hospitals. The scheme will therefore not be used to authorise deprivation of liberty in such cases. No additional mechanism will be inserted into the Mental Health Act to cater for compliant incapacitated patients.

Defining a deprivation of liberty?

3.54 Deprivation of liberty is a human rights concept, and the term used to describe detention of a person in art 5(1) of the European Convention on Human Right (ECHR).⁴⁶⁵ It is understood, in European human rights jurisprudence, as having three elements, all of which need to be satisfied before a particular set of circumstances amount to a deprivation of liberty.⁴⁶⁶

- (1) the objective component of confinement to a particular restricted place for a not negligible period of time;
- (2) the subjective component of lack of valid consent (i.e. that the person does not consent or cannot freely give consent, if they do not have the capacity to do so) to that confinement; and,
- (3) the attribution of responsibility to the State.

3.55 In most of the key ECtHR cases applying the concept to the position of persons of “unsound mind”, it is common ground that consent is absent and the State has responsibility. Attention has been focused on the objective element, the nature of the confinement.⁴⁶⁷ In a prescient comment in her mental health law textbook, prior to the *Cheshire West* decision of the UK Supreme Court, Lady Hale observed: ⁴⁶⁸

Deprivations of liberty are not always easy to spot. Liberty means the physical liberty of the person, not simply the freedom to live one’s life as one chooses. Deprivation is more than mere restriction, but it can cover more than being locked up in a prison cell.... The starting point has to be the actual situation of the person concerned and account must be taken of a whole range of factors: such as the type, duration, effects, the manner of implementation of the measure in question. (*Guzzardi v Italy* [1980] 3 EHRR 33, para 93) [Emphasis added]

Restraint versus deprivation of liberty

3.56 Thus a distinction is made between restraint (which, in England, may be permitted so long as it is reasonable and proportionate under ss 5 and 6 of the MCA), and deprivation of liberty, which will be arbitrary if not properly justified under art 5 of the European Convention. In *HL v United Kingdom*, the European Court of Human Rights held that: ⁴⁶⁹

A deprivation of, and restriction upon, liberty is merely one of degree or intensity and not one of nature or substance.

3.57 In *HL v United Kingdom*, a key factor was that the healthcare professionals treating and managing HL exercised complete and effective control over his care and movements.

⁴⁶⁵ European Convention on Human Rights (entered into force 21 September 1971, as amended by Protocol No. 14 entered into 1 June 2010).

⁴⁶⁶ *Cheshire West*, above n 7 at 37.

⁴⁶⁷ Law Commission Report above n 199 at 3.

⁴⁶⁸ Hale, above n 194 at 16.

⁴⁶⁹ *HL v United Kingdom*, above n 4 at 791.

3.58 When considering the justification for intervention available to health professionals under sections 5 and 6 of the MCA, the Law Society Guidance suggests such interventions will lie along the following continuum:⁴⁷⁰

- (1) “Routine” decisions or interventions in an individual’s life to provide them with care and treatment. These will be taken on the basis of a reasonable belief that the individual lacks capacity to take the decision and that the professional is acting in the individual’s best interests: these can be carried out safe in the knowledge that the professional is protected from liability under s 5 MCA 2005;
- (2) Interventions that constitute “restraint”. Restraint does not merely mean the use of force, but can include the threat of the use of force, or restriction of the individual’s liberty, whether or not they resist.⁴⁷¹ By operation of s 6 MCA, a professional restraining an individual will be protected from liability provided the restraint is proportionate to the risk of and likelihood of harm and is only used where the professional reasonably believes it to be necessary to prevent harm to the person;
- (3) Interventions that go beyond “mere” restraint to a deprivation of liberty. The professional at that point cannot rely upon the provisions of ss 5 and 6 MCA, but authority will be required in the form of an authorisation.

3.59 In assessing the objective element of deprivation of liberty, a distinction can be made between the “neutral” question of whether a person is deprived of their liberty and the “evaluative” question of whether those arrangements are in their best interests.⁴⁷² Under the English DoLS regime, some commentators have queried this distinction, as it is difficult to distinguish between the two when there is a need to protect people against poor standards of care.⁴⁷³ In this respect, the English legislative regime is not directly comparable to New Zealand law.⁴⁷⁴ Here there is arguably a stronger patient protection regime under the Health and Disability Commissioner Act 1994 and the accompanying HDC Code. That said, the Commissioner only has retrospective, not prospective, powers to act on complaints, and therefore is not in a position to assess whether a person is deprived of their liberty and there is no statutory guidance (or advocate available to assist) on how a person’s best interests is to be assessed in these circumstances.⁴⁷⁵

3.60 Focusing on the standard of care provided to people who lack capacity in this context begs the essential question of whether a person is deprived of their liberty. Part of the reasoning in *HL v United Kingdom* concerned the need to independently determine the need for a person’s detention *in advance*, which is why the Court rejected the availability of judicial review or habeas corpus as inadequate remedies.⁴⁷⁶

Positive obligations on the State

3.61 The Strasbourg case law establishes a positive obligation on the State to protect all its citizens against interferences with their liberty, whether by State agents or by private individuals. In

⁴⁷⁰ Law Society, above n 415 at 11 [2.4].

⁴⁷¹ Mental Capacity Act 2005, s 6(4).

⁴⁷² Law Society, above n 415 at 11.

⁴⁷³ Allen, above n 202. Allen points out that the DoLS did nothing to prevent the abuse of people with disabilities at Winterbourne View. See *Winterbourne View: A Serious Case Review - Self Safe Guarding Adults*, (N Flynn) Gloucestershire, 2012.

⁴⁷⁴ In England and Wales, the Care Quality Commission is now the independent regulator of health and social care, <http://www.cqc.org.uk/>.

⁴⁷⁵ See Chapter 4: Best interests- a standard for decision-making.

