

Bundle BCU Mental Health Legislation Committee 6 August 2026

1 10:00 - PRELIMINARY MATTERS

- 1.1 MH26.38 Welcome & Apologies
Gareth Williams, Chair
- 1.2 MH26.39 Declarations of Interest
Gareth Williams, Chair
- 1.3 MH26.40 Minutes from the Previous Meeting 14 May 2026
Gareth Williams, Chair
 - 1.3 Unconfirmed Minutes Public MHLC 14.5.26
- 1.4 MH26.41 Action Log
Gareth Williams, Chair
 - 1.4 Summary Action Log PUBLIC

2 ROUTINE REPORTING FOR ASSURANCE

- 2.1 10:05 - MH26.42 Mental Health Act Assurance Report
Matthew Joyes, Deputy Director of Legal Services
 - 2.1.1 MHA Assurance Report - Cover Sheet
 - 2.1.2 MHA Assurance Report - Report
- 2.2 10:20 - MH26.43 Mental Capacity Assurance Report
Michelle Denwood, Director of Safeguarding & Public Protection
 - 2.2.1 MHLC DoLS and MCA Update Report
 - 2.2.2 APPENDIX 1 Supreme Court Judgment DoLS 2026
 - 2.2.3 APPENDIX 2 DoLS MCA Action Plan following the Supreme Court Judgment 2026
 - 2.2.4 APPENDIX 3 BCUHB DoLS Supreme Court Judgment Briefing Paper
 - 2.2.5 APPENDIX 4 Duty-Screening Form No-deprivation
 - 2.2.6 APPENDIX 5 BCUHB DoLS Flowchart following the Supreme Court Judgment
- 2.3 10:35 - MH26.44 Healthcare Inspector Wales (HIW) Assurance Report
Matt Joyes, Deputy Director of Legal Services
 - 2.3 HIW Assurance Report
- 2.4 10:45 - MH26.45 Associate Hospital Managers Update Report
Matt Joyes, Deputy Director of Legal Services
 - 2.4 AHM Update Report
- 2.5 10:55 - MH26.46 Report from the Power of Discharge Group
Matt Joyes, Deputy Director of Legal Services
 - 2.5 POD Chairs Report
- 2.6 11:05 - MH26.47 Mental Health Advocacy Group
Teresa Owen, Executive Director of Allied Health Professionals & Health Sciences
 - 2.6 MHLC Annual Statutory Advocacy report 060826

3 FOR INFORMATION

- 3.1 11:15 - MH26.49 Corporate Governance Report
Pam Wenger, Director of Corporate Governance
 - 3.1.1 Corporate Governance Report
 - 3.1.2 Mental Health Legislation Committee ToR
 - 3.1.3 Cycle of Business for the MHL Committee 2026-27
- 4 11:20 - CLOSING BUSINESS
- 4.1 MH26.50 Agree Items for Referral to Board / Other Committees
Gareth Williams, Chair
- 4.2 MH26.51 Review of Meeting Effectiveness
Gareth Williams, Chair
- 4.3 MH26.52 Date of the Next Meeting - 12 November 2026
Gareth Williams, Chair
- 4.4 MH26.53 Resolution to Exclude the Press & Public
'Those representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960'

Betsi Cadwaladr University Health Board (BCUHB)
Unconfirmed Minutes of the Mental Health Legislation Committee
held in Public on 14 May 2026
held in the Boardroom, Carlton Court, St Asaph and via Microsoft Teams

Committee Members Present	
Name	Title
Gareth Williams	Chair
Prashant Bhat	Consultant Psychiatrist
Michelle Denwood	Director Of Safeguarding and Public Protection
Jenny Gilmore	Associate Hospital Manager
Dyfed Jones	Independent Member
Matthew Joyes	Deputy Director of Legal Services
Wendy Lappin	Mental Health Act Legislation Manager
Teresa Owen	Executive Director of Allied Health Professionals & Health Sciences
Alberto Salmoiraghi	Consultant Psychiatrist
Rhian Watcyn Jones	Independent Member (via teams)
Philip Williams	Associate Hospital Manager
Committee Support	
Philippa Peake-Jones	Head of Corporate Governance
Harriet Abbott	Minute Taker

PRELIMINARY MATTERS

MH26.20 Welcome and Apologies

Apologies were received from Clara Day, Dyfed Edwards, Debbie Eyitayo, Ffion Johnstone, and Angela Wood.

MH26.21 Declarations of Interest

No declarations of interest were received.

MH26.22 Unconfirmed Minutes of the Meeting held on 5 February 2026

It was agreed that the minutes of the meeting held on **5 February 2026** were a true and accurate record.

MH26.23 Matters Arising & Action Log

The Committee reviewed the action log and noted the forthcoming development session. It was agreed that this will be scheduled within the next three months, with a date to be circulated to relevant members at the earliest opportunity.

It was resolved that the Committee:

- **AGREED** to close the actions that were proposed for closure.



ROUTINE REPORTING FOR ASSURANCE

MH26.24 Mental Health Act (MHA) Assurance Report

The item was presented jointly by the Deputy Director of Legal Services and Mental Health Act Legislation Manager. The following points were highlighted:

- The Mental Health Act continues to be managed effectively across the organisation, with no fundamental issues requiring escalation at this time.
- Since the previous meeting, monies have been identified for a permanent link role with CAMHS which will provide support back to the service, creating a more stable position within the Mental Health Act team. Sickness absences and phased return has impacted on team capacity over the last quarter.
- The new Mental Health Act is now law, with phased implementation over the coming years.
- An increase in rectifiable errors has been noted, specifically in March. This is believed to relate to increased capacity within the new roles, allowing more capacity to scrutinise.
- An increase in Section 136s is also noted, with a high percentage discharged. A Task & Finish group between BCUHB and North Wales Police is underway to address several areas, including Section 136, with ways of working under review and to understand reason for increasing rates with relevant actions in place.

In discussing the item, the Committee:

- Reviewed the data presented within the report and noted the importance of effectively sharing information with partners, including North Wales Police and Local Authorities. It was advised that working relationships with Local Authorities varies across the region and a task and finish group has been established with partners invited to attend. A brief update on the Task and Finish group is to be included as an appendix with the Mental Health Act Assurance Report at the next Committee meeting, and to include information such as powers under the new act and work being done to reduce numbers.
- Noted a low use of Section 136s for under 18-year-olds over the past 12 months.
- Noted the differing levels of response from Local Authorities and felt this was useful to explore to see what could be done to improve engagement. It was considered that often there is no single point of access, and how this approach often aids working relationships and provides improved governance, similarly to the approach used with North Wales Police.
- Noted areas within the new act that may cause challenge and referenced the need of ensuring the least restrictive intervention is used.
- Safeguarding aspects of enquiries are taking place to identify learning opportunities.

The following action was agreed:

- **Action MH26.24.1:** A brief update on the Task & Finish group is to be included as an appendix with the Mental Health Act assurance report at the next committee meeting.

It was resolved that the Committee:

- **NOTED** the report.

MH26.25 Mental Capacity Assurance (MCA) Report

The item was presented by the Deputy Director of Legal Services. The following points were highlighted:

- Work is moving forward with the commissioning of the MCA service, with the aim of a nationally procured service.
- Regarding staffing requirements and training, this is now aligned with ESR and skill sets to ensure KPIs are identified. Positive data has been seen in regard to the MCA training compliance. It was noted that Welsh Government monies have been vital for this work, and whilst these are permanent funds, the Health Board is required to submit evidence on how this is spent for evaluation.
- A new national pilot form has been implemented, with the Health Board linking in with the national team. Results will be disseminated once received.
- Whilst there is no current timescale for implementation of an electronic record, the Health Board are linked in with the national team to identify core domains for inclusion.

In discussing the item, the Committee:

- Noted the awaited judgement from the Supreme Court, and the anticipated changes to the framework.
- Queried the reporting process regarding the Mental Health Advocacy group and the reporting process. Further discussion to be held outside of the meeting to understand if a specific update is required as a standing item at Committee to ensure appropriate governance.

The following actions were agreed:

- **Action MH26.25.1:** Further discussion to be held to understand if a specific update from the Mental Health Advocacy group is required as a standing item at Committee

It was resolved that the Committee:

- **NOTED** the report.

MH26.26 Healthcare Inspectorate Wales (HIW)

The Deputy Director of Legal Services presented the item, highlighting the following points:

- There were no inspections during this period, however, there has been an HIW visit to a community team recently which will feature in the next report. Following the visit some actions were produced around how the organisation monitors how patients receive their rights. Short term actions are in place, with the long-term focus on implementation of a new electronic system.

It was resolved that the Committee:

- **NOTED** the report.

MH26.27 Associate Hospital Managers Update Report

The item was presented by the Deputy Director of Legal Services. The following points



were highlighted:

- Performance, whilst under target, has increased significantly. Prior to Christmas 2025 this was 47% and is now 67%. This is a self-set target for good practice.

In discussing the item, the Committee:

- Noted several cases where hearings were stood down due to unavailability of panel members and discussed the potential reasons for this. Assurance was given advising sufficient notice of hearings to ensure availability and any required workload adjustment. There has also been reallocation to the wider legal services team to prevent similar issues, due to increased capacity.
- Noted the inclusion of reasons for hearings not being held following previous action from Committee and requested that future reports also include the length of the delay.
- Noted the annual audit information incorporated within the report and were advised that the annual formal audit report will be available in January 2027.
- Noted issues regarding delayed receipt of paperwork, and how this can impact of hearings and avoidable delay.
- Were advised of ongoing work to support patients subject to Community Treatment Orders (CTOs) to attend hearings and ensure their attendance preference is recorded. Staff are working with patient care coordinators to ensure there is opportunity for patient contribution. This was an area requiring improvement previously highlighted by HIW.

The following actions were agreed:

- **Action MH26.27.1:** future reports include the length of the delay for postponed hearings or those not held.

It was resolved that the Committee

- **NOTED** the report.

MH26.28 Report from the Power of Discharge Group

The item was presented by the Deputy Director of Legal Services. The following points were highlighted:

- The Power of Discharge Group continues to meet quarterly.
- Ongoing training on paperwork is progressing well, with positive collaboration.
- A new Associate Hospital Manager (AHM) has joined the group recently.
- Areas of concern include:
 - i) Hearing format: patient preference on hearing format is now sought. There is often preference for in person from AHMs as this can allow better patient engagement.
 - ii) Delays in packages of care: packages of care continue to cause extended hospital stays, creating challenges. Delays often relate to financial constraints, placement availability and homelessness.

In discussing the item, the Committee:

- Highlighted the need to ensure reference within the Terms of Reference (ToR) regarding the Medical Director of Mental Health & Learning Disabilities or Clinical



Lead can nominate a lead to attend.

- Raised concern over delays caused by packages of care, and were advised this is recorded as a risk, and is a national issue. The importance of considering discharge criteria was highlighted to ensure legal and appropriate detainment. The Committee requested this issue is referred to the Quality, Safety and Experience (QSE) Committee to gain assurance.
- Noted the reduction in Out of Area (OOA) placements.
- Raised a query regarding AHM access to section 117 plans, and it was agreed for this to be explored operationally outside of the meeting.

The following actions were agreed:

- **Action MH26.28.1:** update of delays to packages of care regarding MHLD to be received at QSE Committee.

It was resolved that the Committee

- **NOTED** the report.
- **APPROVED** the POD Terms of Reference
- **APPROVED** the AHM appointment

FOR INFORMATION

MH26.29 Corporate Governance Report

It was resolved that the Committee:

- **NOTED** the report.

CLOSING BUSINESS

MH26.30 Agree Items for Referral to Board / Other Committees

The Committee wishes to alert members of the Board that:

- There is low and stable use of Section 136 powers in under-18s, and noted improving performance trends in Associate Hospital Manager hearings following recovery from earlier capacity issues.
- Pressures associated with delayed discharge pathways and packages of care create potential risk to the appropriate and proportionate application of Mental Health Act powers across the system.
- Continuing operational pressure related to Section 136 activity, including a high proportion of discharges with no mental disorder identified, was noted as a system concern.
- Ongoing inter-agency dependencies, including variable local authority engagement, continue to contribute to delays outside the direct control of the Committee.

The Committee wishes to assure members of the Board that:

- Mental Health Act governance, monitoring and statutory reporting arrangements remain robust and compliant with legislative requirements.
- Inspection findings, audit outcomes and issues identified through Associate Hospital Manager scrutiny are subject to active oversight and tracked action.



- Work is ongoing to stabilise Mental Health Act workforce capacity and strengthen resilience within legal and administrative support functions.

The Committee wishes to advise members of the Board that:

- Had an interesting discussion of informal admissions from section 2 detentions and whether this was a positive or negative indicator.
- Future assurance should continue to triangulate Mental Health Act activity with quality, safety and patient experience intelligence.

The Committee agreed that the emerging risk relating to delayed packages of care impacting the appropriate application of Mental Health Act powers should be escalated to the Quality, Safety & Experience Committee for system-level oversight.

MH26.31 Review of Meeting Effectiveness

The Committee:

- Welcomed the openness and transparency reflected through the meeting, with a focus on comprehensive data and valuable discussion.
- Emphasised the importance of ensuring feedback on items from Board or other committee meetings on relevant items.

MH26.32 Date of next meeting

6 August 2026

MH26.33 Resolution to Exclude the Press and Public

'Those representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960'



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Mental Health Legislation Committee Action Log - PUBLIC

Updated 14.07.26

Open Actions						
Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
1	MH26.5.4	5/2/2026	Mental Health Act Assurance Report Number of hearings and first place of safety rates to be reviewed in 12 months to identify potential trends.	Chair	February 2027	Remain Open Included on forward workplan.
Actions Proposed for Closure						
1	MH26.28.1	14/5/2026	Update of delays to packages of care regarding MHL D to be received at QSE Committee	Teresa Owen	September 2026	Proposed for closure Added to QSE forward workplan for inclusive in the next MHL D update at QSE.
2	MH26.24.1	14/5/2026	Mental Health Act Assurance Report A brief update on the Task & Finish group is to be included as an appendix with the Mental Health Act assurance report at the next committee meeting.	Matthew Joyes	August 2026	Proposed for closure 02.06.26 – noted on august agenda
3	MH26.27.1	14/5/2026	Associate Hospital Managers Update Report Future reports include the length of the delay for postponed hearings or those not held	Matthew Joyes/Wendy Lappin	August 2026	Proposed for closure 02.06.26 – noted on august agenda
4	MH26.25.1	14/5/2026	Mental Capacity Assurance Report Further discussion to be held to understand if a specific update from the Mental Health Advocacy group is required as a standing item at Committee	Teresa Owen	August 2026	Proposed for closure 17.06.26 – update requested and included on August agenda



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5	MH25.24.1	8/5/2025	HIW Assurance Report Section 17 leave to reviewed at future date and reported back to Committee	Teresa Owen	February 2026 August 2026	Proposed for closure 16.10.25 - To be covered in workshop session 06.05.26 – timescale updated to allow time for workshop to be arrange with all required attendees 14.07.26 – workshop scheduled for 20.08.26
6	MH25.39.1	7/8/2025	Matters Arising & Action Log Circulate a briefing on hearings and right to discharge (compare and contrast Mental Health Tribunal and Associate Hospital Managers) and agenda an item on this for the next meeting	Matthew Joyes	February 2026 August 2026	Proposed for closure 16.10.25 - To be covered in workshop session. 13.11.25 – To be discussed a future workshop session. 06.05.26 – timescale updated to allow time for workshop to be arrange with all required attendees 14.07.26 – workshop scheduled for 20.08.26
7	MH25.40.1	7/8/2025	Mental Health Assurance Report Informal workshop regarding MHA Sections to be arranged	Alberto Salmoiraghi, Pam Wenger, Matthew Joyes	February 2026 August 2026	Proposed for closure 16.10.25 - To be covered in workshop session. 06.05.26 – timescale updated to allow time for workshop to be



						arrange with all required attendees 14.07.26 – workshop scheduled for 20.08.26
Closed Actions (as agreed at meeting on 14 May 2026)						
Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
1	MH25.22.2	8/5/2025	Mental Health Act Assurance Report Arrange for an update on children's services to be added to agenda for a future meeting (alternatives to access)	Prash Bhat/Louise Bell	November 2025	Closed 16.10.25 – Matthew Joyes to check with CAMHS for update. Agreed to include paragraph in next assurance report for Nov 25 meeting. To be added to AAA report and transferred to Executive Committee at next meeting. 13.10.25 – Advised in meeting, risks & mitigations actively managed operationally. Issue to be raised via the Vice Chairs Network by the Chair. 02.04.26 – agreed to close. Agreed in October meeting to be taken through OLT, prior to EC.
2	MH25.07.1		MH25.21 Matters Arising & Action Log A copy of the national standard of accessible / easy read information to come back to a future meeting as a pack for review. A request was made that this would be made available	Teresa Owen	July 2025	Closed Information available below https://jcc.nhs.wales/our-



