

Scottish Public Law Group Seminar - 19 November 2015

The Scottish Law Commission project on deprivation of liberty in the context of adult incapacity: Was Stair Right?

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Introduction

I have distributed a set of pictures to accompany this talk. It is not a handout. The four illustrations will permit digression as I speak. I have also given my talk a title: 'Was Stair right?'

I want to start by eliciting a rough sense of familiarity with the issue of deprivation of liberty in the context of adult incapacity. Before I do, there is no shame. I see this as a fascinating issue, but then I spent five years on it. It is not a matter that has come before the Scottish Courts in any significant way.

I am going to ask about the Bournemouth cases, by which I mean *R v Bournemouth Community and Mental Health NHS Trust ex parte L* [1999] 1 AC 458 and *HL v UK* (2005) 40 EHRR 32. There is a clue to what happened just in those names and that order.

How many people are familiar with the Bournemouth cases?

How many people are familiar with the Supreme Court decision in the case of *Cheshire West (P v Cheshire West and Chester Council; P and Q v Surrey County Council* [2014] UKSC 19, March 2014)?

How many people have read some or all of the Scottish Law Commission Report on the issues?

Well, I hope you will be more familiar after the next 20 minutes.

Bournemouth

Eighteen years ago at this time (that is, in November 1997) a man only ever known publicly as HL was resident in a psychiatric hospital in Surrey called Bournemouth. Here is a picture of a similar institution in Lanarkshire, Hartwood hospital (and this was the nurses' home). This story starts in previous types of institutional care. Bournemouth hospital closed around that time. HL had severe autism, and behavioural difficulties. He had been a long term resident in the hospital but about three years earlier, had moved into the community, to live with adult carers. The reason he was back in hospital concerned an episode at a day centre. He was taken to hospital without the consent of his carers; HL himself was said to lack decision-making capacity (which is a continuum). It was argued in court that he was

compliant, therefore there could be no deprivation of liberty. If there was a deprivation of liberty, it was justified because of necessity.

After Strasbourg, the position was that he had been deprived of his liberty, his compliance was irrelevant and the doctrine of necessity was not good enough to be the lawful process required. Article 5 had been breached.

The Deprivation of Liberty Safeguards were then introduced in England and Wales. The project was led by the Department of Health and done in quite a short time. The safeguards proved very complicated, very demanding, and the whole regime was poorly understood.

People struggled to determine when the care of a person with cognitive impairment amounted to a deprivation of liberty, a problem not helped by the fact that the statutory definition was tied to Strasbourg case law.

Cheshire West

The next chapter of this story is set in the Supreme Court in October 2013, when seven judges sat to consider two appeals. These related to the circumstances of three individuals, two in small group homes and one living with a foster carer. All three situations were held to have amounted to deprivation of liberty, though the first appeal was a unanimous decision and the second a four/three split. The test which emerged was that anyone who is subject to continuous supervision and control and not free to leave is deprived of their liberty.

Lady Hale observed that if something would be a deprivation of liberty for her, then it is for a person with cognitive impairment too. A gilded cage is still a cage.

In response, I suggest that the context is all – whether a cage represents confinement or protection depends on the dangers presented to you by your environment.

Consequences of the decision

- There were 137,540 DoLS applications received by councils between 1 April 2014 and 31 March 2015, the most since the safeguards were introduced in 2009. This is a tenfold increase from 2013-14 (when the figure was 13,700).

From last quarter, to end September, the figures are running at about 200,000 per annum for England. About a fifteen fold increase. The statistics are not entirely satisfactory – 27 of 152 local authorities provided no figures. And – Hampshire had 418 in September, the City of London 6. Is there really a 70 fold variation between local authorities? It has been estimated that local authorities require another £1.5bn to comply fully with the DoLS regime.

Scotland

‘An over-reliance on judicial procedures [whereby a universalist approach is taken to seeking welfare guardianship] whenever individuals lack capacity to make any decisions about their care and treatment will result in an unsustainable demand on the statutory services involved in implementing the legislation. The net result will be a process of professional assessment, application and judicial decision-making which is cursory, routine and overly bureaucratic. It will provide only the semblance of the rights of the individual being protected.’

Mental Welfare Commission, 2012, in their response to our Discussion Paper.