⁴⁷⁶ Gledhill, above n 403 at 130. As Gledhill points out, the Government Committee’s response on the draft Mental Health Bill in 2004 and the suggestion that DoLS authorisations would be given *after* people had been detained, “somewhat misses the point”.

legal terms, the State is responsible for an objective deprivation of liberty to which the individual in question subjectively cannot consent.⁴⁷⁷ Article 5(1)(e) of the European Convention requires that formal authority is provided to render that detention lawful. The failures of public bodies to ensure that there is proper consideration, in advance of the decision being made, of the necessity of removing individuals from their home and placing them in institutional care in their best interests, have been evident in some high-profile cases where damages were awarded for the unauthorised deprivation of liberty.⁴⁷⁸

- 3.62 The positive obligation of the State to take measures “providing effective protection” extends to “private” deprivations of liberty (by an individual or body), even where the State has had no part in making the arrangements.⁴⁷⁹ Applying these principles, in *A Local Authority v A*⁴⁸⁰ it was held that where the State (in this case a local authority) “knows or ought to know” that a person is subject to restrictions imposed by a private individual that arguably amount to deprivation of liberty, then the State’s positive obligations under art 5 would be triggered. These obligations include the duty to investigate, in order to determine whether there is in fact a deprivation of liberty. If the State is satisfied there is no deprivation of liberty, it will have discharged its immediate obligations. However, its positive obligations in certain circumstances require ongoing monitoring of the situation.⁴⁸¹
- 3.63 Thus, after Lord Steyn identified the Bournemouth gap, the decision of the ECtHR in *HL v United Kingdom* has been a catalyst for change in English law, leading to amendments to the MCA and development of the DoLS. In addition, the UK Supreme Court decision in *Cheshire West* has expanded the scope of the circumstances to which the procedural protections, provided by the DoLS, must apply. The European human rights jurisprudence also confirms that States must proactively ensure there are legal safeguards in place, supported by a speedy review process, to ensure that individuals who lack capacity are not arbitrarily detained.

⁴⁷⁷ *Storck v Germany* (2006) 43 EHRR 6 [93] sets out the principle that the State may be accountable even for private deprivations of liberty. In this case, the state became involved when the applicant was brought back to a private psychiatric hospital after she escaped. In addition, the national court must apply the provisions of national law in a manner compatible with the rights protected by the Convention. This case was applied in *Cheshire West*.

⁴⁷⁸ Cases where the COP has awarded damages for a deprivation of liberty include: *Hillingdon v Neary*, above n 462, where Mr Neary was awarded £35,000 plus costs; *A Local Authority v Mr and Mrs D* [2013] EWCOP B34, damages of £27,500 plus costs; and *Essex County Council v RF* [2015] EWCOP 1, where the authority was ordered to pay £60,000 for a substantive breach whereby RF would not have been detained if the authority had acted lawfully.

⁴⁷⁹ *Stanev v Bulgaria* (2012) 55 HER 22 at [120]; *Re A and Re C* [2010] EWHC 978 (Fam), Munby J, at [95].

⁴⁸⁰ *A Local Authority v A* [2010] EWHC 978 (FAM), Munby J.

⁴⁸¹ In *Staffordshire County Council v SRK & Ors* [2016] EWCOP 27, Charles J, when applying the decision in *Cheshire West*, had to consider when the State’s positive obligations under art 5 of the ECHR are engaged in the context of arrangements made by a deputy in administering a personal injury compensation payment. There was a private deprivation of liberty (as the arrangements were not made by the local authority) and there was a need to ensure that there were welfare orders and an ability to review the arrangements in place.

3C: NEW ZEALAND – IMPLICATIONS OF THE BOURNEWOOD GAP

Identifying the Bournewood gap in New Zealand

- 3.64 The case law under the ECHR and the MCA is highly relevant and likely to be influential in New Zealand courts due to the similarity in the principles – drawn from international and domestic laws – that protect the right not to be arbitrarily detained in Europe and New Zealand.⁴⁸² New Zealand is not a party to the ECHR, but the European jurisprudence is highly relevant to interpretation of the equivalent liberty rights that are guaranteed by the international human rights instruments to which New Zealand is a party; plus the English common law backdrop to such liberty rights – in the tort of false imprisonment and writ of habeas corpus – has been imported into New Zealand common law.
- 3.65 It is possible that a similar case to *Bournewood* could arise in New Zealand, under s 22 of the NZBORA. This is a similar provision to art 5 of the European Convention. In fact, a case concerning informal detention in a dementia unit has already arisen as a complaint under the HDC Code.
- 3.66 In *Taikura Trust*,⁴⁸³ Ms A, a 43-year-old woman with a complex history of mental illness and alcohol abuse, was held in a secure dementia unit for almost a year, against her will, without legal authority. Although initially she had been admitted to hospital appropriately, having been assessed as not having the capacity to make decisions relating to her care and welfare, the hospital incorrectly assumed that a personal order under the PPPR Act had been obtained from the Court that covered her care. Despite expressing a wish for a more suitable placement, Ms A was effectively detained for over a year in this dementia unit, against her wishes and contrary to her needs. Moreover, despite her capacity changing over time, she was not reassessed.
- 3.67 The Health and Disability Commissioner found there was a failure to provide appropriate care, to Ms A under Right 4 of the HDC Code. Regardless of whether there was a court order placing Ms A in the dementia unit, it was still a breach of her right to receive proper care for the healthcare providers not to take the steps to reassess her capacity and address her inappropriate placement in the dementia unit. The case went to the Human Rights Review Tribunal, where the two Auckland service providers who were responsible agreed to pay compensation to Ms A's estate (as she had subsequently died after her release from unlawful detention).⁴⁸⁴

⁴⁸² Butler and Butler, above n 397 at 95: "Reference to decisions of the ECtHR has been relatively frequent in New Zealand case law and this level of citation and consideration of European Cases is likely to be maintained as New Zealand courts continue to draw on decisions of the United Kingdom courts deciding cases under the Human Rights Act 1998 (UK), which incorporates much ... of the European Convention into UK law."