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			bilingually.			structure/mhldvg/mha/easy-read/ 16.10.25 - Easy read currently only in English. TO reviewing and will raise with WG colleagues 13.11.25 – Welsh translation outstanding on website. PPJ to chase. 05.02.26 – information noted as outstanding on website. TO to follow up.
3	MH26.5.2	5/2/2026	Mental Health Act Assurance Report Include reference to resourcing and MHA in AAA report for the Board in March.	Philippa Peake-Jones	February 2026	Closed Referenced in AAA report for Board.
4	MH26.5.1	5/2/2026	Mental Health Act Assurance Report Data inconsistencies to be reviewed and amended for implementation in the new performance report.	Matt Joyes / Wendy Lappin	May 2026	Closed 31.03.26 – to be included in future reports
5	MH26.5.3	5/2/2026	Mental Health Act Assurance Report Request follow up on previous Mental Health Practitioner pilot in East Area.	Teresa Owen	May 2026	Closed 31.03.26 – on agenda
6	MH26.8.1	5/2/2026	Associate Hospital Managers Update Report Narrative explaining reason for hearings not held to be included in future reports.	Matt Joyes / Wendy Lappin	May 2026	Closed 31.03.26 – to be included in future reports
7	MH26.9.1	5/2/2026	Report from the Power of Discharge Group Data regarding any experienced delays to be gathered for monitoring, with an update	Matt Joyes / Wendy Lappin	May 2026	Closed 31.03.26 – on agenda



			provided at the next meeting			
8	MH26.6.1	5/2/2026	Mental Capacity Assurance Report Follow up with the Vice Chair regarding outcome of previous agreement of discussing at the Vice Chairs Network for improvement in response rates.	Chair	May 2026	Closed 02.04.26 - Raised at vice chair network meeting
9	MH26.6.1	5/2/2026	Mental Capacity Assurance Report The risk register to be updated to reflect the risk relating to the IMCA service	Chris Walker	February 2026	Closed 02.04.26 – risk resolved.



Mental Health Legislation Committee

ADRODDIAD SICRWYDD DEDDF IECHYD MEDDWL (MHA) MENTAL HEALTH ACT (MHA) ASSURANCE REPORT

Dyddiad y Cyfarfod Date of Meeting	06 August 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Wendy Lappin Mental Health Act Legislation Manager Matthew Joyes Deputy Director for Legal Services
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Teresa Owen, Executive Director of Allied Health Professionals and Health Science Pam Wenger, Director of Corporate Governance
Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol **Executive Summary**

This assurance report provides an overview of the operation and governance of the Mental Health Act (MHA) across the Health Board for the quarter ending **June 2026**, highlighting activity levels, compliance, identified exceptions, and associated risks.

The report provides assurance that Mental Health Act (MHA) administration and monitoring arrangements across the Health Board remain robust, with the majority of detentions and statutory processes being managed appropriately. Mental Health Act training has resumed with high levels of staff engagement, and preparations continue for future implementation of the Electronic Patient Record system, which is expected to improve reporting capabilities. The MHA Team continues to manage a staffing vacancy, with recruitment activity underway.

Three notable exceptions were identified during the quarter:



- **Section 2 detention lapsed** due to the Responsible Clinician failing to undertake a review before expiry. Following review by the covering Responsible Clinician, no further detention was required. Investigation confirmed escalation processes were followed appropriately.
- **Section 2 detention deemed invalid** following admission from England because English statutory paperwork was used for admission into Wales. A new assessment and application were completed locally to rectify the situation.
- **One Section 136 detention exceeded the standard timeframe**, ending at 36 hours after a lawful 12-hour extension due to the individual being medically unfit for assessment. The patient was subsequently assessed and admitted under Section 2.

The Health Board continues to see a decrease in trend activity under Sections 2 and 3, consistent with previous quarters. Use of emergency holding powers remained proportionate and appropriate with low numbers for S5(4) and Section 4 detentions. The number of patients subject to Community Treatment Orders showed modest variation across areas, with an increase in East and West.

Rectifiable errors decreased during the quarter. One fundamentally defective error was identified, relating to the invalid Section 2 application noted above.

Section 136 activity remained broadly consistent with previous reporting periods. Detentions involving children and young people remains low, with no under-18s admitted to adult psychiatric wards during the reporting period. Around 56–59% of those detained under Section 136 were already known to mental health services

Forensic activity and detained patient transfers were managed appropriately.

Mental Health Review Tribunal and Hospital Managers' hearing activity continued as expected, there were eight patients discharges this quarter, two by the Associate Hospital Managers and six by the MHRT.

Tribunal Process Changes – Operational Risk

The Mental Health Review Tribunal (MHRT) is introducing a revised hearing listing process whereby hearing dates will be allocated before consultation with Responsible Clinicians. This may create increased pressures on clinical teams, particularly for Section 2 hearings where statutory timescales are short. There is a risk of increased hearing rearrangement requests and disruption to clinical commitments. Impact monitoring and feedback to MHRT will be undertaken following implementation.

The overall position provides satisfactory assurance. Detention activity continues to show a gradual downward trend, compliance monitoring remains effective, documentation errors have reduced, and only three notable exceptions were

identified, all of which were investigated and appropriately managed. The Committee should note the ongoing vacancy within the MHA Team, forthcoming changes to Mental Health Review Tribunal listing arrangements, and the need to maintain vigilance around statutory review deadlines and cross-border admission paperwork requirements.

The MHA Team continues to monitor progress of the new Mental Health Act.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Power of Discharge Group	21/07/2026	Noted

Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms

CTO	Community Treatment Order
RC	Responsible Clinician
POS	Place of Safety
SOAD	Second Opinion Appointed Doctor
MHA	Mental Health Act
MHRT	Mental Health Review Tribunal

ASESIAD / ASSESSMENT		
Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Priorities	    	
	1. Building an effective organisation	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: 4. Improving quality outcomes and experience.	
Yr Egwyddorion Dylunio Design Principles	People First Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	The MHA Team continues to experience significant capacity pressures within the team, with Royal Assent being gained for the Mental Health Act 2025 this will increase workloads and demands on the team going forward.	
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	The use of the Mental Health Act sections apply to all persons and all policies in relation to the use of the Mental Health Act have been equality impact assessed.
Asesiad o'r Effaith Economaidd-gymdeithasol <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable
Ansawdd	Galluogwyr Ansawdd Enablers of Quality	Meysydd Ansawdd

<i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	All Apply	Domains of Quality All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant</u> <u>Wellbeing of Future Generations Act – Wellbeing Goals</u>	Not Applicable	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog <i>A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog:</i> Armed Forces Covenant Due Regard Duty <i>Have you considered the Armed Forces Covenant Due Regard Duty?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau (Pobl / Ariannol) Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.	



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Section 3	11		
Section 17	12		

The Mental Health Act 1983 (MHA) provides for the assessment and treatment of people with a mental disorder and sets out the rights that they have. Under this law, a person can be admitted, detained and treated in hospital for a mental disorder without their consent. The MHA also provides more limited community-based powers, community treatment orders and guardianship.

In 2007 the Act was amended to ensure that service users are receiving the treatment they need and to provide professionals with a clearer framework.

The MHA Code of Practice is issued under section 118 of the Mental Health Act 1983 by the Welsh Ministers and after being laid before the Senedd. The Code provides the principles and guidance on how the MHA should be applied in practice. The Code is Statutory Guidance and persons are required to have regard to the Code in carrying out their functions under the MHA.

Connections between the Mental Health Act 1983 and other legislation, in particular the Mental Health (Wales) Measure 2010, are detailed in the Code.

The "Hospital Managers" (i.e. the Health Board) retain the ultimate responsibility for the execution of all duties or acts carried out by staff in relation to the MHA including ensuring that the grounds for detaining service users are valid and legal.

The Mental Health Act 2025 received Royal Assent in December 2025 and will be implemented over a number of years through incremental changes.

The next steps for the implementation of the Mental Health Act 2025 include:-

Development of Detailed Guidance - the government is working on detailed guidance for the new Act before it comes into force.

Strengthening Patient Rights - The Act aims to strengthen patients rights, including the right to appeal against detention and access to second opinions.

Patient Representation - Patients will have the right to choose a 'nominated person' to represent their interests and participate in key decisions.

Enhanced Access to Tribunals - Enhanced access to Mental Health Tribunals with automatic referrals made earlier and at more frequent intervals.

Strengthening Community Mental Health Services - Embedding the Human Rights Act legal duties within community mental health services.

These steps are part of a broader effort to ensure that the new Mental Health Act 2025 is effectively implemented and that it serves the needs of patients and the community.

Executive Summary:

During the previous quarter, the Mental Health Act (MHA) Team continues to carry a vacancy interviews are to be held at the end of July. Mental Health Act training for Health Board staff resumed with sessions having a high number of registrations.

The reports will remain as currently produced pulled from an excel database until the new Electronic Patient Record system is implemented, it is hoped that the reporting data will be produced from this system.

The Associate Hospital Managers scrutiny and the Administrators scrutiny audit reports will be produced on a yearly basis and presented at first meeting within each year.

The MHRT have reviewed their processes in regards to thier listing system for hearings, in the near future when a case is registered the date for a hearing will be set without prior consultation with the Responsible Clinician (RC), if the date set requires changing this will be possible only by completion of a request form which must have agreement from the legal representative (deadline 48 hours prior for a section 2 and three weeks prior for any other detention). Work has been undertaken by the MHA office and the MHRT Caseworker for North Wales to gather information on preferred days for the RCs to try to ensure there are minimal requests for changes. It must be noted that Section 2 applications may not be able to fall within the RCs preferences due to the legaslativie timescales for when a hearing must be held. The President of the MHRT has stated that they will be open to feedback within thier forums once the changes have been implemented fully.

Exceptions are reported throughout the report as below:

There was a Section 2 which lapsed. (Datix Ref 178103) The consultant failed to review the patient prior to the end of the detention. The covering RC reviewed following the expiry and determined that the patient did not require a further detention. To date there have been no further periods of detention under the Mental Health Act. The datix determined that all escalation and follow up processes were followed and appropriate personel were informed and actions taken.

A Section 2 was deemed invalid on admission to the hospital. The patient was a direct admission from England, the application had been completed on an English form which is unable to be accepted by a Welsh Hospital. On discover the AMHP service responsible for the application was contacted, due to the AMHP not being available a new application was unable to be received. The local AMHP service stepped in to assess and complete a new application.

There is one exception to report for S136 detentions which ended (lapsed) at the 36 hour timescale, the detention had been extended for 12 hours due to the patient not being medically fit for assessment, the patient was informed and agreed to stay for an assessment and was supported by the liaison service. On assessment the patient was admitted under a Section 2 to the psychiatric unit and an appropriate bed.

Section 5(4) Nurses Holding Power (up to 6 hours): Criteria: "...the patient is suffering from mental disorder to such a degree that it is necessary for their health and safety or for the protection of others for them to be immediately restrained from leaving the hospital". Secondly the nurse must believe that "...it is not practicable to secure the immediate attendance of a practitioner or clinician for the purposes of furnishing a report under subsection (2). The nurses who can use this power are those registered in either Sub-Part 1 or 2 of the register maintained under article 5 of the Nursing and Midwifery Order 2001 whose registration includes an entry indicating that the nurse's field of practice is either mental health nursing or learning disabilities nursing.

Section 5(2) Doctors Holding Power (up to 72 hours): Criteria is: that an application for compulsory detention "ought to be made". Patient must be in-patient, can be used in general hospital.

Section 4: Admission for emergency (up to 72 hours): Criteria: "it is of urgent necessity for the patient to be admitted and detained under section 2" and that compliance with the provisions relating to application under that section "would involve undesirable delay"

Section 2: Admission for assessment (up to 28 days): Criteria needs to be met:

- a) is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period;
- b) ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons

Section 3: Admission for treatment (up to 6 months, renewable for 6 months, 12 monthly thereafter): Criteria

- a) is suffering from mental disorder of a nature or degree which makes it appropriate for him/her to receive medical treatment in hospital;
- b) it is necessary for the health and safety of the patient or for the protection of other persons that he/she should receive such treatment and it cannot be provided unless he is detained under this section;
- c) appropriate medical treatment is available for him/her

Section 17A: Supervised Community Treatment, also referred to as a CTO – its duration is up to 6 months, renewable for 6 months and 12 months thereafter.

Section 17E: Recall – the recall can last for up to 72 hrs. The clinical team must decide to release from Recall, Revoke or Discharge

Section 17F: Revocation. Once a patient has been revoked, essentially the Section 3 comes back into force - which can last up to 6 months, renewable for 6 months, then 12 monthly thereafter.

Section 135 Warrant to search and remove: Section 135(1) – warrant to enter and remove: Section 135(1) empowers a magistrate to authorize a police constable to remove a person lawfully from private premises to a place of safety. Section 135(2) – warrant to enter and take or retake. Section 135(2) concerns the taking into custody of patients who are unlawfully absent.

Section 136 Place of Safety (up to 24 hours): The powers of section 136 provide authority for a police officer who finds a person who appears to be suffering from mental disorder, in any place other than a private dwelling or the private garden or buildings associated with that place, to remove or keep a person at, a place of safety under section 136(1) or to take a person to a place of safety under section 136(3)

Section 35: Remand to hospital for report on accused's mental condition – for up to 28 days but can be extended to a maximum of 12 weeks.

Section 36: Remand of accused person to hospital – up to 28 days but duration will be set by the Court – maximum of 12 weeks.

Section 37: Hospital Order or Guardianship Order - up to 6 months, renewable for 6 months, 12 monthly thereafter

Section 37/41: Hospital Order with Restrictions – made with no time limit

Section 38: Interim Hospital Order – up to 12 weeks, but duration set by the Court – maximum 12 months

Section 47/49: Transfer of sentenced prisoners (including with restrictions)

Section 48/49: Transfer of other prisoners (including with restrictions) for urgent assessment

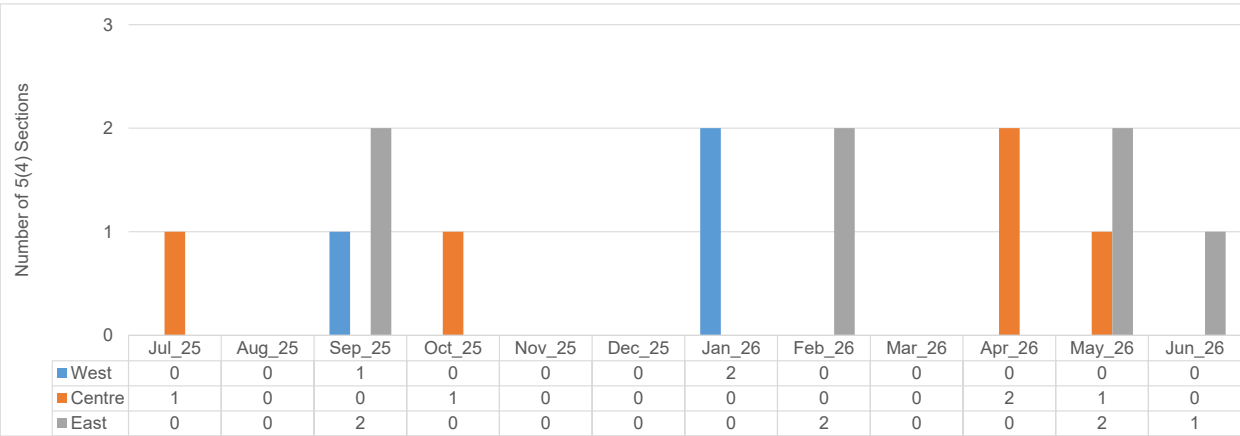
Section 62: Emergency Treatment of a detained patient regardless of section status

Rectifiable Errors: concerned with errors resulting from inaccurate recording, errors which can be rectified under Section 15 of the Act

Fundamentally Defective Errors: concerned with errors which cannot be rectified under section 15

Lapses of section: refers to sections that have come to the end of their time period. It is not good practice for sections to lapse and reasons are investigated.