The timeline for the SLC project was that an Advisory Group was formed in 2010 and a scoping paper prepared (an internal document). The Discussion Paper was published in 2012; responses were received and analysed, a policy paper was produced in 2013 (another internal document) and the report was published in 2014.

Could we be like Pilate? Could we put the problem in the ‘too difficult’ drawer?

No – because there was a legal problem, which is that our law does not provide a specific process for deprivation of liberty. The Scottish Law Commission has a track record in incapacity law – the Adults with Incapacity (Scotland) Act 2000 was based on SLC work. I have heard this described as an area of Scots law which has been codified. This is a positive comment – codification was an early goal in the lives of the Law Commissions.

The independence of the Scottish Law Commission and its potential to try to take account of comments across the range of interests, which is very wide, also made it a suitable body to examine the issue. And this is not just a legal problem. In our jurisdiction, people are being over-restricted. But the backdrop is of a struggle to provide care. It is not just Article 5 which is involved, but Articles 2 and 3 as well. It reflects the struggle between welfare and justice or, if you prefer, between protection and autonomy.

We decided to concentrate on people who are more restricted and to introduce a process for them. We aimed to do less, and do it well.

Firstly, hospitals. We became aware of the tagging of people with cognitive impairment in general hospitals. Our initial idea was to ban informal admission to hospital of those who couldn’t consent to it. In their response, the Royal College of Psychiatrists described this as a *reductio ad absurdum* – my many years of interpreting language and my small retained ability in Latin enabled me to realise they didn’t like it.

So we recommended that where measures are being taken, such as tagging or locking people in, there should be a process, added into current processes for securing consent to medical treatment, to underpin the adoption of such measures and to allow rights of challenge.

Turning to the community – we focused on the matters of where people live and how people live.

We do have people living where they don't want to and, in essence, if that is occurring, the decision needs to be taken by a court. This is about someone's home, and the conclusion is not only for reasons of lawful process, but also because it is possible that people will be compulsorily returned to a place, and we should not be doing that on an *ad hoc* basis.

How people live? One response suggested that the main problems in the area are over-use of restraint, seclusion and sedation. We tried to address that.

Our scheme tries to build on the difference between restriction of liberty (protected by Article 2 of Protocol 4, which is signed but not ratified by the UK) and deprivation of liberty. It also tries to be straightforward for non-lawyers to operate – many problems in England are related to the difficulty in knowing when there is a deprivation of liberty. So, what did we do?

We appreciated that definition is for Strasbourg. So we created 'significant restriction of liberty', which is supposed to capture the point on the spectrum where restriction is so great that it becomes deprivation. Then we provided that use of any two of three types of measure amounts to significant restriction of liberty. The types of measure are locked main door, seclusion, and control of the person's actions, including by medication. We then made further recommendations about process and authorisation. We borrowed shamelessly but with attribution from Melbourne – the Victorian Law Reform Commission – which had, in its impressive report on guardianship, drawn up a process called collaborative authorisation. Authorisation in our scheme is to involve key personnel – doctors, Mental Health Officers and managers. There is the possibility of authorisation by a welfare power of attorney. Rights of involvement and of challenge for the person involved are included in the scheme.

The Scottish Government has said it will consult further.

In England and Wales, the matter has ended up on the Law Commission's desk. It is very unusual for them to be behind us. We have no term for that, albeit we have coined a phrase for the opposite way round, 'putting a kilt' on something. They aren't doing that anyway, although they have used one or two of our ideas, again attributed. They have said there won't be legislation before 2017.

I want to leave you with three thoughts.

First, a recognition – I believe concentrating on the most restricted people is reasonable, and it is interesting that the unanimous decision in the Supreme Court related to the person in that position. There is something about a highly intrusive regime that instinctively means it needs authorisation. But many people’s quality of life is affected by restrictions that are more than they need. There are care homes where people are never out, and even the garden is locked. We need good policies and a good inspection service.

Secondly, it was observed early on by an Advisory Group member that we should not forget that we are here to fix a legal problem. We want to make people’s lives better, but we have to recognise that law is not always the best way to alleviate social and personal predicaments.

Thirdly – what did James, Viscount Stair have to say?

In 1681, he said this. ‘We may also... restrain a furious person, one who is inferring violence to himself, in his life or limbs, because this is not against any act of his lawful liberty, and is done as a duty in us of love and mercy’.

So, more than 300 years ago he saw the tension in the area. This tends to suggest that this will not be an easy problem to solve.