⁴⁸³ *HDC Opinion 08HDC20957 Auckland District Health Board, Taikura Trust, Aranui Home and Hospital Ltd (Trading as Oak Park Dementia Unit)* (3 November 2010). The Commissioner's opinion and the case before the Human Rights Review Tribunal did not expressly address the right not to be arbitrarily detained under s 22 of the NZBORA.

⁴⁸⁴ The Tribunal made declarations against Taikura Trust and Aranui Home and Hospital Limited (trading as Oak Park Dementia Unit) for failures of care and breaches of Ms A's rights by failing to provide services in a manner that respected her dignity and independence and failing to provide services with reasonable care and skill. This case has been referred to by many commentators and was raised by Dr Katie Elkin (Associate Commissioner, Health and Disability Commission) to Alison Douglass regarding this research project (18 August 2014). *Director of Proceedings v Taikura Trust – Needs Assessment and Service Co-ordination Service* HRRT No. 024/2011 [2012] NZHRRT 3 (22 March 2012) *Director of Proceedings v Aranui Home & Hospital Ltd – Rest Home* HRRT No. 025/2011 [2012] NZHRRT 4 (22 March 2012).

- 3.68 Right 7(4) of the HDC Code,⁴⁸⁵ based on the common law principle or doctrine of necessity,⁴⁸⁶ was not specifically relied upon to justify Ms A's detention in *Taikura Trust*. Ms A's initial admission to hospital for care was perhaps defensible on that basis, but her ongoing detention was not. The principle of necessity imposed a clear obligation on the staff, which was not met, to ensure the provision of secure care continued to be in her best interests. Furthermore, even when Ms A objected to her longer-term care, no independent review process was activated, particularly none involving a court or tribunal. Obtaining a retrospective PPPR Act order would not have addressed the problem of there being a lack of safeguards that are intended to operate in advance of the person's detention or, in this case, Ms A's ongoing detention. This case therefore illustrates the existence of the Bournemouth gap in New Zealand.
- 3.69 Right 7(4) of the HDC Code is a pragmatic response to the need for everyday decision-making, and for common sense decisions to be made on a short-term basis, for people who, for a range of reasons, are unable to consent to their healthcare. Martin has suggested that Right 7(4) is best seen as a set of protections for consumers who cannot consent to treatment.⁴⁸⁷ In more strictly legal terms, however, the so-called right provides a defence for health practitioners to HDC Code liability, rather than a safeguard for people who lack capacity and are unable to consent.⁴⁸⁸ It does not provide procedural protections, or an independent review process, for people who lack capacity on an ongoing basis, concerning decisions such as sedation, forcible restraint, or use of coercion in their detention, whether compliant or not, or concerning decisions about their living arrangements or their forcible transport to a place of residence.
- 3.70 There will be many instances where the lawfulness of a person's initial detention in care would be clearly justified under the principle of necessity but the original reasons for their detention may cease to be valid if their condition changes. Their ongoing detention may then become a disproportionate response to the situation, and a breach of s 22 of the NZBORA.⁴⁸⁹ Moreover, under New Zealand law, the precise situations in which providers may rely on Right 7(4), or must, instead, seek a court order, are not fully clear. In practice, it seems that providers tend not to risk relying on Right 7(4) alone in more contentious cases, such as where a family dispute exists about where to place an older family member, where the person strenuously objects to the proposed arrangements (particularly their admission to a secure dementia unit), and where there is no obvious family member or friend available who is concerned about the person's long-term interests. In those cases, therefore, more formal legal arrangements may be sought. As a result, providers' conduct in this regard may be inconsistent and idiosyncratic.⁴⁹⁰

⁴⁸⁵ HDC Code, Right 7(4) is set out in full in Appendix C Legislation and International Human Rights Conventions and is also discussed in Chapter 5 Best Interests and Chapter 6 Research on People who Lack Capacity.

⁴⁸⁶ See Chapter 5 Best Interests and a discussion of a history of the declaratory jurisdiction and the doctrine of necessity. *Re F (Mental Sterilisation)* [1990] 2 AC 1. In England, the common law doctrine of necessity as established in *Re F* and refined in subsequent case law has largely been superseded in relation to acts of care and treatment by Mental Capacity Act 2005 ss 5 and 6.

⁴⁸⁷ Martin, above n 389.

⁴⁸⁸ Although a defence in its own right, Right 7(4) is subject to clause 3. This provides that healthcare providers will not be in breach of any of the rights in the HDC Code if they have taken 'reasonable actions in the circumstances'. This would include taking into account the urgency of the required treatment and resource implications.

⁴⁸⁹ *Zaoui*, above n 407 at [175].

⁴⁹⁰ Anecdotally, and in the writer's experience, there are inconsistent approaches by DHBs as to whether they will rely on Right 7(4) or seek a court order under the PPPR Act, in these circumstances in the absence of a court order.

Current problems and practice

- 3.71 The lack of legal safeguards to protect the liberties of people with impaired capacity is therefore a major issue for health and disability providers, including clinicians and social workers, particularly those working with people with dementia who are in some form of secure or locked residential care.
- 3.72 There are also people with milder forms of dementia who may retain some degree of capacity or understanding but, with time, their dementia can expect to progress and their reasoning will deteriorate to the extent they will become unable to contribute to decision-making to any great extent. Furthermore, the “compliant” (or “non-dissenting”) person with dementia may not actively object to their placement, even if it does involve detention, but they may not be able to give meaningful consent to it. Whether detained in a secure dementia unit or in lower levels of hospital or residential care, they will face ongoing care decisions and financial questions concerning their care in circumstances where they are not capable of making, and in some circumstances participating in, decisions affecting them.
- 3.73 The case studies below, based on real situations, demonstrate the problems encountered when people who lack capacity are placed in residential care or supported living arrangements, and there is no adequate legal process for oversight or review of restrictions on their liberty. In all three cases the people would meet the “acid test” for deprivation of liberty: they are under the continuous supervision and control of those caring for them *and* not free to leave.⁴⁹¹