Section 5(4) - BCUHB	May 2026	June 2026	Monthly Change	Previous Quarter	Latest Quarter	Quarter Change	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 5(4) during Quarter	Quarter 5(4) Sections
Section 5: Application in respect of patients already in hospital	3	1	➡	4	6	⬆	4	1 Centre	3
								1 East	3
								3 West	0



A Section 5(4) will be used if a qualified nurse of the prescribed class (mental health or learning disability trained) feels that it is necessary to detain a patient to await the arrival of a doctor for assessment. The 5(4) will be used if there are no doctors immediately available and the nurse feels this is in the best interest of the patient.

The three instances within the East were for the same patient, the detentions were enacted by different members of staff, the dates were not within close proximity of each other and therefore an appropriate use of the Act.

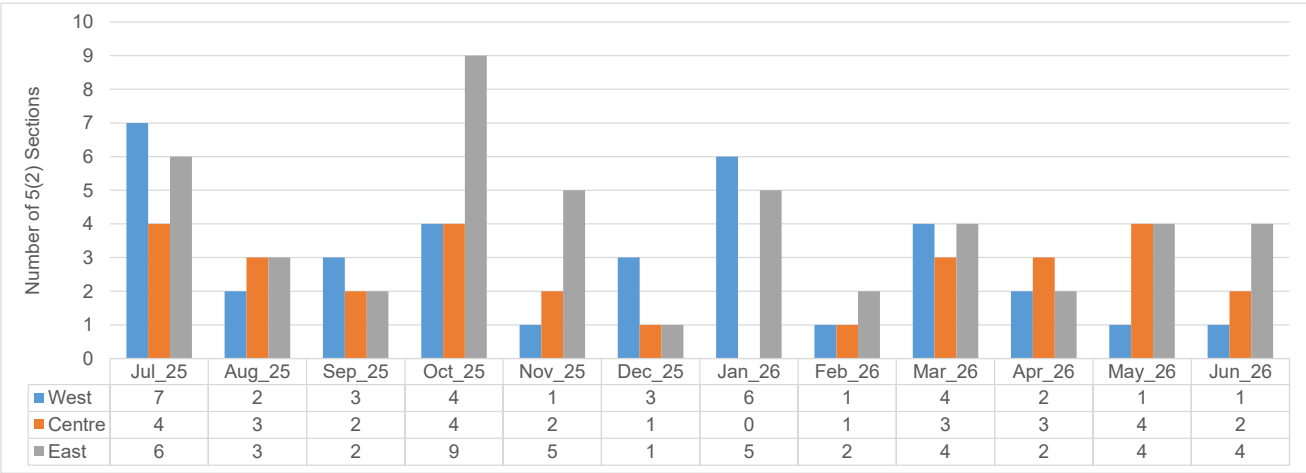
LAPSES
None to note.

WEST		
The data above does	Duration (hh:mm)	Outcome

CENTRE		
Month	Duration (hh:mm)	Outcome
Apr_26	01:38	Section 5(2)
Apr_26	00:07	Section 5(2)
May_26	01:30	Section 5(2)

EAST		
Month	Duration (hh:mm)	Outcome
May_26	04:20	Section 5(2)
May_26	03:28	Section 5(2)
Jun_26	01:11	Informal

Section 5(2) - BCUHB	May 2026	June 2026	Monthly Change	Previous Quarter	Latest Quarter	Quarter Change	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 5(2) during Quarter	Quarter 5(4) Sections
Section 5: Application in respect of patients already in hospital	9	7	↓	26	23	↓	28	1 East	10
								2 Centre	9
								3 West	4

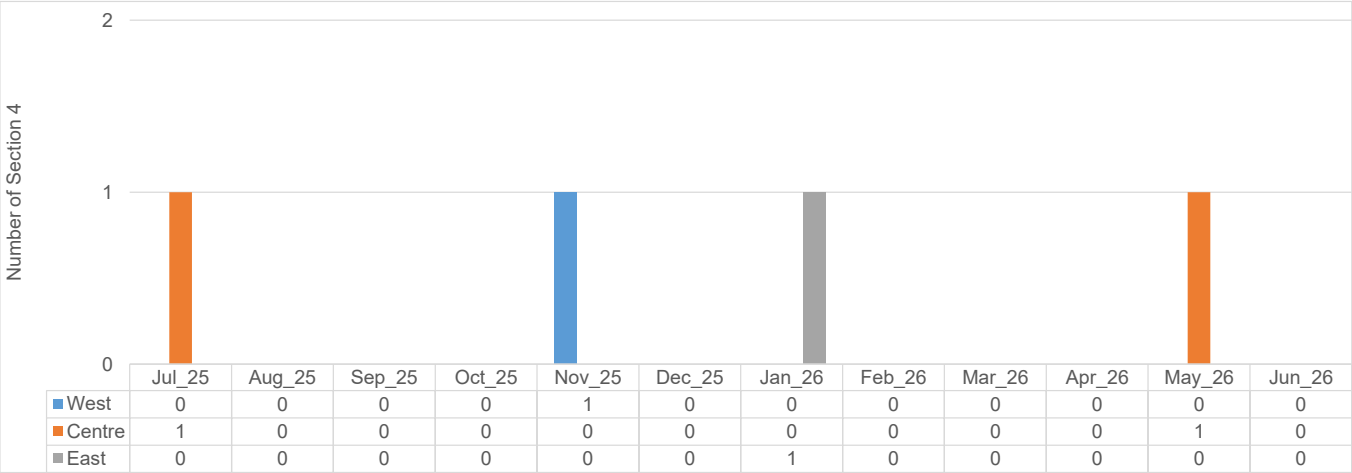


Section 5(2) Outcomes			
	Apr 2026	May 2026	Jun 2026
Section 2:	4	3	2
Section 3:	0	1	2
Informal:	3	4	4
Lapsed:	0	0	0
Invalid:	0	0	0
Discharged:	0	0	0
Other:	0	0	0

A Section 5(2) on occasions will be enacted within the acute hospital wards for this period there was one which resulting in informal admission to the psychiatric unit.

There are no exceptions to report this period.

Section 4 - BCUHB	May 2026	June 2026	Monthly Change	Previous Quarter	Latest Quarter	Quarter Change	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 4 during Quarter	Quarter Section 4
Section 4: Admission for assessment: Cases of emergency	1	0	↓	1	1	➡	1	1 Centre	1
								2 East	0
								2 West	0



The use of section 4 is a relatively rare event and figures remain low.

Section 4 will be used in emergency situations where it is not possible to secure two doctors for a section 2 immediately and it is felt necessary for a persons protection to detain under a section of the Mental Health Act.

There are no exceptions to report.

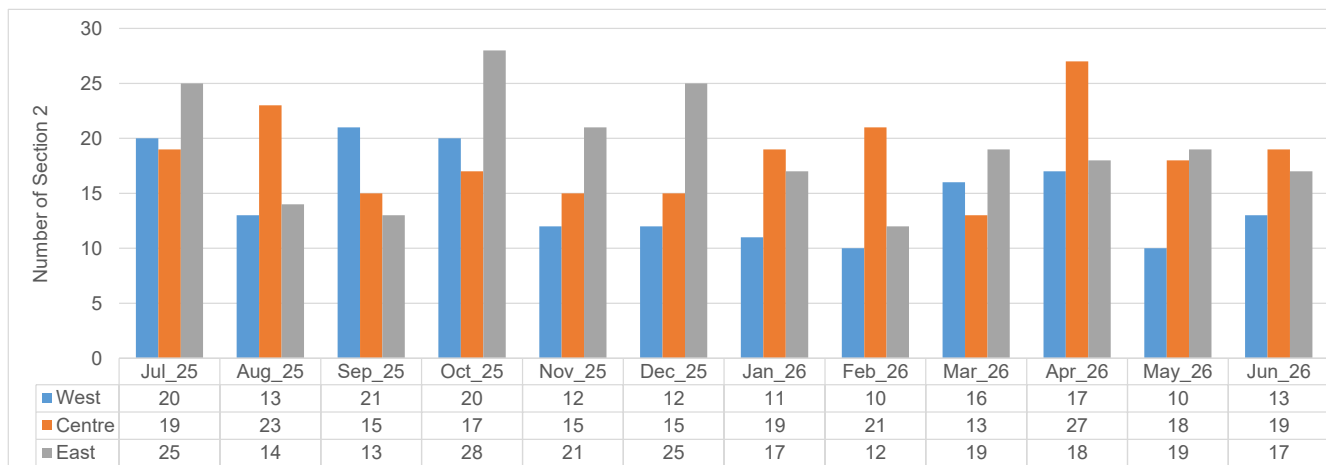
The Section 4 used in this reporting period resulted in informal admission to the unit and was an appropriate use of the Act.

WEST		
Month	Duration (hh:mm)	Outcome

CENTRE		
Month	Duration (hh:mm)	Outcome
May_26	68:40	Informal

EAST		
Month	Duration (hh:mm)	Outcome

Section 2 - BCUHB	May 2026	June 2026	Monthly Change	Previous Quarter	Latest Quarter	Quarter Change	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 2 during Quarter	Quarter Section 2
Section 2: Admission for assessment	47	49	↑	138	158	↑	156	1 Centre	64
								2 East	54
								3 West	40



* data is as at position and is subject to change

A section 2 will be enacted following holding powers 5(4) or 5(2) or via a regrade from a section 4 or an informal admission. Section 2 is also used as a direct admission detention.

There were two young people placed on a section 2 this quarter, both direct admissions to an age appropriate bed.

EXCEPTIONS:

There are two exceptions to report this period.

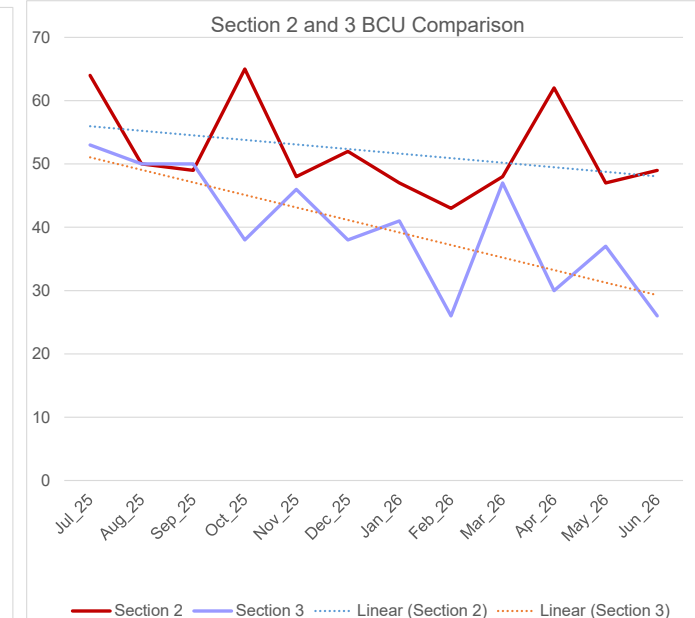
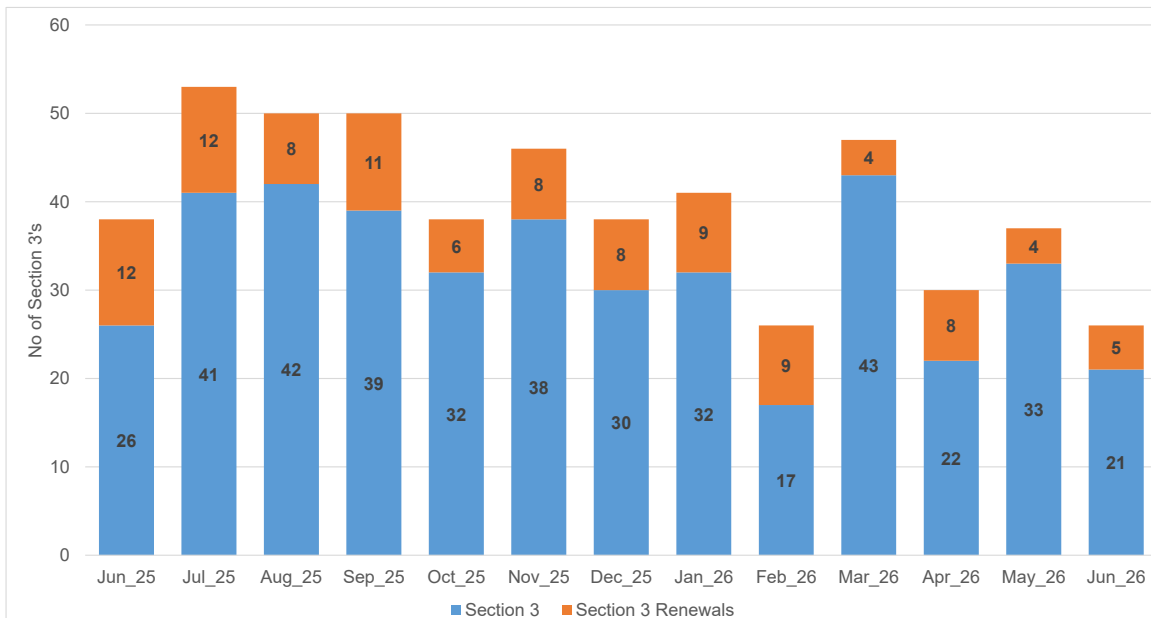
(West) A S2 lapsed, the RC did not review the patient within the appropriate time, the patient has not been subject to any further detentions.

(Central) A S2 was classed as invalid, the application to the hospital was on an English form and digitally signed, for an admission into Wales the application MUST be on a Welsh form.

Section 2 Outcomes			
	Apr 2026	May 2026	Jun 2026
Section 3:	11	17	7
Informal:	15	20	14
Lapsed:	1	0	0
Pending:	0	0	0
Discharged:	13	4	13
Transferred:	12	13	14
Invalid and Other:	0	0	2

0

Section 3 - BCUHB	May 2026	June 2026	Monthly Change	Previous Quarter	Latest Quarter	Quarter Change	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 3 during Quarter	Quarter Section 3
Section 3 (Including Renewals): Admission for treatment	37	26	↓	114	93	↓	121	1 East	39
								2 Centre	29
								3 West	25



* data is as at position and is subject to change

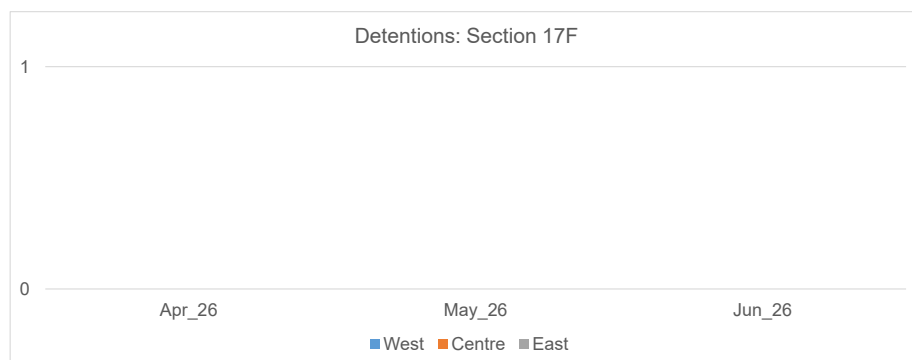
These numbers also include any renewal sections undertaken within the month. As with the data for section 2 it is hard to interpret these figures in isolation and previous months figures are prone to change due to admissions into the Health Board.

