The Department of Health has recently published its third annual report on the use of the Deprivation of Liberty Safeguards (DoLS) since they were introduced into the Mental Capacity Act 2005 (MCA) by the Mental Health Act 2007 on 1 April 2009.

The introduction of the DoLS process resulted from the violations of articles 5(1) and 5(4) of the European Convention on Human Rights found in HL v United Kingdom [2004] ECHR 471. In that case, HL was an incapacitated adult who complied with the deprivation of his liberty.

The lack of statutory safeguards meant that he could not have challenged his deprivation of liberty in a court or tribunal, and there was no process by which another person might have brought such proceedings on his behalf.

Impact assessment
It is the role of a managing authority (i.e. care homes and hospitals) to make urgent authorisations under the DoLS process and/or to request standard authorisation assessments be carried out by supervisory bodies (local authorities and trusts).

Before the implementation of the DoLS, the government’s impact assessment for the statutory scheme predicted that approximately 5,000 people in England who lacked capacity to make decisions about their treatment and care were likely to be being unlawfully deprived of their liberty.

However, in the first two years of their introduction, I was surprised to find so few applications for DoLS authorisations were being made or even considered. In my view, the reason for the low number of applications related more to a lack of understanding of the new provisions by managing authority staff, than to the number of incapacitous residents being deprived of their liberty within their care.

Nonetheless, the new data for 2011-2012 shows that there has been a steady and almost continuous increase in the number of DoLS applications each year, which is contrary to the Department of Health’s (DoH) predictions that applications would fall at a constant rate between 2009 and 2016.

It is the care home or hospital that must ask for an authorisation and, if requested, the local authority or trust must provide assessors. London has the lowest number of authorisations made, which may be surprising. I would suggest that the huge disparity between the number of standard authorisations issued by different local authorities is likely to result from a lack of training of management and staff at different residential homes.

Only eight per cent of authorisations made were granted (cumulatively) for a period of over a year. Just over half were granted for three months or less. This is perhaps surprising when the majority of people who lack capacity in care homes (rather than hospitals) might be thought unlikely to regain capacity, given permanent mental disability such as learning disability, or progressive brain degeneration, such as in dementia.

Indeed, the figures confirm that almost 60 per cent of all authorisations related to those over the age of 75, and 53 per cent of all applications related to those with a diagnosis of dementia.

The DoH’s figures make it clear that there are far fewer authorisations made by trusts, and this is likely to result from the fact many patients will be acutely unwell, bed bound, and perhaps unable to express a wish to, or to in fact, leave. For all practical purposes, they may simply be compliant, although if they requested their discharge and were thought to lack capacity, no doubt they would be prevented from discharging themselves.
However, if they are too ill to contemplate leaving or to so attempt, in reality it is unlikely that an authorisation will be sought, even if required, since to fail to do so is a reversion to the state of the law prior to HL v UK.

Best interests
A supervisory body has no discretion to refuse to grant a standard authorisation if it has received copies of the assessments, all of which are positive (paragraph 50(1) of schedule A1). It is surprising, therefore, that only just over half of all requests lead to authorisations being made.

While this is double the prediction, one would expect training to minimise the number of applications requested where the person concerned would be ineligible for DoLS protection.

Non-grant will arise where the person did not meet all of the eligibility criteria, where they were not being deprived of their liberty, or where the deprivation of liberty was not in a person’s best interests. 81 per cent of refused applications related to the latter.

In 93 cases, a standard authorisation was not granted, even though a best interests assessor considered the person to be deprived of their liberty. In very few cases, a best interests assessor’s conclusion that, notwithstanding the fact that the restrictions amount to a deprivation of liberty, they are not in the person’s best interests, will lead to the refusal of an authorisation.

This is because in A County Council v MB (by the Official Solicitor as her litigation friend), and JB [2010] EWHC 2508 (Fam), the court criticised a best interests assessor for providing a negative best interests assessment when there was no practical alternative to the placement in the short term.

Charles J suggested that in such cases, the appropriate course would be to recommend an authorisation for a short period of time, as an interim measure, while an alternative care plan involving less restriction on liberty was produced.

Other negatives of the DoLS system include the fact that the process is invariably both costly and time-consuming for supervisory bodies.

The volume, length and sheer number of unwieldy COP forms is a source of frustration. There has been talk for several years of streamlining the forms, but this has not occurred as yet.

Further, the quality of assessments carried out by assessors vary throughout England and Wales. There has been a confusion by best interests assessors as to what conditions can be recommended pursuant to paragraph 43 of schedule A1 under DoLS and the purpose of attaching such conditions.

By way of paragraph 53(2), the supervisory body must have regard to the recommendations implement conditions, but in my experience, almost invariably any recommended conditions will be included in the authorisation.

It is of concern that the courts themselves have weakened the new system of protection.

Imperfect science
The DoLS system is not perfect: the DoLS forms are repetitive, which necessarily leads to wasted time and money, and, as with any new legislation, the courts have needed to interpret and clarify the law.

However, the process has introduced an important system of checks and balances to ensure the UK’s compliance with articles 5(1)(e) and 5(4) of the European Convention on Human Rights, and provided a clear route to review, which was not afforded to the incapacitated prior to the scheme’s implementation.

Yet it is a rare case in which, despite a past violation of article 5, the person who has had their rights breached receives compensation. The court process does not provide an obvious pathway to compensation, and the application of the overriding objective, as set out in rule 3 of the Court of Protection Rules 2009, makes it unlikely that the court would consider it proportionate to hold a trial on historical short ‘gaps’ in authorisations. Are the protections within the DoLS process therefore illusory?

Unfortunately, the courts have since made a number of decisions which have weakened the important protections for the incapacitated introduced by the DoLS process.

Notably, the approach of Parker J in Mig & Meg (2012) EWHC 785 (Fam), approved by the Court of Appeal in P & Q (2011) EWCA Civ 190, permitting relevance to be attached to the ‘purpose’ of restrictions when assessing whether or not there has been a deprivation of a person’s liberty has confused that question with whether or not such deprivation is in their best interests.

In accord, Munby LJ in Cheshire West & Chester Council v P [2011] EWCA 1257 considered it permissible when determining whether or not there was a deprivation of liberty “to have regard both to the objective ‘reason’ why someone is placed and treated as they are and also to the objective ‘purpose’ (or ‘aim’) of the placement”.

The Court of Appeal held that where it would not be possible for a person to live a ‘normal’ life without restriction regardless of where the person lived, then they would not be deprived of their liberty.

Thus, “in the case of an adult with disabilities, the relevant comparator is an adult of similar age with the same capabilities and affected by the same condition or suffering the same inherent mental and physical disabilities and limitations”.

The effect of these two judgments is that in very few cases would the ordinary restrictions placed on residents of nursing and care homes amount to a deprivation of their liberty. This might explain the 16 per cent dip in authorisations being made between December 2011 and April 2012.

While any procedure introduced to enhance and protect the rights of the vulnerable must be welcomed, it is of concern that the courts themselves have weakened the new system of protection. Despite the courts’ assertions otherwise, I suggest that these key decisions were made for policy reasons in order to reduce the volume of authorisations required and the number of cases finally starting to come before the Court of Protection.

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