Case of Mrs A: older adult with dementia – compliant patient needing long-term residential care

- 3.74 Mrs A⁴⁹² is a 78-year-old woman who is brought to the hospital after her neighbours found she had fallen over outside her house. She is treated for delirium secondary to infection, but during the course of admission it becomes clear that she has an underlying dementia of at least a moderate degree. In the medical ward she is agitated, wanders, and resists care. On one occasion she flees the ward, apparently concerned that she is in imminent danger. She is subsequently admitted to the psychogeriatric inpatient unit under the MH(CAT) Act.
- 3.75 Mrs A settles on the ward, but remains at risk of falls and wandering. A visit by staff to her home reveals stockpiled prescribed medication and that she has been incapable of looking after herself or the house. Nevertheless, she now wants to return home without care, although discussions with her establish that she has little real appreciation of her mental and physical problems and the risks associated with them. Mrs A’s family agrees that, on discharge from hospital, she will need residential (and most likely dementia) care. Mrs A has not executed an EPOA and, as is often the case, the facility to which she will go therefore requires a court order to be in place to authorise her admission when she cannot consent to her care.

⁴⁹¹ *Cheshire West*, above n 7.

⁴⁹² Case study provided by Dr Mark Fisher, consultant psychiatrist, Mental Health Services for Older People, Middlemore hospital, Counties Manukau DHB.

Discussion

- 3.76 Mrs A's circumstance is a common scenario for people with dementia for whom residential care is proposed as part of their care. Even if Mrs A had an appointed attorney under an EPOA, or a welfare guardian, these decision-makers are not necessarily well equipped to navigate the admission or placement process on her behalf, and they may have a conflict of interest concerning the decision to admit her to residential care as their own personal situation may be significantly affected, for better or worse, by that decision. They are not necessarily well placed, therefore, to determine whether admission to residential care is in her best interests. Moreover, even if the Court is involved in ordering Mrs A's admission, and considers whether a less restrictive intervention is available, a court has limited ability to exercise ongoing oversight of the implementation of a "one-off" personal order of that kind.⁴⁹³
- 3.77 The health services, in this situation, are often caught in a dilemma, between wishing to discharge someone from a busy hospital ward (to prevent "bed blocking"), and taking the time and expense to seek orders from the court. Going to court may incur delays and may seem to impose an ongoing responsibility to see the court process through to its conclusion, some months later, even though by then the person's care will have been transferred to another provider.⁴⁹⁴ The HDC Code requires health and disability services to be of an "appropriate standard of care", in a manner appropriate to a person's needs, that optimises their quality of life and with cooperation between providers.⁴⁹⁵ Practices, therefore, as to when and how to use the court process, vary across DHBs, along with the extent to which DHBs expect their clinicians to rely on Right 7(4) of the HDC Code instead of getting an order from the court.⁴⁹⁶

⁴⁹³ An interim personal order can be for up to 6 months and extended again for a total of 12 months, followed by a final order for a maximum of 12 months: Protection of Personal and Property Rights Act 1988, ss 10, 14 and 17.

⁴⁹⁴ Under s 7 of the PPPR Act, a wide range of people, including health professionals, social workers and managers of institutions can apply for interim personal orders, as can family members. There are a range of orders that may be obtained under s 10 of the PPPR Act, a "placement order" under s 10(1)(e) requires: "that the person be provided with living arrangements of a kind specified in the order". See Chapter 1B Overview of the PPPR Act and Appendix C New Zealand Legislation.

⁴⁹⁵ HDC Code of Rights, Right 4 (3), (4) and (5). Right 4 (5) provides: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."

⁴⁹⁶ In some regions, significant delays are experienced in progressing applications under the PPPR Act for a s 10 placement order. The Auckland DHB for example, is undertaking a PPPR Act project with the goal of streamlining the PPPR process to enable in-patients to be moved to long term accommodation as quickly as possible. There are often extended lengths of stay for patients in Auckland Hospital requiring PPPR applications before they can be discharged. There were many factors identified in causing the delays, including clinicians' understanding and confidence with capacity assessments and PPPR applications, and with long delays in the Family Court. The scope of this project is the Older Persons Wards and General Medical wards but there are also concerns across community and mental health teams. (Email communication from Lisa Swann, project leader, Auckland DHB 19 February 2016 and Interview with Wayne Campbell, social worker and advanced clinician, Auckland DHB, 23 February 2016).

Case of Mrs D: refusal to leave home and admission into residential care

3.78 Mrs D lives at home in squalor.⁴⁹⁷ Community professionals, including her GP, have expressed concerns about her severe cognitive decline. She lives alone, with her adult daughter being her main caregiver, although it is suspected the daughter abuses her mother. Mrs D has poor mobility and there are concerns about her personal care and nutrition (there is no food in the fridge). Mrs D has refused to let the community psycho-geriatric team enter her home, and neither a capacity nor a needs assessment has been undertaken.⁴⁹⁸

Discussion

3.79 It is not uncommon for older adults to live at home in relatively isolated circumstances with no-one to act for them.⁴⁹⁹ In this situation where persuasion may not be possible, clinicians may have to decide whether to use the compulsory assessment procedure under the MH(CAT) Act to admit them into care.⁵⁰⁰ Very often, the person has a family, but the family is fractured and unable to make the necessary application under the PPPR Act for a personal order, or they are unwilling or unable to pay a lawyer to do so.⁵⁰¹ There are added complications where there is an abusive relationship, or family conflict, or sizable assets involved.

3.80 A court order – during its life – allows a facility to care for someone in a secure environment, but getting the person to that facility, from their home, can be difficult and involve coercion. It can involve a person being uplifted from their home, being transported against their will, and then being detained in the new environment. This situation is a very different dynamic to where a person has already left their home and has been admitted to hospital for medical care.