There are no exceptions to report this review period.

There were two under 18s detained under a Section 3 this quarter, both within an age appropriate setting.

Both Section 2 and Section 3 numbers continue on a downward trend.

Section 17 A-F - BCUHB	May 2026	June 2026	Monthly Change	Previous Quarter	Latest Quarter	Quarter Change	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 17 during Quarter	Quarter Section 17
Section 17A (Including Renewals)-17F: Community Treatment Orders	9	8	↓	22	23	↑	25	1 West	9
								2 Centre	7
								2 East	7



This quarterly data 17A shows the numbers of patients who are being placed on a CTO for the first time, as well as any renewals within the month. 17E data shows those who have been recalled to hospital from their CTO and 17F data shows those who have had their CTO revoked and become subject to a Section 3.

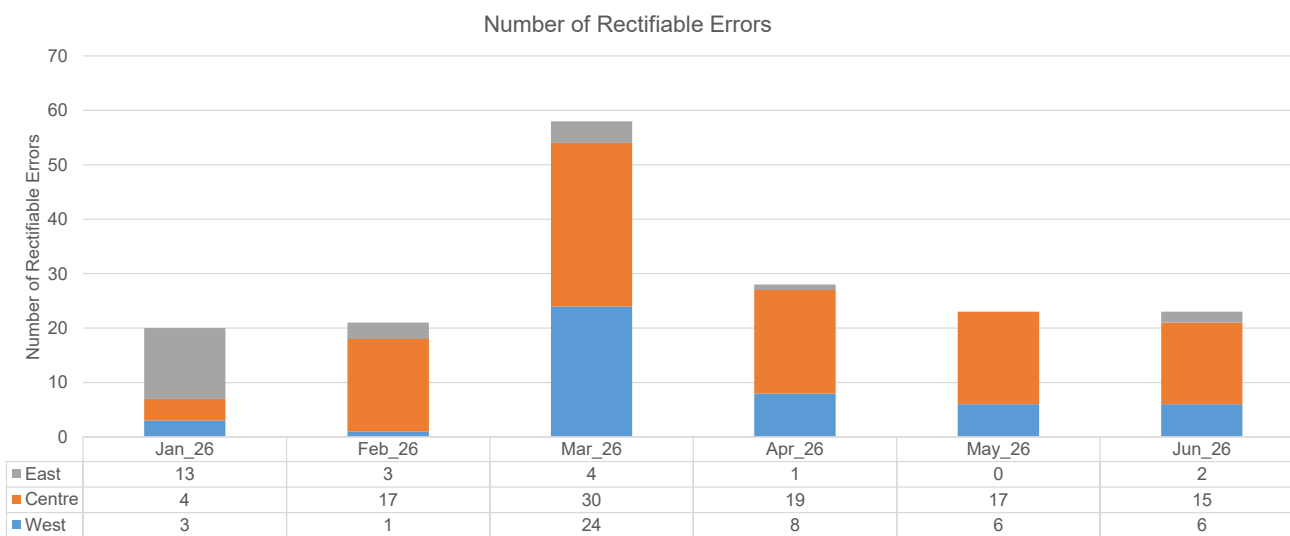
There are no exceptions to report this period.

The number of patients on a CTO at the end of June are:

West = 12
 Central = 11
 East = 12

East and West have seen an increase, Central remains the same compared to the previous quarter.

Fundamental and Rectifiable Errors	May 2026	June 2026	Monthly Change	Previous Quarter	Latest Quarter	Quarter Change	Quarter Average (last 4 quarters)	Area Rank by numbers of Errors during Quarter	Quarter Errors
Fundamental and Rectifiable Errors in line with Health Boards in Wales	23	24	↑	99	75	↓	74	1 Centre 52 2 West 20 3 East 3	



Rectifiable Errors

Rectifiable errors were previously reported on a quarterly basis and benchmarked with the other health boards throughout Wales. Due to capacity to produce this report Cardiff and Vale have discontinued the report. There has been no progress in regards to this starting again.

Errors will be calculated due to missing data within documents such as middle names missing parts of an address or an obvious slip of the pen such as dating 2025 rather than 2026.

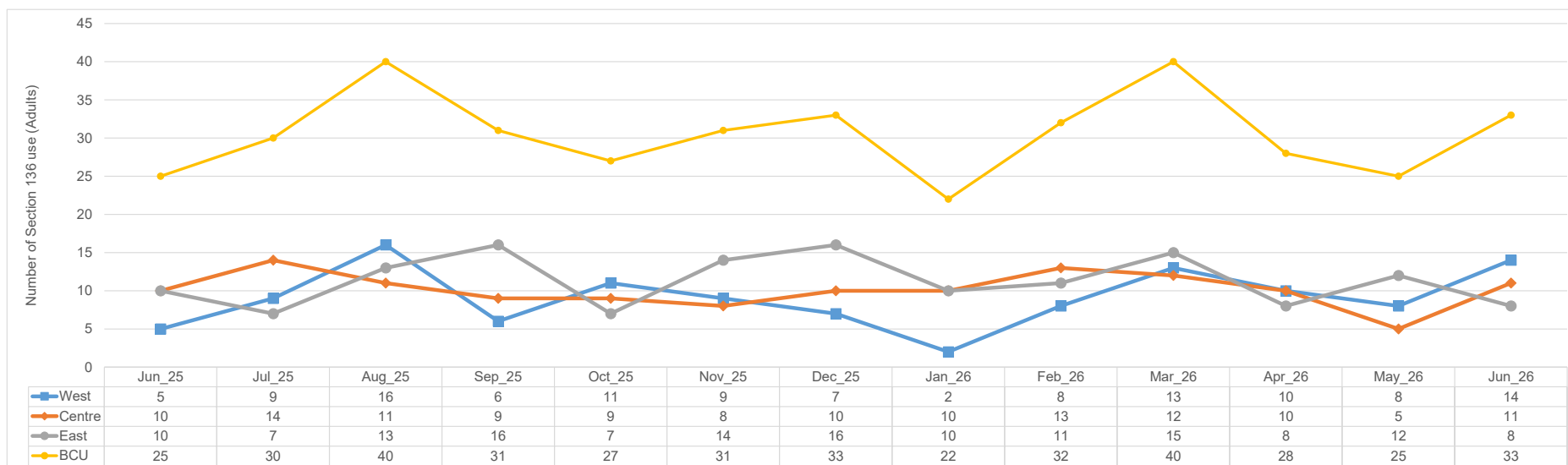
It is important to note that rectifiable errors can be amended under Section 15 of the Mental Health Act and do not render the detention invalid.

The number of errors has seen a decrease this quarter.

Due to no benchmarking report being produced it is hard to quantify these figures and justify reasons without extensive scrutiny of all the detention paperwork. The monitoring of errors does provide assurance to the Health Board that the Mental Health Act office staff are scrutinising documents and ensuring these are rectified.

It is worthy to note that all these errors are able to be rectified and do not render the detention invalid. One fundamental defect error was identified this quarter as noted under the Section 2 data.

Section 135 - 136	May 2026	June 2026	Monthly Change	Previous Quarter	Latest Quarter	Quarter Change	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 during Quarter	Quarter S.136 detentions
Section 135 and 136: Patient transfers to a place of safety (Adults)	25	33	↑	94	86	↓	93	1 West	32
								2 East	28
								3 Centre	26



C

The data above does not include S135 or under 18's.

Monthly S136 reports are produced for the Mental Health Division and CAMHS.

There were four S135s within the quarter resulting in three admissions and one discharge.

There is one exception to report for S136 detentions which ended at the 36 hour timescale after a 12 hour extension was agreed due to the person not being medically fit for assessment. The patient was assessed when able to be and detained under the Mental Health Act and accepted into an appropriate bed.

Section 136	May 2026	June 2026	Monthly Change	Previous Quarter	Latest Quarter	Quarter Change	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 during Quarter	Quarter S.136 detentions
Section 136: Patient transfers to a place of safety (Adults)	25	33	↑	94	86	↓	93	1 West	32
								2 East	28
								3 Centre	26

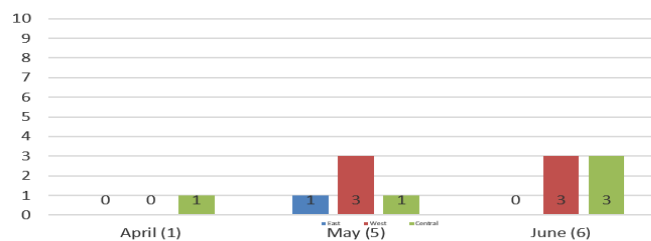
Section 136 Outcomes

	Apr 2026	May 2026	Jun 2026
Discharged:	13 45.00%	15 56.00%	15 45.00%
Informal Admission:	10 35.00%	5 18.00%	6 18.00%
Section 2:	3 10.00%	6 22.00%	12 37.00%
Section 3:	2 7.00%	1 4.00%	0 0.00%
Other:	1 3.00%	0 0.00%	0 0.00%

Section 136 - Known to Service

	Apr 2026	May 2026	Jun 2026
Yes	17	16	17
Yes (percentage)	59.00%	59.00%	52.00%

Of those discharged, how many were discharged as having no mental health disorder



The data shows figures from outcomes recorded and whether a patient is known to service.

For this quarter those discharged with no mental disorder from the total detentions are:

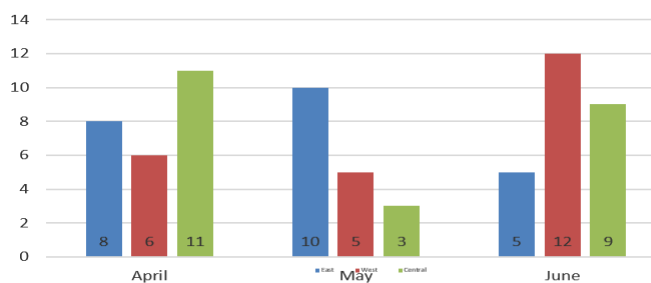
April 1%

May 18%

June 18%

The Criminal Justice Liaison Service actively assists the police by providing advice and information to signpost people in crisis to other avenues rather than the police using the S136 power if this is an appropriate option for the last quarter 32 persons have not been made subject to a S136 due to this service.

Section 136: Detentions over 4 hours



Whilst the Health Board notes detentions that may last over four hours in some instances this may be unavoidable due to the requirement for medical needs to be met prior to an assessment, or in some circumstances risks may be greater if discharge occurs out of hours.

Of the total number of patients discharged:

April (13)

69% were discharged with follow up from services
23% discharged and referred to services
8% discharged no mental disorder

May (15)

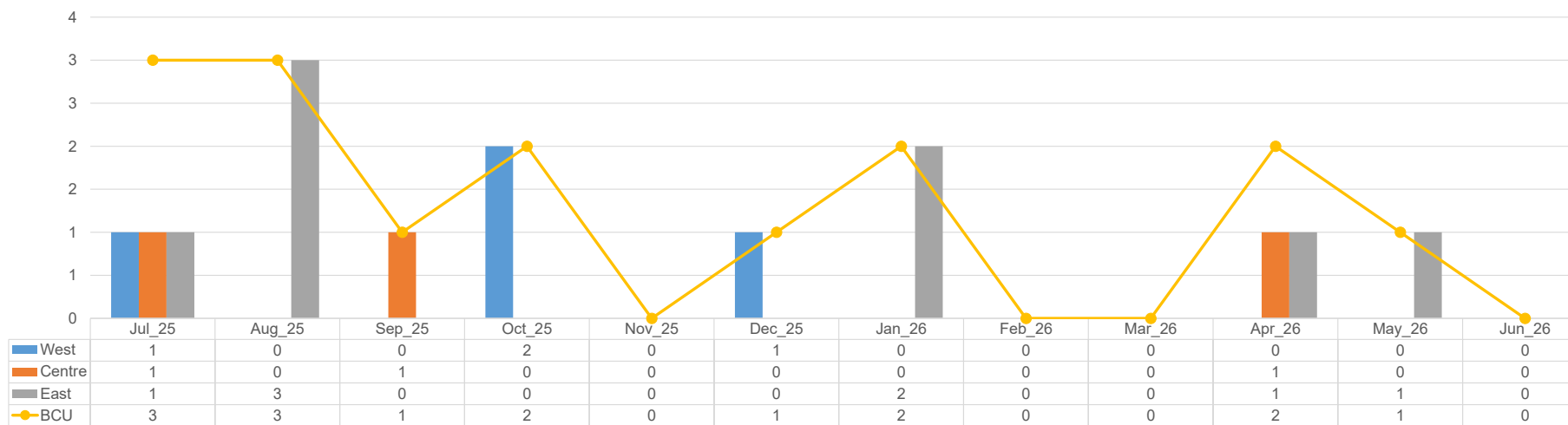
40% were discharged with follow up from services
27% discharged and referred to services
33% discharged no mental disorder

June (15)

27% were discharged with follow up from services
33% discharged and referred to services
40% discharged no mental disorder

Section 135 - 136 (Under 18)	May 2026	June 2026	Monthly Change	Previous Quarter	Latest Quarter	Quarter Change	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 (<18) during Quarter	Quarter <18 S.136 use
Section 135 and 136: Patient transfers to a place of safety (<18)	1	0	↓	2	3	↑	4	1 East 2 Centre 3 West	2 1 0

Under 18s Section 136 Detentions



The tables below shows the ages of young persons assessed and the outcomes for the year period April 26 - March 27.

Under 18 Assessments	
AGE	Number of Assessments
11 and 12	
13	1
14	
15	
16	
17	2

Outcome of Assessments	
Outcome	Number
Returned Home	1
Returned to Care Facility	2
Admission to childrens ward	
Admission to Adult ward / S136 suite	
Admission NWAS / CAMHS	
Admission OOA	
Other (Friends, Hotel, B&B)	

5

Month of Admission	Place of Assessment	Outcome	Assessing Clinician	Total Hours	Age
April	Wrexham Maelor	Discharged	CAMHS & Adult	19:54	13
April	Ysbyty Glan Clwyd	Discharged	CAMHS	14:35	17
May	Wrexham Maelor	Discharged	CAMHS & Adult	14:31	17

The Assistant Area Directors of the CAMHS service are notified straight away of a young person, 15 and under who is detained under a S136. Within hours the MHA office notify, out of hours the responsibility lies with the duty staff.

Average PoS hours: 16:20 hrs which is an increase on the previous quarter of 14:25hrs

Under 18's admitted to Adult Psychiatric Wards

There were no under 18's admitted to the adult unit this period.

The table below shows the county that the young persons originated from and where they were assessed for the period April 26 - March 27

County Originated from and where assessed:

	East	Central	West
Wrexham	1		
Flintshire	1		
Denbighshire		1	
Conwy			
Gwynedd			
Ynys Môn			
Out of Area/NFA			

Section	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026
Section 35:	0	0	0	0	0	0	0	0	0	0	0	0
Section 37:	1	1	1	1	0	0	0	0	0	0	0	0
Section 37/41:	9	8	8	8	8	8	8	8	8	7	7	7
Section 38:	0	0	0	0	0	1	1	1	1	1	1	1
Section 47:	4	4	4	4	4	3	2	1	1	1	1	1
Section 47/49:	5	5	5	5	5	5	5	5	5	5	5	5
Section 48:	0	0	0	0	0	0	0	0	0	0	0	0
Section 48/49:	0	0	0	0	1	1	1	1	1	2	2	2
Section 3:	1	1	2	2	2	2	3	3	3	3	2	2
Section 45A	0	0	0	0	0	0	0	0	0	0	0	0
Total:	20	19	20	20	20	20	20	19	19	19	18	18

Ty Llywelyn Medium Secure Unit is a 25 bedded all male facility. The nature of the forensic sections does not always generate rapid activity.

There are no exceptions to report this period.

Total Transfers for the Quarter

	Apr 2026	May 2026	Jun 2026
Internal Transfers	14	18	13
External Transfers (Total)	14	12	7
External Transfers (In)	7	7	5
External Transfers (Out)	7	5	2

Internal Transfers

This data only includes detained patient transfers between BCU facilities, including the transfer of rehab patients which will be part of their patient pathway. A transfer due to step down/up needs will include transfer to PICU or rehab wards, adult to older persons, MSU to rehab.

External Transfers

This data only includes detained patient transfers both in and out of BCU facilities. The majority will be facilities in England may include complex cases requiring specialist service or may require an out of area bed if the Health Board cannot facilitate admission at the time. Those repatriated are returning to their home area or transferring in for specialised care.

Patients detained in Independent Hospitals (in Wales and outside of Wales)

There are a number of persons who will be detained in independent hospitals that are offering services required. These people are monitored by the Continuing Healthcare Service and Team to ensure that they are in the correct placement for their needs.

Transfers In

April 2026

West = two patients
Central = five patients

There were 14 transfers in between areas in April.

May 2026

West = one patient
Central = two patients
East = four patients

There were 18 transfers in between areas in May.

June 2026

West = three patients
Central = one patient
East = one patient

There were 13 transfers in between areas in June.

Total internal transfers in was 45.
Central = 21, East = 13 and West = 11

Transfers Out

April 2026

Central = one patient
West = six patients

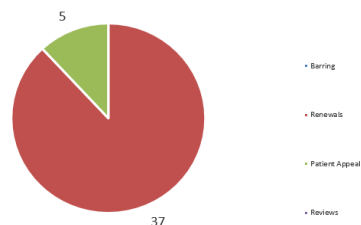
May 2026

Central = one patient
East = one patient
West = three patients

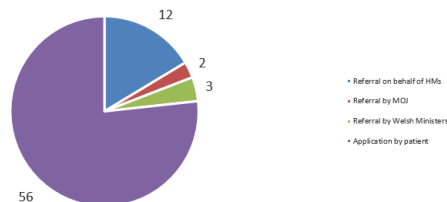
June 2026

West = two patients

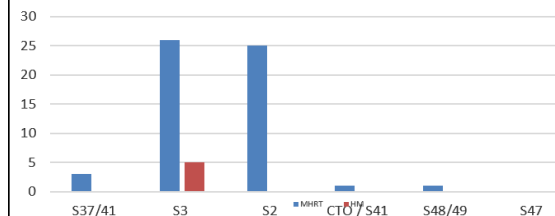
Hospital Managers Panel Hearings scheduled
April - June 2026 (n42)



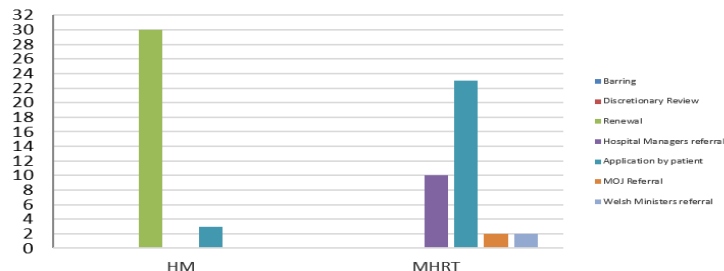
Mental Health Review Tribunals scheduled
April - June 2026 (n73)



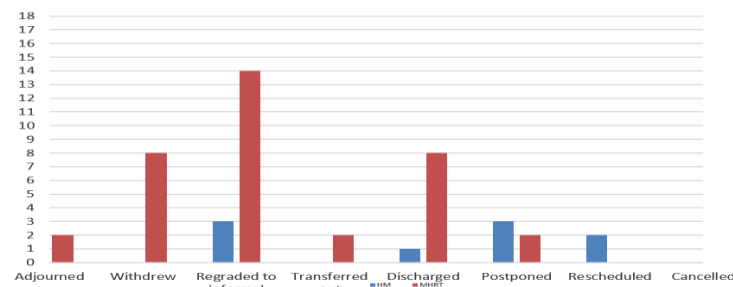
Type of patient appeals received
April - June 2026
56 MHRT and 5 Hospital Managers



70 Hearings Held April - June 2026 by type



45 Hearings not held April - June 2026



The above charts show the number of Associate Hospital Managers Hearings and Mental Health Review Tribunals scheduled to take place for the quarter April - June 2026.

There were 115 hearing scheduled this period which included 61 applications from patients. 70 hearings took place of which 26 were patient applications.

Eight patients were discharged from thier detention this quarter. Six by the MHRT (2 x S3, 3 x S2 and 1 CTO) and two by the Associate Hospital Managers (1 x S3 and 1 x CTO).

Mental Health Legislation Committee

Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) Q1 2026/27 Update

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Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol Executive Summary

This report provides assurance on the Health Board's compliance with its statutory responsibilities under the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) for Quarter 1 2026/27. It highlights activity, performance, risks, and improvement work undertaken to support the delivery of MCA and DoLS responsibilities across the organisation.

DoLS activity continues to rise significantly across the Health Board, with application numbers maintaining a strong upward trend. Despite increasing demand, the quality of DoLS documentation has improved, demonstrated by a reduction in paperwork requiring amendment or correction.

Compliance with MCA training has also continued to improve. Both the Level 1 and Level 2 training have exceeded the organisational target of 85%. Increased engagement within clinical areas has strengthened staff's knowledge, confidence and application of MCA and DoLS requirements in practice. Overall, rising activity has not adversely affected quality, with continued improvements evident across key areas.

Additional Welsh Government funding continues to support efforts to reduce the DoLS backlog. While rising DoLS applications numbers remains challenging, the additional assessments undertaken during evenings and weekends has helped to alleviate pressures. The DoLS/MCA Team continues to work closely with the national MCA/DoLS network to share learning, escalate concerns and contribute to service improvement.

A significant legal development occurred following the Supreme Court judgment in; *The Attorney General for Northern Ireland's Reference (Deprivation of Liberty) [2026] UKSC 16 (AGNI)*, which overturned the 2014 *Cheshire West* ruling. The judgment introduces a revised legal test for deprivation of liberty, adopting a more balanced and context-specific approach while maintaining existing human rights protections. This change presents both opportunities and risks and the implementations for practice and service demand will need to be assessed. Given this recent legal change, further progress on the implementation of Liberty Protection Safeguards (LPS) is not currently anticipated. (Please see Appendix 1 for the full judgment).

Corporate Risk CRR 24-03 remains in place, recognising the risk that increasing DoLS activity could result in delays to authorisations and consequently unlawful deprivations of liberty. Following review by the Health Board Risk Management Group and Formal Executive Group, the risk score remains at 12. MCA and DoLS risks continue to be monitored through established governance arrangements, with regular reporting to the Executive Group. No additional actions are proposed beyond those currently in place, and there are no financial implications arising from this report. A review of all Risks is being undertaken by the Safeguarding team; this will include DoLS.

The committee is asked to note the contents of this report and recognise the continued commitment of the DoLS/MCA Team in meeting its statutory duties. Despite sustained operational pressures, many of which are reflected nationally, the DoLS/MCA Team remains focused on providing assurance, maintaining quality and working towards ongoing service improvements.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Not applicable for this report		

Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms

DoLS	Deprivation of Liberty Safeguards
IMCA	Independent Mental Capacity Advocacy
CoP	Court of Protection
MCA	Mental Capacity Act
LPS	Liberty Protection Safeguards
RPR	Relevant Persons Representative

AGNI

The Attorney General for Northern Ireland
Reference (Deprivation of Liberty) [2026] UKSC 16

Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) Q1 2026-27 Update

1. Y SEFYLLFA SITUATION

- 1.1 The activity recorded within the report provides oversight and organisational assurance in relation to the Health Board's statutory duty under the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA 2005) for the period of Q1 2026-27. The paper highlights key areas of progress and challenge across DoLS activity, NHS Wales MCA/DoLS Network engagement, MCA training compliance and developments relating to the IMCA Service and retendering process.
- 1.2 DoLS reports throughout the Organisation in accordance with the Safeguarding Reporting Framework. This Framework reinforces Organisational engagement, reporting and escalation by the Safeguarding Governance and Performance Group, and key Forums and Committees. The functions of the Safeguarding and Public Protection DoLS Team include the legal responsibility of Supervisory Body, which must provide scrutiny and independence.

2 Y CEFNDIR BACKGROUND

- 2.1 The MCA and associated DoLS place statutory duties on the Health Board to ensure that individuals who lack capacity are supported to make decisions and that any deprivation of liberty is lawfully authorised, necessary, proportionate and in the individual's best interests.
- 2.2 BCUHB DoLS/MCA Team provides strategic oversight, operational coordination, and professional advice in relation to the compliance with legislative requirements, national guidance, and best practice. This includes the management of the DoLS applications, oversight of authorised processes ensuring the promotion of person-centred approach to decision making and ensuring individuals human rights are upheld.
- 2.3 Regular reporting of DoLS and MCA activity provides assurance to the organisation by identifying areas of pressure, emerging risks and performance trends, whilst ensuring compliance with legislative requirements. This reporting supports continuous improvement and strategic planning, including implementation of AGNI (Supreme Court Judgement). It also supports preparedness for future legislative developments relating to deprivation of liberty safeguards.



3 MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION

3.1 National and Legal developments

The Supreme Court judgment in *Attorney General for Northern Ireland's Reference (Deprivation of Liberty) [2026] UKSC 16* (AGNI) has provided further clarification in relation to the interpretation of deprivation of liberty and the application of Article 5 rights. The implications of the judgment are currently being considered nationally and the Health Board will continue to monitor developments and assess any impact on local practice and governance arrangements.

- 3.2 National developments continue to focus on improving the authorisation, governance and notification of deprivation of liberty arrangements. The Health Board continues to review local processes and governance arrangements to support compliance with statutory requirements and promote best practice.

- 3.3 The new Supreme Court judgment does not remove safeguards or reduce human rights protections. Instead, it revises the legal test for determining whether a deprivation of liberty exists. Introducing a more balanced and context-based approach, closely aligned with cases that have been heard in the European Court of Human Rights. This change presents both opportunities and risks for organisations responsible for ensuring compliance with the MCA and associated safeguards.

- 3.4 The judgment presents both opportunities and risks for the Health Board. Potential benefits include a more proportionate and person-centred approach to decision making, greater recognition of an individual's individual circumstances when assessing whether a deprivation of liberty exists. Increased use of professional judgement in applying the legal test is essential. The change may also reduce unnecessary administrative processes, enabling resources to be focused on individuals who require the greatest level of scrutiny and safeguarding.

- 3.5 Whilst these developments may support a more balanced approach, there is a risk of inconsistency in interpretation and application across services, particularly whilst national guidance and emerging case law continue to develop. There is also a risk that individuals who would previously have been considered deprived of their liberty may no longer fall within the revised legal test, potentially resulting in reduced levels of formal oversight.

- 3.6 It will essential to maintain robust governance, training, quality assurance and professional support arrangements to ensure that decisions remain lawful, consistent and focused on safeguarding individuals' rights under the Mental Capacity Act 2005 and Article 5 of the European Convention on Human Rights.

- 3.7 An action plan has been developed to support implementation of the AGNI judgment and to mitigate identified risks. Whilst the Health Board awaits formal national guidance, local processes and practice are being reviewed and adapted to reflect the Supreme Court judgment, supported by ongoing governance oversight and risk assessment. (Please see Appendix 2 for the Health Boards action plan).

3.8 Local Implementation Activity:

- 3.9 Since publication of the AGNI judgment, the Health Board has undertaken a range of activities to support implementation of the revised legal position and mitigate associated risks. A local action plan has been developed to identify key workstreams, responsibilities and timescales required to support the implementation of the revised legal position.
- 3.10 A briefing paper outlining the implications of the judgment and associated changes to practice has been developed and circulated across the Health Board. The briefing paper provides guidance on the responsibilities of key professionals and organisations involved in the DoLS process. Including Managing Authorities, Section 12(2) Doctors, Best Interest Assessors (BIAs) and other stakeholders. To support accessibility and awareness the briefing paper has also been published on the Health Board's DoLS / Safeguarding webpage. (Please see Appendix 3)
- 3.11 The Health Board has reviewed and updated information available on the DoLS webpage to reflect the AGNI judgment, including the removal of references which focus solely on the former *Cheshire West* acid test. Information has been revised to support understanding of the revised legal test and its practical application.
- 3.12 Operational changes have also been introduced within the DoLS Team, including the implementation of a screening and triage process to review incoming applications against the revised legal criteria. This has enabled the team to provide early advice and support to Managing Authorities where applications may no longer meet the threshold for a deprivation of liberty under the revised legal test. A new Duty/Screening out document has been developed and is currently being utilised in draft format while progressing through approval stages. (Please see Appendix 4).

In addition, meetings have been established both within the DoLS Team and with key partners, including Local Authority colleagues and the Independent Mental Capacity Advocacy (IMCA) Service. These discussions have supported the sharing of learning, consideration of complex cases, development of local approaches and collaborative preparation for future national guidance.

- 3.13 Local DoLS training materials and documentation are being reviewed and amended where required to reflect the revised legal position. Whilst further work is anticipated as national guidance and Wales-wide approaches emerge, these actions have enabled the Health Board to respond proactively to the judgment and support staff in applying the revised legal framework. A practical step by step decision making flowchart has been developed to support the Managing Authorities (Hospital wards) incorporating the key practice implications of the Supreme Court Judgment providing guidance for day to day clinical decision making. (Please see Appendix 5).

3.14 NHS Wales MCA/DoLS Network:

The MCA/DoLS National Workforce Group continues to meet, enabling stakeholders to jointly consider issues of local concern that may have wider or national relevance and providing a forum for collaborative working. Following the Supreme Court judgment in *Attorney General for Northern Ireland's Reference (Deprivation of Liberty) [2026] UKSC 16*, additional meetings have been convened to consider the implications of the judgment, share emerging learning and support greater consistency of practice across Wales. Whilst awaiting formal national guidance, discussions have focused on the potential impact of the judgment on existing processes, documentation, training and operational practice.

- 3.15 DoLS Processes: The next formal meeting of the National MCA/DoLS Workforce Group is scheduled to take place during Quarter 2 of 2026–27. It is anticipated that discussions will focus on the implications of the AGNI judgment, including consideration of policies, processes, training requirements, documentation and governance arrangements. The Health Board will continue to actively participate in this work and will support the development of consistent approaches across Wales where appropriate.
- 3.16 MCA Training: MCA and DoLS training arrangements remain established within the Health Board. Following publication of the AGNI judgment, minor amendments have been made to local DoLS training materials to reflect the revised legal test and emerging understanding of the implications for practice. Discussions have also taken place with colleagues across Wales to share learning, consider potential training requirements and promote consistency of approach. Whilst no national training package or agreed Wales-wide position has yet been developed, this remains an area for further exploration through the National MCA/DoLS Workforce Group.
- 3.17 DoLS Paperwork: Prior to the AGNI judgment, significant progress had been made in developing revised DoLS documentation, including a new DoLS Form 1 (DoLS Application Form). A six-month pilot had been undertaken and feedback evaluated. Following publication of the judgment, implementation of the revised paperwork has been paused to allow consideration of the wider implications for deprivation of liberty processes and documentation. Locally, the Health Board has commenced a review of relevant paperwork to ensure alignment with the revised legal position. In parallel, discussions have taken place with colleagues across Wales to share learning, review emerging issues and consider potential amendments to documentation. Whilst no nationally agreed documentation has yet been finalised, collaborative work is ongoing to explore opportunities for greater consistency in forms, processes and practice across Wales.