Case of Mr G: high level of restriction and living in the community

3.81 Mr G⁵⁰² is 31 years of age. He has severe autism spectrum disorder, and, although he is unable to verbally communicate, his psychologist says his level of intellectual function is unable to be accurately assessed. He became increasingly difficult to manage at home during his teenage years and now lives in a different town to his parents. He lives alone, but is supported with 24-hour one-on-one staffing by a community trust in a rented house. His

⁴⁹⁷ Case study from Phil Sunitsch, Social Worker, Mental Health Services for Older People, Southern DHB.
⁴⁹⁸ Compare this case study with a case in the COP, *Re AJ (Deprivation of Liberty Safeguards)* [2015] EWCOP 5, Baker J, where a breach was found when the local authority failed to take appropriate steps to ensure any deprivation of liberty had been suitably authorised *prior* to removing AJ from her home and placed in care. See also *A Primary Care Trust v P and Ors* [2009] EW Misc 10, Hedley J.

⁴⁹⁹ Email communication from Phil Sunitsch, social worker, Mental Health Services for Older People, Southern DHB (19 May 2015 and 31 March 2016).

⁵⁰⁰ The legal criteria for mental disorder in s 2 of the MH(CAT) Act under the second limb is that the mental disorder (as defined) either(a) poses a serious danger to the health or safety of that person or others; or (b) seriously diminishes the capacity of that person to take care of himself or herself.

⁵⁰¹ A person does not need to have a lawyer to make a Court application and some assistance may be available from the Family Court office however, where the applicant is unrepresented the Court-appointed lawyer to represent the person subject to the application is often put in the position of providing assistance at least to make sure all the relevant information is before the Court.

⁵⁰² The writer represented Mr G in the Family Court for the purpose of the appointment of his welfare guardian (Family Court reference suppressed).

welfare guardian is a former carer who has maintained a good relationship with him, and, although moving to another city, has kept in regular contact with his current carers.⁵⁰³

- 3.82 Mr G poses significant management difficulties. He is at risk of harming himself directly, if unsupervised, through, for example, severe bites to himself, or indirectly, by running out on to the road, and being hit by traffic. To manage his behaviour, his liberty is severely restricted through the use of locks, including deadlocks on his bedroom windows and bedroom door in the house.⁵⁰⁴

Discussion

- 3.83 Mr G is completely dependent upon the community trust that cares for him and has limited contact from his welfare guardian. While the welfare guardian is involved with significant decisions with respect to his care, there is no ongoing oversight of the restrictions on his liberty, or the restraints, that are necessary to manage his care. There is only the trust's own care plan, including a risk assessment. On occasions, there has been tension between the welfare guardian's views on suitable restrictions and the community trust's understandably risk-averse approach to managing his care.⁵⁰⁵ Mr C is receiving excellent care, but in fact he is subject to greater physical and psychological isolation and restrictions on his liberty than would be the case for some people with an intellectual disability detained with court orders under the IDCCR Act.⁵⁰⁶

The role of needs assessments

- 3.84 A complicating factor in all these cases is the needs assessment process and the extent to which such assessments determine the level of care that a person will receive, and correspondingly, the level of restriction imposed on their liberty. A "needs assessment" refers to a clinical assessment (often of an older person or a younger adult with disabilities) to determine their level of functioning and the level of funding they require, in the provision of long-term DHB-funded disability support services. It is usually conducted by the Needs Assessment and Service Coordination service (NASC)⁵⁰⁷ and occurs around the time a decision is made to discharge a person from hospital or move them to alternative living

⁵⁰³ Mr G is very fortunate in this respect because there are many people in his situation who do not have a welfare guardian and there is no public guardian or advocate that can fulfil this role other than voluntary welfare guardian trusts.

⁵⁰⁴ Compare this case study with *A Local Authority v PB and P* [2011] EWHC 2675 (COP), Charles J, where it was determined it was in P's best interest to remain living in a supportive care regime rather than be returned home to his mother, given P's high level of needs.

⁵⁰⁵ For example, there was a period when Mr G "trashed" his flat in response to deadlocks being put on his windows and door to his bedroom. The welfare guardian considered this behaviour entirely predictable and an inevitable consequence of placing further restrictions upon him.

⁵⁰⁶ In this case, the disparity between the high level of restrictions whilst under a PPPR Act order compared to the potential for a lower level of detention for compulsory care under the IDCCR Act was observed by the lawyer, the psychologist, the GP, and by the Family Court Judge who made the welfare guardian order.

⁵⁰⁷ See M Duggal "Health Services for Older People: the role of District Health Boards" in Diesfeld and McIntosh, above n 228 at 207. Ministry of Health 2014/15 Service Coverage Schedule (23 December 2013). Responsibility for providing long-term disability support services to older people devolved to the DHBs from the Ministry of Health in October 2003 by the Health Sector Transfers (Provider Arrangements Order 2003).

arrangements. It may effectively determine whether they need secure dementia care or hospital level care, or whether they can remain in their own home with support.⁵⁰⁸

- 3.85 The needs assessor considers the person's mental health and cognitive impairment when assessing their level of functioning, but the process does not purport to be a legal assessment of a person's capacity for decision-making. The particular NASC can be either a contracted external agency or a department within a DHB, the latter giving rise to the perception, if not the possibility, of a conflict of interest.⁵⁰⁹