3.18 Performance and Activity:

The Health Board continues to experience an upward trend in DoLS applications, which aligns with the wider national position. A total of 633 applications were received in Q1 2026–27, marking a 5.0% increase on last year's figures (603). This increase contributes to service pressure but also indicates improved staff awareness, learning, and adherence to statutory duties under the MCA and DoLS framework.

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- 3.19 Although application numbers have increased considerably, the average delay between receipt of an application and completion of the standard authorisation remains at approximately five to six weeks. This backlog varies over time and is consistent with the wider position across Wales. Other Health Boards and Local Authorities are also experiencing comparable or greater delays.
- 3.20 Following the AGNI judgment, it is anticipated that the volume of DoLS applications may reduce over time as Managing Authorities become more familiar with the revised legal test and its application in practice. However, as the judgment is relatively recent and national guidance is still awaited, the full impact on referral activity remains unclear. Together with the ongoing demand and caseload pressures, it is expected that any reduction is unlikely to be immediate, whilst awareness develops and existing caseloads continue to be managed. Application trends will continue to be closely monitored and reported through existing governance arrangements.
- 3.21 Welsh Government acknowledges the continued increasing demand placed on the Health Board and has continued to provide financial support. This funding has enabled and continues to allow additional capacity through engagement of Best Interest Assessors (BIAs) and Section 12 (2) Doctors, who undertake assessments during evenings and weekends. As a result, this supports the reduction of delays relating to authorisation.
- 3.22 **Welsh Government (WG) Monies:**
- As previously outlined, WG has confirmed that the additional annual funding provided is permanent. The funding is divided into two funding streams. Stream 1 supports DoLS and MCA activity. Stream 2 is intended to strengthen IMCA services and provide Relevant Persons Representative (RPR) services.
- 3.23 From 2026-27 onwards the funding for the DoLS and MCA activity will be automatically allocated to the Health Boards budget each year. An annual report must be submitted to WG at the end of each financial year to demonstrate how the funding has been utilised and the progress achieved. While the funding for the provision of IMCA and RPR Services has also been made permanent, access to these funds will continue to be subject to a formal annual bidding process.
- 3.24 Despite the use of a bidding process, full WG funding confirmation for IMCA and RPR services has been agreed for 2026-27. This is following consultation and agreement from all 6 Local Authorities in relation to how the funding is spent.
- 3.25 As previously advised, WG has been undertaking ongoing work to develop arrangements whereby this permanent annual funding for IMCA and RPR services would be automatically allocated to Health Boards budgets. This would result in removing the requirement for an annual bidding process. At present, we are still awaiting further clarification and confirmation from WG regarding the proposed arrangements and implementation timescales. Once introduced it is anticipated that the funding will be ringfenced to support the IMCA and RPR services and help mitigate risks.
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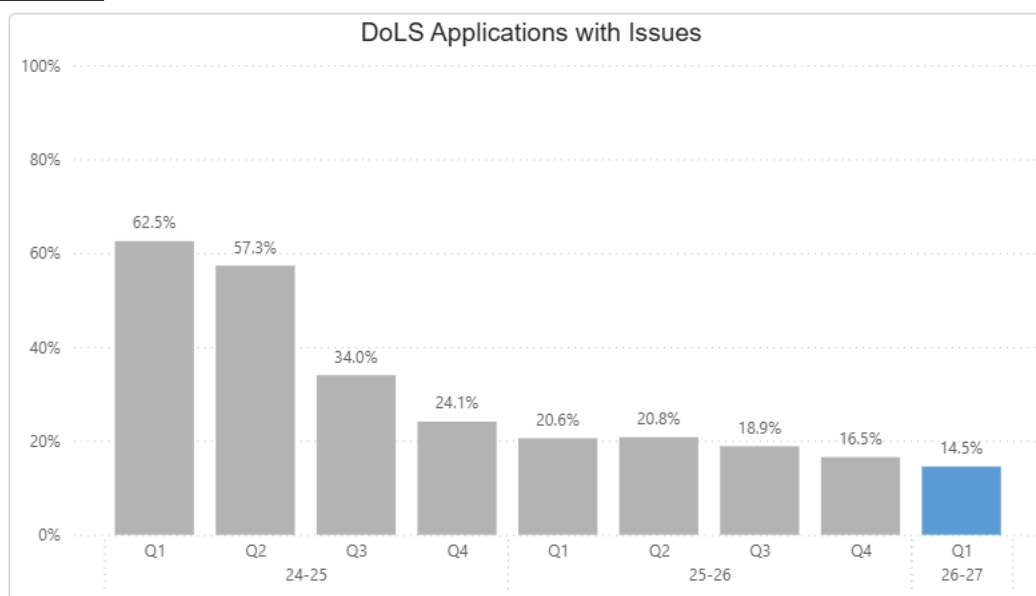
- 3.26 It should also be noted that the recent AGNI judgment may have implications for future IMCA and RPR service requirements. The full impact is not yet known; however, potential changes could include a reduced demand for RPR services in relation to DoLS alongside an increased need for IMCA advocacy support. Further consideration will be required as the wider implications of the judgment becomes clearer.
- 3.27 WG funding continues to enable us to reduce the DoLS Backlog, recruit into secondment roles, including the MCA Training Lead, extra administrative support, and a data analyst. These roles provide essential capacity and strengthen the wider DoLS/MCA system in response to ongoing increases in demand. The Health Board are currently reviewing these posts with a view to make some permanent changes to strengthen the DoLS/MCA Team. WG continues to monitor and review these initiatives to evaluate the performance and progress, ensuring effective delivery of statutory duties and to support improvements in patient care.
- 3.28 **Independent Mental Capacity Advocacy (IMCA):**
- The Health Board hold geographical responsibility for the provision of an IMCA service across North Wales. Meaning that the IMCA service enables the Health Board (HB) and Local Authorities (LA) to meet the statutory requirement of the offer of advocacy services to service users across North Wales. The provision of IMCA and paid Relevant Person Representative (RPR) services is a statutory obligation introduced under the Mental Capacity Act 2005 (MCA) to ensure individuals are provided with a legal independent safeguard.
- 3.29 Welsh Government continues to provide the Health Board with additional funds for the provision and strengthening of the IMCA and Relevant Persons Representative (RPR) services in North Wales. This permanent funding secured by the Health Board via a WG bidding process and is awarded by WG with strict spending guidelines. Contract review meetings for the provision of North Wales IMCA service are held twice per year.
- 3.30 The Health Board has engaged in the national procurement process for the provision of the IMCA services, which is expected to reduce the risk associated with the current contractual arrangements. The procurement process is now live and open to the market, with the tender period underway. The Health Board will participate in the evaluation process scheduled for Q2 of 2026/27, with a view to awarding the contract and implementing the new arrangements from 1 January 2027.
- 3.31 Table 1 below presents the number of referrals made.

Table 1:

YEAR	IMCA REFERRALS
1 April 2022- 31 March 2023	551
1 April 2023- 31 March 2024	573
1 April 2024- 31 March 2025	656
1 April 2025- 31 March 2026	722

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- 3.32 Important to note, IMCA figures reflect the number of referrals received and do not capture the total level of activity undertaken. Each referral generates multiple actions, including, visits, phone calls, professional contact and report writing. Activity may also involve engagement with solicitors in cases requiring decisions needed to be made by the Court of Protection (CoP). The data demonstrates a clear increase in referrals over the past four years. This is likely linked to improved visibility on hospital wards and proactive awareness raising undertaken by both the IMCA Service and the Best Interest Assessors (BIA's).
- 3.33 The current level of IMCA provision is reliant on Welsh Government funding, which has enabled significant increases in service capacity across North Wales. Without this additional funding, there is a risk that current service levels could not be sustained. Potentially resulting in delays in allocations and increased risk of non-compliance with statutory duties. Although the implementation of Liberty Protection Safeguards (LPS) is currently on hold, WG's direction to strengthen IMCA and paid RPR services remains in place, with the continued focus on maintaining and developing advocacy capacity. While future arrangements for IMCA and paid RPR funding may differ, commissioning responsibility for IMCA services will remain with the Health Board.
- 3.34 Moving forward, the impact of the recent AGNI judgment on future service demand is not yet clear and may alter the balance of need between advocacy and RPR services. It is too early to determine the extent of any impact and referral trends and service demand will therefore continue to be monitored over the coming months.
- 3.35 **Strategic Implications Assessment and Analysis**
- MCA and DoLS activities and objectives are aligned to the agreed strategic objectives identified within the Safeguarding and Public Protection Governance and Reporting activity to support performance and obtain assurance against compliance with legislation and statutory guidance.
- 3.36 **DoLS Documentation Audit:**
- The independent audit undertaken by the Health Board Audit Team in Q1 2026-27 reviewed 633 DoLS applications. Overall, the submitted DoLS documentation was of a high standard, although minor errors continued to be identified. Our established process ensures these issues are detected immediately by the Supervisory Body (DoLS Team) upon receipt of the application. Any paperwork requiring correction is returned promptly to the Managing Authority for amendment. The revised documentation is then resubmitted within the required legislative timescales and does not result in any delay to the authorisation process. This approach also supports timely operational reflection and promotes continuous quality improvement.
- 3.37 Table 2 below illustrates the percentage of applications during each quarter in 2024-25, 2025-26 and 2026-27. The table demonstrates a significant improvement in the quality of the paperwork.
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Table 2:



During Q1 2025–26, an average of 20.6% of applications contained errors within the submitted paperwork. In Q1 2026–27, this reduced to 14.5% (represented by the blue bar). This demonstrates a notable improvement in the quality of applications submitted by frontline staff and reflects the ongoing efforts of the DoLS/MCA Team and all Health Board services involved in completing DoLS applications.

3.38 Analysis:

During Q1, 92 applications were identified as having issues. However, **all applications** were corrected within the required legislative timescales. Most of these issues were minor and required only minimal amendment.

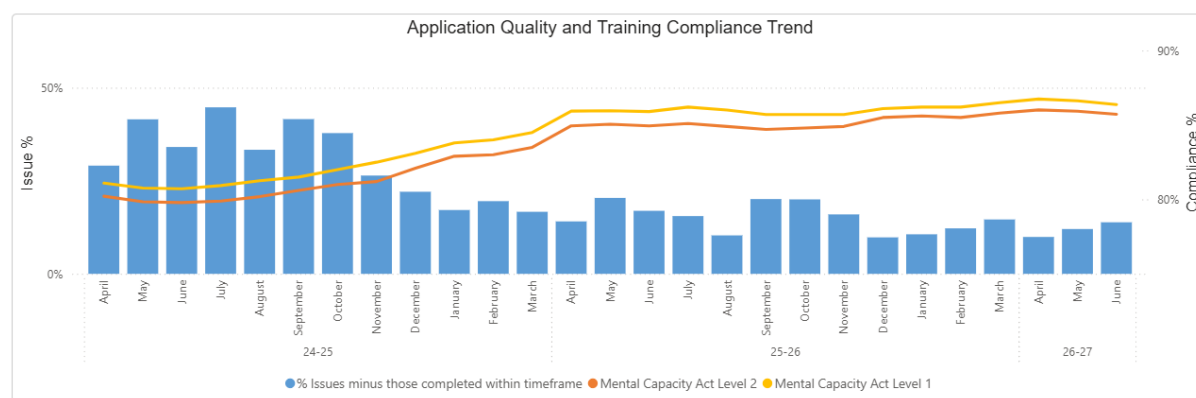
Overall, 14.5% of applications submitted in Q1 2026–27 contained errors, representing an improvement compared with the same period last year and a continued improvement on the previous quarter.

The submitted applications continue to identify four (4) main themes:

- No inclusion of the Mental Capacity Assessment Form. The findings from the audit reported that the Managing Authority (Hospital Ward) had completed the Form but had not included it as part of the initial set of paperwork.
- Mental Capacity Assessments were completed incorrectly. Like the omission of Mental Capacity Assessments, the forms suffered from minor inaccuracies such as a lack of address or date of birth. These are resolved immediately by the Managing Authority.
- The DoLS application documentation was not completed correctly. It was reported that it was not signed or was not dated correctly. Issues were resolved quickly and we plan to include enhanced monitoring of timescales.
- Missing details regarding communication and medical information. When the application is submitted the Managing Authority it must provide current medical information.

- 3.39 Although the errors identified are minor and do not impact patient care or the patient's journey, it remains important to drive continuous improvement to support effective governance, ensure legislative compliance and minimise the risk of challenge within the court of protection (CoP). A robust quality assurance process is in place, with all applications reviewed by the DoLS/MCA Team on receipt and feedback provided within 24 hours where required. In addition, Best Interest Assessors and our MCA Training Lead offer ongoing support to clinical teams through ward visits, advice, guidance and targeted learning opportunities to strengthen staff knowledge, confidence and practice.
- 3.40 Table 3 below shows the trend between the quality of the DoLS applications and MCA Level 1 and Level 2 training compliance. There continues to be a clear improvement in compliance with Level 1 and Level 2 MCA training and a significant reduction to the errors in DoLS paperwork.

Table 3: 2024-27:



3.41 Training

The BIAs continue to provide targeted MCA training tailored to service needs. Level 3 DoLS/MCA training is delivered monthly, alongside bespoke ward-based support for areas with higher application volumes. All registered staff at Band 5 and above are encouraged to complete Level 3 training. Training materials and supporting resources have also been updated to reflect the implications of the AGNI judgment, pending the publication of formal guidance.

- 3.42 The updated All Wales Mandatory Level 1 and Level 2 MCA e-learning modules are now live on ESR, enabling the Health Board to progress the development of updated versions of the MCA Level 1 and Level 2 workbooks to further support non clinical staff in meeting mandatory training requirements.
- 3.43 The Health Board have recorded further improvement in MCA training compliance (see Table 4 and Table 5 below) in 2026-26.

Table 4:

Compliance by Health Economy June 2026

Grouped Org L4	Staff	MCA Level 1	MCA Level 2	Average	Modules below 85%
Corporate Services	12040	84.2%	82.5%	83.4%	2
Health Community Centre (HCCX)	5454	86.5%	87.4%	87.0%	
Health Community East (HCEX)	5526	88.9%	87.5%	88.2%	
Health Community West (HCWX)	4488	87.7%	87.6%	87.7%	
Integrated Clinical Delivery - Primary Care (ICDP)	255	88.2%	87.2%	87.7%	
Integrated Clinical Delivery - Regional Care (ICDR)	1687	85.0%	85.5%	85.2%	
Mental Health & LDS (MX00)	2315	91.2%	91.6%	91.4%	
Midwifery and Womens Services (WXXX)	856	81.9%	81.7%	81.8%	2
Total	32621	86.4%	85.7%	86.0%	

3.44 Table 5:

Competency	Q1 2025-26	Q1 2026-27	Trend
Mental Capacity Act Level 1	85.9%	86.4%	↑
Mental Capacity Act Level 2	84.9%	85.7%	↑

Q1 2026-27 has seen an overall increase in MCA training compliance in the last 12 months, with the overall compliance rate now above the organisational target of 85% in both MCA level 1 and level 2.

3.45 Analysis:

Training compliance and understanding of DoLS and the MCA remain key priorities. Targeted support is provided to areas with lower compliance levels through additional training, guidance and engagement. The BIAs maintain a visible presence across Managing Authorities through ward visits, attendance at team meetings and the provision of practical advice to promote learning and good practice. A virtual training programme also remains available to support accessibility and uptake. Best Interest Assessors remain based within each District General Hospital, providing ongoing support and encouraging attendance at DoLS/MCA training opportunities.

3.46 Court of Protection (CoP)

The Team respond to and support front line colleagues when cases have been referred to the Court of Protection (CoP) for the following reasons:

- **Section 21A Challenge:** Patients have a right in law to challenge the detention if the patient feels it is unlawful. (Article 5(4) ECHR).
- **Section 16 MCA (2005):** Relating to welfare decisions.

3.47 The number and complexity of cases engaged in the Court of Protection arena can fluctuate. Legal challenge has resulted in intensive Court of Protection activity and as a result external legal services are commissioned in some cases to support the Court process.

3.48 The court expects the Health Board to take appropriate steps to escalate the case and legal advice must be sought promptly. There are now new arrangements in place for accessing Legal Services. All requests for external legal advice and support must be sent to the BCU Legal Services Department. Requests should no longer be sent directly to NHS Wales Shared Services Legal and Risk (L&R) or other external legal providers.

3.49 There are currently no open Section 21A challenges (DoLS challenges). The DoLS/MCA Team continues to provide advice and support to clinical teams and maintains oversight of potential Court of Protection (CoP) cases to ensure appropriate legal frameworks are considered at an early stage. Whilst legal challenge activity remains low, this can fluctuate over time. The potential impact of the recent AGNI judgment on future legal challenge activity and CoP applications is not yet fully understood and will continue to be monitored as further guidance and case law emerge

Useful links for staff:

[BCU Legal Services - Home \(sharepoint.com\)](#)

[Legal Advice and Support Request Form \(office.com\)](#)

3.50 Court of Protection – Deprivation of Liberty (CoP DoL)

No update, activity continues to adhere to legislation, policy, and process

4 RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION

4.1 Identified risk in relation to the commissioning of IMCA services. Please note, The Health Board has engaged in the national procurement process for the provision of the IMCA services, which is expected to reduce the risk associated with the current contractual arrangements. The procurement process is now live and open to the market, with the tender period underway. The Health Board will participate in the evaluation process scheduled for Q2 of 2026/27, with a view to awarding the contract and implementing the new arrangements from 1 January 2027.



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- 4.2 Continuous risk of individuals being deprived of their liberty unlawfully, this is highlighted within the risk register.
- 4.3 AGNI Judgment: The recent AGNI judgment has introduced a degree of uncertainty regarding the application of the deprivation of liberty framework in practice. Whilst national guidance is awaited, there is a risk of variation in interpretation and application across services, potentially resulting in individuals not being considered under the appropriate legal framework. To mitigate these risks the DoLS/MCA Team continues to review local processes, provide advice and training and monitor emerging guidance to support consistent and legally compliant practice.

5 ARGYMHELLION RECOMMENDATIONS

The Mental Health Legislation Committee is asked to:

- 5.1 Receive the updated paper for information and note the contents.
- 5.2 Note the continued progress made with regards to the DoLS Applications. Including the reduction to the backlog and improvement to the quality of the paper work.
- 5.3 Note the improvement to the MCA Training compliance.
- 5.4 Note the actions undertaken to date to support implementation of the AGNI judgment and mitigate associated risks
- 5.5 Note the next steps in relation to future IMCA procurement activity from January 2027.
- 5.6 Note The Executive Board has been updated on the implications of the recent Supreme Court judgment. A paper outlining the judgment, recommended changes, and planned activity was presented to the Board. The paper was presented to and approved by the Executive Board on the 1st July 2026.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Priorities	     4. Improving quality, outcomes and experience Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	People First Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	Risk CRR 24-03: There remains an established corporate risk associated with DoLS. It is recognised, that the risk of increased DoLS activity may result in unlawful deprivation of liberty if authorisations are delayed. Following a review at the Health Board Risk Management Group and the Formal Executive Group, the risk is currently scored at 12. Risks relating to DoLS and MCA continue to be reported to the Executive Group for oversight. No further actions are proposed at this time beyond those already in place. There are no financial implications for this report.
<u>Deddf Llesiant</u> <u>Cenedlaethau'r Dyfodol -</u> <u>Nodau Llesiant</u> <u>Wellbeing of Future</u> <u>Generations Act – Wellbeing</u> <u>Goals</u>	Not Applicable Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not necessary for this report
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
	Do/Yes: ☐	Naddo/No: ☒

Asesiad o'r Effaith Economaidd-gymdeithasol <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Canlyniad/Outcome:	Not necessary for this report
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
<u>Answdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Answdd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Galluogwyr Answdd Enablers of Quality Whole-systems Perspective	Meysydd Answdd Domains of Quality All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant</u> <u>Wellbeing of Future Generations Act – Wellbeing Goals</u>	Not Applicable	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog <i>A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog:</i> Armed Forces Covenant Due Regard Duty	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not necessary for this report
	Os naddo, dylech gynnwys y rheswm:	

Have you considered the Armed Forces Covenant Due Regard Duty?	If no, please include rationale:	
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i>	Do/Yes: ☐	Naddo/No: ☒
Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Canlyniad/Outcome:	Not necessary for this report
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i>	Do/Yes: ☐	Naddo/No: ☒
Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Canlyniad/Outcome:	Not necessary for this report
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
	The AGNI judgment has introduced changes to the interpretation of deprivation of liberty which may impact local practice. While further national guidance is awaited, the Health Board is reviewing processes and updating training to support legal compliance and mitigate the risk of challenge arising from inconsistent application of the legal framework.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	
Resource Impact <i>(People / Financial)</i>		

Appendix 1 – Supreme Court Judgment 2026

Appendix 2 – DoLS/MCA Action Plan following the Supreme Court Judgment

Appendix 3 – BCUHB Briefing paper following the Supreme Court Judgment

Appendix 4 – Duty - screening tool – No Deprivation

Appendix 5 – BCUHB DoLS Flowchart following the Supreme Court Judgment



JUDGMENT

A Reference by the Attorney General for Northern Ireland of a devolution issue under paragraph 34 of Schedule 10 to the Northern Ireland Act 1998

before

Lord Reed, President
Lord Hodge, Deputy President
Lord Lloyd-Jones
Lord Sales
Lord Stephens
Lady Rose
Lady Simler

JUDGMENT GIVEN ON

2 June 2026

Heard on 20, 21 and 22 October 2025

Applicant – Attorney General for Northern Ireland
Tony McGleenan KC
Alex Ruck Keene KC (Hon)
Dame Brenda King, Attorney General for Northern Ireland
(Instructed by the Office of the Attorney General for Northern Ireland)

Respondent – Lord Advocate
Dorothy Bain KC, Lord Advocate
Ruth Crawford KC
Lesley Irvine
(Instructed by the Scottish Government Legal Directorate)

Intervener – Secretary of State for Health and Social Care
Joanne Clement KC
Zoe Gannon
(Instructed by the Government Legal Department)

Intervener – The Official Solicitor
Emma Sutton KC
Rhys Hadden
(Instructed by the Official Solicitor)

Intervener – Mind, Mencap and the National Autistic Society
Victoria Butler-Cole KC
Arianna Kelly
Oliver Lewis
(Instructed by Irwin Mitchell LLP and Mind)

Intervener – The Mental Welfare Commission for Scotland
David Welsh
(Instructed by Anderson Strathern LLP)

LORD SALES AND LADY SIMLER (with whom Lord Reed, Lord Hodge, Lord Lloyd-Jones, Lord Stephens and Lady Rose agree):

1. Introduction

1. This reference, brought by the Attorney General for Northern Ireland (“the Attorney”), who is the chief legal adviser to the Northern Ireland Executive Committee, the devolved government of Northern Ireland, concerns the question of what counts as “deprivation of liberty” under article 5(1) of the European Convention on Human Rights (“the Convention”) for adults (by which we mean those aged 16 and over) assessed as not having the mental capacity under domestic law to make decisions for themselves about their residence and care arrangements, who are living in community settings amounting (or potentially amounting) to confinement.

2. The question arises in domestic law as well as under article 5 of the Convention. That is because the definition contained in the mental capacity legislation (both in England and Wales and in Northern Ireland) is directly linked to article 5 of the Convention. In Northern Ireland, section 306(1) of the Mental Capacity Act (Northern Ireland) 2016 (“the MCA 2016”) provides:

“‘deprivation of liberty’ means a deprivation of liberty within the meaning of Article 5(1) of the Human Rights Convention (and for the purposes of any reference to a deprivation of liberty, it does not matter whether the deprivation of liberty is done by a public authority or not)”.

The same is true of the analogous provision in England and Wales, where the Mental Capacity Act 2005 (“the MCA 2005”) provides by section 64(5) that, in the MCA 2005, “references to deprivation of a person’s liberty have the same meaning as in Article 5(1) of the Human Rights Convention.” It follows that any analysis of whether a person has in fact been deprived of liberty must have close regard to the jurisprudence of both the domestic courts and the European Court of Human Rights in Strasbourg (“the European court”) on the interpretation of that article.

3. Article 5 of the Convention provides, so far as material:

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

(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants; ...

4. 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.

5. Everyone who has been the victim of arrest or detention in contravention of the provisions of this Article shall have an enforceable right to compensation.”

4. Article 5 of the Convention (“article 5”) is concerned with protection of physical liberty and the protection of the individual against arbitrary interference by the state with his or her right to liberty. In *Storck v Germany* (2005) 43 EHRR 6 (“*Storck*”), the European court held that a deprivation of liberty for the purposes of article 5 has three elements:

- (i) the “objective element,” ie the person is confined to a particular restricted space for a material period of time;
- (ii) the “subjective element,” where there is no “valid consent” to that confinement, as that concept is used by the European court; and
- (iii) attribution, in other words, the state is responsible, either directly or indirectly for that confinement.

Each of the elements has been considered in the jurisprudence of the European court, as we discuss below.

5. The paradigm case of deprivation of liberty is detention in a cell, but so far as article 5(1)(e) is concerned, this has extended to include detention in psychiatric hospitals and certain social care institutions. Any procedure for the lawful deprivation of liberty of a person of unsound mind (ie under article 5(1)(e)) must satisfy certain minimum conditions: the person must be reliably shown to be of unsound mind on the basis of objective medical evidence save where emergency detention is required; the individual’s mental disorder must be of a kind to warrant compulsory confinement; and the validity of continued confinement depends upon the persistence of the mental disorder warranting compulsory confinement: see *Winterwerp v Netherlands* (1979–80) 2 EHRR 387, para 39; reiterated in the context of deprivation of liberty in care homes in *Stanev v Bulgaria* (2012) 55 EHRR 22, GC (“*Stanev*”), para 145.

6. Moreover, for those who are deprived of their liberty within the meaning of article 5(1), article 5(4) entitles a detained person to institute proceedings by which the lawfulness of the detention is decided speedily by a court. For those purposes, the detention of persons of unsound mind (article 5(1)(e)) constitutes “a special category”, since they may need assistance to present their case to a court. Under article 5(4) the person concerned should have access to a court and the opportunity to be heard either in person or, where necessary, through some form of representation, and a person detained for an indefinite or lengthy period is entitled to have the lawfulness of their detention reviewed at reasonable intervals: see *Winterwerp*, para 55. For those who lack legal capacity to institute legal proceedings, the European court has held that “special safeguards” are called for to make “the right guaranteed by article 5(4) as nearly as possible as practical and effective for this particular category of detainees as it is for other detainees ... automatic judicial review might be one means of providing the requisite safeguard, it is not necessarily the only means”: see *MH v United Kingdom* (2014) 58 EHRR 35, para 82.

7. Inevitably, there are cases where persons who (by reason of mental health problems or other mental impairments) are unable to look after themselves and who lack mental capacity to “consent”—in the relevant sense—to confinement may need, for their own safety and best interests, to be accommodated under care and treatment regimes involving a degree of control over their lives; and sometimes those regimes may amount to a deprivation of liberty within the meaning of article 5. In *HL v United Kingdom* (2004) 40 EHRR 32 (“*HL*”) (discussed further at paras 152–156 below), an autistic man who was profoundly mentally disabled and lacked capacity under domestic law to consent to admission to hospital for treatment was held by the European court to have been deprived of liberty when he was admitted informally to Bournwood Hospital, a secure psychiatric hospital. The court held that article 5(1) and (4) had been breached because the deprivation of liberty was not in accordance with a procedure prescribed by law and so was arbitrary; and the procedures for challenging the deprivation of liberty by way of judicial review or an application for habeas corpus did not comply with article 5(4) as there was no procedure by which he could seek a merits review of his detention (para 140). (At the time of the decision in *HL*, there was also no framework in Northern Ireland for authorisation of deprivation of liberty other than under the Mental Health (Northern Ireland) Order 1986 (SI 1986/595), which provided for admission for assessment and treatment of a mental disorder, or by way of a court order.)

8. Following *HL*, with a view to ensuring compliance with article 5, the United Kingdom legislatures had to introduce schemes for the many thousands of mentally incapacitated people who are confined in hospitals, care homes and elsewhere in circumstances amounting to a deprivation of liberty within the meaning of that article. The MCA 2005 was amended by section 50 of the Mental Health Act 2007 to insert new sections 4A and 4B. Deprivation of liberty was only permitted under the MCA 2005 in three circumstances: (i) by authority of the Court of Protection by an order under section 16(2)(a); (ii) by authorisation under a new administrative scheme provided for in Schedule A1 (as inserted by section 50(5) of and Schedule 7 to the 2007 Act) and known as the “Deprivation of Liberty Safeguards scheme” (“the DOLS scheme”), which related only to confinement in hospitals and in care homes falling within the meaning of the Care Standards Act 2000 (see paragraph 178 of Schedule A1); and (iii) under section 4B, which allows deprivation of liberty if it is necessary in order to give life-sustaining treatment or to prevent a serious deterioration in the person’s condition while a case is pending before the court.

9. So far as the administrative authorisation process is concerned, the deprivation of liberty safeguards were directed at securing professional assessment, by people independent of the hospital or care home in question, of whether the individual concerned lacked the capacity to make their own decision about whether to be accommodated in the hospital or care home for the purpose of care or treatment (paragraph 15 of Schedule A1) and whether it was in their best interests to be detained (paragraph 16 of Schedule A1). Provision was also made for the relevant person’s representative and an independent mental capacity advocate to be involved, for effective review by the supervisory body granting the authorisation and for the ability to have the lawfulness of the detention reviewed speedily by a court. The Northern Ireland Assembly responded to the decision in *HL* by incorporating similar deprivation of liberty safeguards into the MCA 2016, albeit not referred to in those terms.

10. In relation to incapacitated adults deprived of liberty in other settings the administrative authorisation process in England and Wales was not available in Northern Ireland, and any deprivation of liberty could only be authorised by the Court of Protection on an application made to that court. For incapacitated adults subject to residence or care arrangements not regarded as amounting to deprivation of liberty, there was no requirement for any person or body responsible for their living arrangements to seek authorisation. However, that did not (and does not) mean there is a complete absence of safeguards for this cohort of people. Those incapacitated adults have the protection of article 8 of the Convention in the event of interference with their right to respect for private, family and home life (see for example, *Hillingdon London Borough Council v Neary* [2011] EWHC 1377 (COP); [2011] 4 All ER 584, paras 151–152 per Peter Jackson J). The right to respect for private life may require that their views are sought and taken into account, where they are able to express an opinion about the circumstances in which they are living. There are also other safeguards in the MCA 2005: see sections 1(5), 1(6), 4, 6, 35–41, and 44. Decision-makers in England and Wales were (and continue to be) required to have regard to the Code of Practice issued pursuant to the MCA 2005, and that Act requires them to act in the individual’s best interests. Support plans for the provision of, and arrangements for, care and accommodation by local authorities after a community care assessment are expected to be subject to at least annual reviews. In addition, local authorities are under a duty to investigate any safeguarding issues that may arise in a residential placement and, like NHS bodies and placement providers, owe duties of care to service users at common law.