The mental health legislation (MH(CAT) Act) and its interface with the PPPR Act

- 3.86 While the MH(CAT) Act and the PPPR Act are overlapping regimes, they serve different purposes and operate differently.⁵¹⁰ Incapacity to consent to treatment is not required for a person to be subject to the MH(CAT) Act, yet some people are subject to both laws in the course of receiving healthcare, or regarding their living arrangements. An international review has highlighted that there may be at least a third of all patients in healthcare settings, and 45 percent patients in psychiatric settings, who do not have capacity for decision-making.⁵¹¹ When considering how legal safeguards for deprivation of liberty might work, it is therefore important to address the interface between these two regimes.
- 3.87 Under the MH(CAT) Act, where a person has been certified by two doctors as meeting the complex statutory definition of "mental disorder", a person can be detained, and assessed, and treated by a psychiatrist (referred to as their responsible clinician).⁵¹² Then, after about a month's assessment, an application can be made for them to be placed under a compulsory treatment order (CTO) – either an in-patient or community order – provided they continue to meet the relevant criteria. The MH(CAT) Act covers only "treatment for mental disorder", but it authorises various forms of restraint, including detention in order to keep the person safe and to make sure they are receiving the treatment and investigations deemed necessary.⁵¹³
- 3.88 Whether undergoing assessment, or receiving treatment under a CTO, the person has recourse to a number of legal protections under the MH(CAT) Act.⁵¹⁴ They can challenge

⁵⁰⁸ In 2003, the Ministry of Health released best practice guidelines for the assessment processes of older people. New Zealand Guidelines Group *Assessment Process for Older People* (NZGG, Wellington, 2003) https://www.health.govt.nz/system/files/documents/publications/assess_processes_gl.pdf.

⁵⁰⁹ The NASC are not accountable as providers under the HDC Code as they do not fall within the definition of "disability services" under the Health and Disability Commissioner Act 1994 and therefore are not subject to complaints under the HDC Code. In 2009, former Commissioner Paterson recommended the NASC be included in this definition among other changes to the Act, but these changes were not expressly supported by the current Commissioner Hill's 2014 review of the Act and HDC Code: New Zealand Law Society submission on the 2014 review of the Health and Disability Commissioner Act and HDC Code, 17 February 2014. http://www.lawsociety.org.nz/_data/assets/pdf_file/0012/75999/l-HDC-Act-and-Code-Review-17-02-14.pdf.

⁵¹⁰ As observed by Atkin and Skellern, given the two Acts deal with the same people and similar issues, "it is a little surprising that the disparity is so great and the gaps so obvious", B Atkin and A Skellern, 'Adults with Incapacity: the PPPR Act' in Dawson and Gledhill, above n 92 at 347.

⁵¹¹ Lepping, Stanly and Turner, above n 29.

⁵¹² Mental Health (Compulsory Assessment and Treatment) Act 1992, s 2. The legal criteria for mental disorder in s2 of the MH(CAT) Act under the second limb is that the mental disorder (as defined) either (a) poses a serious danger to the health or safety of that person or others; or (b) seriously diminishes the capacity of that person to take care of himself or herself.

⁵¹³ Mental Health (Compulsory Assessment and Treatment) Act 1992, s 28.

⁵¹⁴ Specific rights are listed in Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 63A – 75.

their detention (or their compulsory status) before a court while undergoing assessment;⁵¹⁵ the CTO itself must be made (and be reviewed after six months) by the Family Court,⁵¹⁶ after a hearing, and they can apply periodically to the Mental Health Review Tribunal to be discharged from a CTO if it is made indefinite by the Court.⁵¹⁷ A particular concern about the operation of the MH(CAT) Act and relevant to the issue of ongoing detention under this legislation, is the extensive use of the indefinite form of compulsory patient status, when these CTOs are renewed a second time, about a year after the initial order is made. These indefinite orders, and the small numbers of patients who apply to the Tribunal for discharge from them, are described as “a defining feature of the Act” and it is suggested they should be abolished.⁵¹⁸

- 3.89 A person can only be placed under a CTO by the court and they can be provided with legal representation (although many people are not legally represented for this process). Their legal status and detention is kept under oversight by District Inspectors, who have an ombudsman-type role, and are independent of care providers.⁵¹⁹ There is also provision for regular review of their legal status by the responsible clinician to ensure they still meet the criteria for detention (or compulsory status) whether detained under an in-patient or a community CTO under the MH(CAT) Act. Sometimes the MH(CAT) Act is used to enforce detention and management of a person with dementia in a residential facility, by placing them under an in-patient order and then placing them on leave, with a specified condition of their leave being that they reside in residential care and comply with mental health treatment.⁵²⁰
- 3.90 In New Zealand, there is no obvious legal obligation to place compliant, “non-dissenting” patients under this regime established by the MH(CAT) Act. The upshot is that such patients – who may nevertheless be under the continuous supervision and control of those caring for them and are not free to leave – do not have adequate access to an independent process that reviews the necessity for that form of supervised care. These were the exact circumstances that led to the major legal developments in England, specifically the enactment of the DoLS regime.

Monitoring places of detention in New Zealand

- 3.91 A further aspect to the human rights framework in New Zealand is the national monitoring mechanism for places of detention carried out by a number of government agencies including the Human Rights Commission and the Ombudsman. These mechanisms give effect to New Zealand’s obligations under the United Nations Optional Protocol for the Convention Against

⁵¹⁵ Mental Health (Compulsory Assessment and Treatment) Act 1992, s 12(12).

⁵¹⁶ Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 14(4) and 18.

⁵¹⁷ Mental Health (Compulsory Assessment and Treatment) Act 1992, s 79.

⁵¹⁸ Dawson and Gledhill, above n 92 at 22. This feature of the MH(CAT) Act was also criticised in the UN Committee’s concluding observations on New Zealand in respect of the CRPD: ODI, above n 261 at 3 [22]. See also recent media attention concerning the case of Ashley Peacock and the ongoing use of seclusion while under an indefinite CTO, raising concerns about how deprivations of liberty are assessed and monitored under the MH(CAT) Act: K Johnston, New Zealand Herald, “Autistic man locked in isolation for five years: he’s had everything stripped from him”, 7 June 2016. http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11648771

⁵¹⁹ Mental Capacity Act 2005, ss 94 – 99. District Inspectors are not advocates for patients under the MCA but are described as the “the watchdogs of patients’ rights”. However, they have no jurisdiction over informal patients who are not subject to the MCA. See K Thom, K Prebble “District Inspectors: Watchdogs of Patients’ Rights” in Dawson and Gledhill, above n 92 at 131.

⁵²⁰ The “detention” in a rest home while on “leave” under 31 and 30(2)(b), could be challenged as s 113 of the MH(CAT) Act only expressly authorises the detention of those under in patient orders in “hospital”.

Torture (OPCAT).⁵²¹ Until now, this monitoring has mainly focused on prisoners in correction facilities, and on people detained under the IDCCR Act and the MH(CAT) Act.

3.92 The most recent monitoring report under the OPCAT has expressed concern that there are many situations in which people are deprived of their liberty that are not currently monitored.⁵²² This includes detention in facilities approved by substitute decision-makers, such as detention in locked aged-care facilities, dementia units, compulsory care facilities, community-based homes and residences for disabled persons. Currently, an estimated 138 aged-care providers in New Zealand with locked facilities potentially fall within the scope of OPCAT. The report recommends that the Government review the scope of the OPCAT mandate in New Zealand and identify ways to address the gaps in its monitoring of places of detention.

3.93 A further report in 2014 by the United Nations Working Group on Arbitrary Detention expressed concerns about the protection gaps in New Zealand's legal framework that exist for older persons in care settings. This report refers to the PPPR Act and the HDC Code as "the only pieces of legislation that are loosely relevant in this context", and:⁵²³

It is clear that these laws do not set out sufficiently detailed processes by which persons lacking legal capacity may become subject to detention.

3D: REFORM OPTIONS: A PROPORTIONATE RESPONSE

Liberty safeguards – filling the Bournemouth gap

3.94 International and domestic human rights law affirms the right to freedom from arbitrary detention. As identified, New Zealand has a Bournemouth gap that is not filled by the MH(CAT) Act and its accompanying safeguards. There is a broad range of settings where the State is involved with the provision of health and social care to people who lack capacity and are unable to consent or object to their care and living arrangements. Examples include: informal psychiatric patients who are not under the MH(CAT) Act; older adults who may be discharged from hospital into care, including secure dementia units and/or ongoing residential care with various levels of restrictions; those adults who do not wish to leave their home for more institutionalised care; or people with learning disabilities who have supported living arrangements in the community but have substantial restrictions placed upon their liberty. In these circumstances, the people concerned are under the continuous supervision and control

⁵²¹ Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (opened for signature 18 December 2002, entered into force 22 June 2006). OPCAT establishes a dual system of preventive monitoring, undertaken by international and national monitoring bodies. The international body, the United Nations Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT), periodically visits each State Party to inspect places of detention and make recommendations to the State. At the national level, independent monitoring bodies called National Preventive Mechanisms (NPMs) are empowered under OPCAT to regularly visit places of detention, and make recommendations aimed at strengthening protections, improving treatment and conditions, and preventing torture and ill-treatment.

⁵²² Human Rights Commission (2014) *Monitoring Places of Detention: Annual report of activities under the Optional Protocol to the Convention Against Torture (OPCAT), 2013–2014*. www.hrc.co.nz, at 45 noted that, "People detained in these facilities potentially are vulnerable to ill-treatment that can remain largely invisible."

⁵²³ United Nations Human Rights Council (2014) *Report of the Working Group on Arbitrary Detention A/HRC/30/36/Add.2* at [88].

of those who care for them *and* are not free to leave: the acid test for when safeguards are needed in *Cheshire West*.

- 3.95 The Bournemouth gap exists in New Zealand because there are no specific legal safeguards that apply to these situations of detention. Reliance on the common law doctrine of necessity – as is often the case in New Zealand – was rejected by the ECtHR in *HL v United Kingdom* as an inadequate basis for the ongoing detention or monitoring of situations where people are deprived of their liberty. Neither the court procedures currently available under the PPPR Act (personal orders or the appointment of a welfare guardian) nor Right 7(4) of the HDC Code are designed to be effective in identifying deprivations of liberty in advance of a person’s detention. Nor do they provide ongoing monitoring of a person’s detention to ensure that such decisions are the least restrictive option and are made in their best interests. While the interface with the current mental health legislation will need to be addressed, the MH(CAT) Act is not the proper place for the necessary legal safeguards to be located, as it is intended to serve a more limited purpose – authorising and regulating compulsory psychiatric treatment.
- 3.96 The English response to its human rights obligations – enacting the DoLS regime – could be seen as an excessive response to the problem of providing a mechanism to safeguard the interests of people who lack capacity. It has been said: “A sledgehammer must not be used to crack a nut.”⁵²⁴ There are also aspects of the English legislation, both the MCA and the MHA, which are specific to their legal framework and would not apply in New Zealand.⁵²⁵ Plus there is the different population size and different cultural context in which the English law is formed, and the need for the UK to comply strictly with the ECHR. Nonetheless, England has filled the Bournemouth gap and other comparable jurisdictions have taken steps in that direction.⁵²⁶
- 3.97 The Victorian Law Reform Commission (VLRC)⁵²⁷ also undertook a review of the law governing restrictions on liberty, including restraint policies in residential care facilities.⁵²⁸ There are two striking features of this review: firstly, the extent to which the review found that other countries have extra-judicial processes for appointing substitute decision-makers where no other person is available;⁵²⁹ and secondly, that Australia, Canada, and England and Wales, all have a publicly-appointed person (such as a public advocate),⁵³⁰ or a public body or agency

⁵²⁴ *Moonen v Film and Literature Board Review* [2000] 2 NZLR 9 (CA) Baragwanath J, at 14.

⁵²⁵ For example, the system of informal patients under the MHA, s 131(1); the guardianship regime under the MHA to determine residence of some patients under the Act, and that people with learning disabilities come within the MHA.

⁵²⁶ The Victorian Law Reform Commission (VLRC) recommended for example, the introduction of a new a three-person collaborative authorisation process (the person in charge of the residential facility, a medical practitioner and the person’s health decision-maker) limited to deprivations of liberty for persons in residential care who lack capacity to consent to restrictive living arrangements that are imposed for their own health or safety. The VLRC recommendations were prior to *Cheshire West* and the broadening of the scope of DoLS and these particular recommendations have not as yet been acted upon. See also the Mental Capacity Bill, recently passed in Northern Ireland. Above, Chapter 1C Overview of the MCA. There is provision for additional safeguards for “serious interventions” and authorisations for deprivation of liberty (Chapter 4 of Mental Capacity Bill (NI)).

⁵²⁷ See Australian Law reform in Chapter 2A above.

⁵²⁸ The VLRC released a background paper of legislative schemes regulating deprivation of liberty in residential care settings in the UK, Queensland, Ontario, British Columbia and the Yukon: http://www.lawreform.vic.gov.au/sites/default/files/Guardianship_final_report_background_paper_deprivation_of_liberty_safeguards.pdf.

⁵²⁹ Powers of Attorney Act 1998 (Qld), s 63; Health Care Consent Act (SO) 1996 c 2, sch A; Health Care (Consent) and Care Facility (Admission) Act (RSBC) 1996, c 181; Care Consent Act (SY) 2003 c 21, sch B, s 12(1)(c).

⁵³⁰ Queensland, Victoria, Western Australia and South Australia all have an Office of the Public Advocate to aid in implementing guardianship legislation.

(such as a Public Guardian)⁵³¹ available for this purpose, or to manage this process. By comparison, in New Zealand there is no network of public advocates, and no Public Guardian's office, to produce a substitute decision-maker when no other candidate steps forward. There is currently a need for independent welfare guardians, as evidenced by the establishment of volunteer community trusts.⁵³² In addition, where a person's capacity is already impaired, substitute decision-makers cannot be appointed through an extra-judicial process, but only through the Court.

- 3.98 The English experience demonstrates that the key concern is not *whether*, but *how* deprivation of liberty safeguards are provided and how far the revised scheme should extend.⁵³³ The expanded interpretation of the concept of deprivation of liberty by the UK Supreme Court in *Cheshire West* means that under the MCA these safeguards are needed for many more people in care homes and hospitals, as well as in community settings such as foster care placements, than had previously been understood. The starting point for policy makers in New Zealand, however, is to accept the need, in principle, to fill the Bournemouth gap, and then to consider how widely detention should be interpreted and to respond appropriately within the New Zealand context.
- 3.99 The number of people in supported residential or hospital care is likely to grow quite substantially in New Zealand as the community ages and life expectancy increases. It is an ongoing challenge to devise sufficiently flexible and efficient care as well as practical legal safeguards for people likely to need support in deciding where they will live, especially where restrictions are placed on their liberty, even if for their own welfare.
- 3.100 There needs to be a concerted policy and legislative response that reflects the importance of personal liberty and freedom of movement, set within the wider review of mental capacity legislation. Subordinate legislation or guidelines alone would not be sufficient or effective to ensure that an adequate legal framework exists to protect the interests of this vulnerable group. Along with better provision for supported decision-making, proper legal safeguards for people who lack capacity and are deprived of their liberty are urgently required for New Zealand to comply with its obligations under arts 12(4) and 14 of the CRPD.

⁵³¹ In Ontario, the Public Guardian has a wide ranging role in protecting the rights and interests of mentally incapable adults (<https://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/overview.php>). Office of the Public Guardian under the MCA (England and Wales) (<https://www.gov.uk/government/organisations/office-of-the-public-guardian/about>). See Chapter 1C Overview of MCA.

⁵³² For example, the Otago Welfare Guardians Trust and the Wellington Welfare Guardians Trust, <http://welfareguardians.nz/>.

⁵³³ Law Commission, above n 199 at 31.

RECOMMENDATIONS FOR LIBERTY SAFEGUARDS

1. Revised mental capacity legislation should provide legal mechanisms, criteria, and procedures, to govern decisions involving the deprivation of liberty of people who lack capacity, referred to as “Liberty safeguards”,⁵³⁴ including:
 - a) a two-step authorisation process to, initially, identify a deprivation of liberty, and then to monitor an ongoing deprivation of liberty;
 - b) rules governing how such decisions are to be made, by whom, and under what process; when the liberty safeguards are to be used; their duration and discharge;
 - c) a standard stating that decisions should be made in the best interests (and according to the known will and preferences) of the person, when the liberty safeguards apply;
 - d) a speedy mechanism for the designated decision-maker, whether an independent individual (for example, the equivalent of the District Inspector under the MH(CAT) Act) or a public body that can provide independent oversight to authorise a deprivation of liberty, with ready access thereafter to review of the decision by a Tribunal or the Family Court;
 - e) a Code of Practice for health and social service providers to operationalise the liberty safeguards;
 - f) a publicly appointed and independent person or body to be available to act an advocate for people who lack capacity and who have no other suitable person to support and represent them in the liberty safeguarding process; and
 - g) options for ensuring the oversight and monitoring of compliance of these liberty safeguards by a public body or agency (such as a Public Guardian) established under the legislation.
2. A comprehensive review should be undertaken of legislative schemes regulating deprivation of liberty in comparable jurisdictions, including the proposed legislation and changes to the MCA to be recommended by the English Law Commission (due end of 2016).
3. Consultation with the health and disability sector in the development of the liberty safeguards that could be enacted that would have sufficient flexibility to cover the range of environments where deprivations of liberty occur, and could operate in the most effective and cost-efficient way.

⁵³⁴

The term “liberty safeguards” is suggested as preferable to “deprivation of liberty safeguards”. According to the English Law Commission, the naming of the proposed new safeguards has provoked the most debate in the Law Commissions proposals to date. This is because some consultees understood the phrase “deprivation of liberty safeguards” to mean that people were being denied access to legal rights. The English Law Commission is consulting further on this aspect of its review of the legislation: Law Commission, Interim Statement, above n 225.