11. In 2014 this court was asked to determine whether three people who lacked mental capacity to consent to their living arrangements were subject to deprivation of liberty within the meaning of article 5. None of the three was in a situation to which the deprivation of liberty safeguards applied because none of them was in a hospital or registered care home. All three were living in care settings in the community to which the safeguards did not apply. The court held that all three were subject to deprivation of liberty within the meaning of article 5: *Surrey County Council v P*; *Cheshire West and Chester Council v P* [2014] UKSC 19; [2014] AC 896 (“*Cheshire West*”). By a majority, the court held that the “acid test” for deprivation of liberty according to the Strasbourg jurisprudence is whether an individual is subject to “continuous supervision and control” and “not free to leave”: paras 48–49 and 54 (Baroness Hale of Richmond) and para 63 (Lord Neuberger of Abbotsbury). The court held

that lack of objections, that the arrangements are the least restrictive possible, that their living arrangements are as “comfortable” or their lives as “enjoyable” as they could be, are all irrelevant to the question whether they are confined (the objective element of deprivation of liberty: see para 4(1) above). As Baroness Hale put it, “A gilded cage is still a cage”: para 46.

12. The conventional understanding of the decision in *Cheshire West*, so far as concerns England and Wales, is that this court endorsed what appears to have been common ground in that case (and not the subject of argument), that lack of mental capacity of an individual to consent to their care arrangements equates to lack of “valid consent” (in the sense in which that term is used when assessing the subjective element of the *Storck* test, referred to below as “valid consent” for short; this is to be distinguished from other senses in which the European court and domestic courts use the term “consent” in other contexts). In other words, an individual without such mental capacity is treated as unable to give valid consent to confinement. The result following *Cheshire West* is that any confinement in a community setting (for example, with parents or foster parents in a private dwelling or in supported living accommodation) will only be lawful following an order of the Court of Protection or, where available, administrative authorisation under the DOLS scheme.

13. The consequences of the decision in *Cheshire West* have been significant. The approach it adopted to deprivation of liberty has had the effect that a significant number of people across the United Kingdom (estimated at over 400,000) with impaired mental capacity and living in health or social care settings are considered to be deprived of liberty for the purposes of article 5 and as requiring legal safeguards applicable by virtue of such deprivation (as distinct from other, different safeguards applicable by virtue of article 8 or other provisions of the Convention or under other parts of domestic law). It is not in doubt that they are a vulnerable group, potentially at risk and in need of protection. Moreover, merely because their living arrangements are community-based (rather than provided in more formal institutional contexts), does not in itself negate the possibility that those arrangements may give rise to deprivation of liberty within the meaning of article 5. On the contrary, there is evidence that some small residential care homes, and settings offering “independent living”, have subjected vulnerable individuals to restrictive confinement in circumstances involving elements of coercion which may, in context, constitute a deprivation of liberty under article 5: see, for example, the review by the Care Quality Commission, *Learning Disability Services Inspection Programme: National Overview* (2012).

14. The question raised by this reference is whether treating all persons in the vulnerable group we have identified as being subject to a deprivation of liberty under article 5 is correct as a matter of law. This necessarily involves considering the relevant Strasbourg jurisprudence and the scope and correctness of *Cheshire West*.

15. The Minister of Health for Northern Ireland (“the Minister”) wishes to change the practice in Northern Ireland in relation to this cohort of people, so that even where a person lacks mental capacity to make decisions about their care arrangements (applying the statutory test contained in section 3 of the MCA 2016, which is materially identical to the test for capacity in the MCA 2005 considered by this court in *Cheshire West*), they can give the necessary valid consent through the expression of current wishes and feelings that go beyond mere acquiescence regarding their confinement. To achieve this, the Minister intends to issue a revised code of practice under section 288(4) of the MCA 2016 to replace the existing Deprivation of Liberty Safeguards Code of Practice issued under section 288(1) of that Act. In its current draft form, the revised code is at annex 1 to this judgment (“the Revised Code”). The proposed changes are designed to provide that not all those who lack mental capacity to decide on their care arrangements (applying the test in section 3 of the MCA 2016) should be considered unable to give valid consent to confinement for the purposes of article 5. Instead, an individual in this group who can be identified as able to give the necessary positive indications of consent to the circumstances of their confinement, through the expression of wishes and feelings, will be treated as being able to give valid consent. If valid consent could be given, the statutory procedures for authorisation of deprivation of liberty would not apply in those cases (although, of course, other regimes for safeguarding the interests of those individuals will continue to apply).

16. Changes to the administrative arrangements surrounding the Northern Ireland DOLS scheme would also be required. The court was told by the Attorney that administrative arrangements would require the relevant person or body to use a form either to set out an explanation of why, notwithstanding their lack of legal capacity under the MCA 2016 to consent, the individual is nonetheless said to be giving valid consent through the expression of their wishes and feelings; or in any other case (including where the individual has expressed no clear wishes and feelings, or where those wishes and feelings are ambiguous), to seek authorisation under the Northern Ireland DOLS scheme. Where valid consent is given, it would be subject to review, and as a minimum there would be a formal review once a year. A change in the individual's wishes and feelings regarding their confinement would constitute a change of circumstances, requiring review of whether they are, in fact, continuing to give the necessary valid consent, or whether it is necessary to seek authorisation under the Northern Ireland DOLS scheme. If valid consent cannot be demonstrated at any given time, those responsible for confining the person are at risk both of civil and criminal liability in Northern Ireland (sections 9, 269, and 273 of the MCA 2016).

17. Section 24 of the Northern Ireland Act 1998 provides that a "Minister or Northern Ireland department has no power to make, confirm or approve any subordinate legislation, or to do any act, so far as the legislation or act—(a) is incompatible with any of the Convention rights...". The Attorney says that the Revised Code is subordinate legislation, and no one participating in the appeal has disputed this. Nonetheless, we should register that we have some doubt about this proposition. A code of practice is not legislation in the ordinary meaning of the word, but rather a statement of general policy to provide guidance to others exercising discretionary powers of some kind. A code of practice issued under section 288(1) of the MCA 2016 (and revised under section 288(4) of that Act) is stated to be "for the guidance of" various persons and bodies, which tends to confirm this view. However, if the Revised Code is not subordinate legislation, the issuing or revision of a code of practice is an "act" by the Minister, and we do not consider that anything significant turns on the difference between the two for the purposes of the determination of the reference. The Minister recognises that the Revised Code represents a departure from the conventional understanding of the approach endorsed by this court in *Cheshire West*. Accordingly, the Attorney makes this reference to establish the compatibility of the guidance given in the Revised Code with article 5.

The referred question

18. The Attorney has referred the following question to this court:

"Whether the proposed exercise of the Minister of Health's powers under section 288(4) of the MCA 2016 to revise the Deprivation of Liberty Safeguards Code of Practice issued under section 288 of that Act would be invalid by reason of section 24 of the Northern Ireland Act 1998 as incompatible with article 5 of the Convention."

19. The Attorney submits that, although the Revised Code would adopt an approach to the scope and effect of article 5 which would differ from that determined by this court in *Cheshire West*, it would nonetheless satisfy the requirements of article 5 as determined by a proper analysis of the Strasbourg jurisprudence. This is because, the Attorney submits, the decision in *Cheshire West* went beyond the boundaries of the Strasbourg jurisprudence in relation to the subjective element of the concept of deprivation of liberty under article 5, because the decision does not allow for consideration of the views of the affected individual in determining whether their living arrangements give rise to such a deprivation. The Attorney says that the majority in *Cheshire West* misinterpreted that jurisprudence regarding the meaning of valid consent in article 5.

20. The Attorney contends that a significant proportion of those currently treated as being subject to deprivation of liberty for the purposes of article 5 do not, on proper analysis, suffer such deprivation at all. The European court would not find that a deprivation of liberty had occurred in their cases. Rather, this group includes people who are positively happy with their living arrangements and have no desire to leave them, but who are treated nonetheless as having been deprived of liberty and who for that reason are subjected to significant state intrusion into their lives and those of their families, because of the need to authorise that deprivation of liberty, in particular under the Northern Ireland DOLS scheme. The application of that scheme is not only intrusive. It is also expensive to administer and wasteful of resources in a care system which is under considerable strain. The Attorney submits that this court can remedy this situation by changing the current understanding of the subjective element of a deprivation of liberty within the meaning of article 5, arrived at pursuant to the decision in *Cheshire West*, and in particular by revisiting and re-analysing the concept of valid consent as used in that context. The wider definition of that concept which the Attorney proposes, which takes account of the individual's wishes and feelings, would mean that fewer people aged 16 and above without legal capacity under the MCA 2016 to consent to their living arrangements would be regarded as being deprived of liberty in the context of the delivery of health and social care. Safeguards would still be required to ensure that compliance with article 5 was achieved, but the Attorney submits those safeguards would focus on identifying the individual's wishes and feelings, which she says is what is appropriate in this context.

21. The Attorney therefore invites the court to depart from the decision in *Cheshire West* to the extent necessary to enable the Revised Code to be issued. On this basis, she submits that the Revised Code would be compatible with the Convention and therefore valid having regard to section 24 of the Northern Ireland Act 1998. It follows that the Minister would be acting within competence to issue the Revised Code, and the Attorney invites the court to hold that the Revised Code would be compatible with article 5.

The position of the interveners

22. As explained above, both the MCA 2016 (in Northern Ireland) and the MCA 2005 (in England and Wales) link the meaning of deprivation of liberty to the meaning of that concept in article 5. It follows that the question in this reference is likely to have implications for the provision of health and social care to individuals across those jurisdictions. In addition, by virtue of the way in which the competence of the Scottish

Parliament and the competence of the Scottish Ministers are defined under the devolution regime set out in the Scotland Act 1998, by reference to the Convention rights, the question in the reference is likely to have implications for that jurisdiction as well. Further, the Human Rights Act 1998 applies throughout the United Kingdom and also produces legal effects by reference to the Convention rights as regards the interpretation of legislation (section 3) and the exercise of the powers of public authorities (section 6). In these circumstances the court has permitted and been assisted by several interventions from other jurisdictions.

23. The interveners do not all agree that the Revised Code would be compatible with article 5. Nor is the scope of the reference agreed. The Attorney has limited her question to the subjective element of the deprivation of liberty test whereas others take the view that the objective element of the deprivation of liberty must be addressed as well. The position of each of the interveners can be summarised shortly as follows.

24. The Lord Advocate, the senior Law Officer of the Scottish Government, has intervened in the proceedings in the public interest and against the background that legislative reforms adopting an approach similar to that in the Revised Code may be introduced in the Scottish Parliament, if the Revised Code is found to be within competence in Northern Ireland. Her position, in short summary, is that valid consent to confinement for the purposes of article 5 may, with appropriate safeguards, be

given by an individual without legal capacity; and that the decision in *Cheshire West* is no obstacle to the lawfulness of the Revised Code because it did not endorse the proposition that lack of legal capacity to consent automatically equates to inability to give valid consent to the conditions of confinement for the purposes of the subjective element of deprivation of liberty under article 5. On that basis, she considers that it would be open to the court to find that the Revised Code would be compatible with article 5.

25. The Secretary of State for Health and Social Care (“the Secretary of State”) has policy responsibility for health and social care in England (health and social care being devolved matters under each of the devolution statutes, subject to particular reservations). The MCA 2005 extends to England and Wales. The subject-matter of the MCA 2005 is a reserved matter under the Government of Wales Act 2006 and so is reserved to the UK Parliament. The Secretary of State also has policy responsibility generally for deprivation of liberty in the adult health and social care context, and policy responsibility for those parts of the MCA 2005 that concern deprivation of liberty within the meaning of article

5.

26. The Secretary of State’s position is that it is not possible to consider the subjective element of deprivation of liberty under article 5, and in particular the concept of valid consent, in isolation from the objective element of deprivation of liberty, as the starting point is to identify to what an individual is consenting. The overarching question is whether an individual is deprived of liberty within the meaning of article 5. This requires consideration of all three elements of the test (para 4 above) in combination. The Secretary of State submits that the factors relied on by the Attorney in support of her submissions on valid consent (particularly the absence of coercion and evidence that the individual has no objection to the arrangements in question) should properly be considered under the objective element of confinement rather than the subjective element, because they go to the question of whether the individual is actually confined. He submits that the law took a wrong turn in *Cheshire West* and went far beyond the Strasbourg jurisprudence in adopting what was described as “the acid test” (para 11 above) in place of a multifactorial analysis. The Secretary of State therefore invites this court to depart from *Cheshire West*. He submits that if the court were to develop the law on valid consent by working from the erroneous starting point in *Cheshire West*, this would inevitably result in an even greater departure from the Strasbourg jurisprudence than has already taken place. The Secretary of State’s alternative position if the court does not accept that argument is to invite the court to accept the Attorney’s submissions on valid consent, subject to certain caveats.

27. The court also received submissions from Mind, Mencap and the National Autistic Society (“the Charities”). Their joint submission invites the court to refuse to determine the reference in the abstract. But if the court does decide to answer the question posed, they submit that it should rule that the Attorney’s proposed approach to valid consent for the purposes of article 5 is not lawful. The Charities also invite the court to refuse to address the Secretary of State’s submissions on the objective element of deprivation of liberty.

28. The Charities contend that in *Cheshire West* this court proceeded on the unchallenged basis that an individual who lacks mental capacity to consent to their care arrangements cannot give valid consent to those arrangements for the purpose of the subjective element of deprivation of liberty under article 5. The Charities submit that *Cheshire West* concerned only the objective element and included consideration of whether a person needed to display an objection to their care arrangements for the objective element to be satisfied. Read in that way, they say this court need not depart from the decision in *Cheshire West* in order to determine this reference, because the objective element does not fall to be considered at all under the reference as framed by the Attorney. However, if this court decides that the correctness of *Cheshire West* is to be considered, the Charities make a powerful case for retaining the acid test set by *Cheshire West* as a clear and workable test which can readily be understood by health and social care professionals making the decisions about provision of care to those with mental impairments in very varied circumstances. They submit that prior to *Cheshire West* there were high levels of confusion among these professionals about what constituted a deprivation of

liberty. The need for an easily understood and consistent legal definition of an objective deprivation of liberty was central in the charities' intervention in *Cheshire West*, and evidence of this confusion was set out in some detail in that case.

29. So far as the subjective element is concerned, the Charities submit that the Strasbourg jurisprudence supports the view that people who lack capacity according to the MCA 2005 to consent to their particular care arrangements cannot give valid consent for the purposes of article 5. To the extent that this jurisprudence allows for a person lacking such capacity to provide valid consent, this is only where the question of capacity has been determined in a general sense, on a global basis, not where there has been a finding of a lack of capacity with respect to decisions about the particular care and living arrangements for the individual. The legal regimes in Northern Ireland, Scotland and England and Wales do not adopt this generalised approach to capacity, but instead, assess mental capacity in relation to particular decisions taken at particular times and for particular purposes. Where a general removal of legal capacity occurs, it may make sense to ask whether the individual in fact is or was able to give valid consent to the arrangements in a precisely targeted way, but the Charities submit it makes no sense where there has been a specific finding that the individual does not have capacity to consent to the particular arrangements in question. They contend that there is nothing in the Strasbourg jurisprudence to support the test proposed in the Revised Code, namely whether an individual has a "positive attitude" to their care arrangements, and that such an approach is incompatible with article 5. Moreover, such an approach is unworkable and would remove vital safeguards from disabled people who are both vulnerable and at risk, absent necessary safeguards. A test which requires the decision-maker to determine whether an individual has a "positive attitude" about their care is both highly subjective and hopelessly vague.

30. The Charities submit that in the population of people who are deprived of their liberty in an objective sense, there will be a wide range of attitudes, communication styles, cultural backgrounds, life experiences and disabilities. They filed witness statements which set out practical examples which illustrate the serious difficulty that is likely to arise in eliciting wishes from individuals in that group accurately, objectively and without conflicts of interest. Other difficulties include ascertaining whether "behaviour that challenges" a particular set of living arrangements is the result of restrictions in place or is part of an individual's manner of presentation, given their particular form and level of mental impairment (and therefore not to be viewed as an objection or lack of valid consent); the difficulty of responding to fluctuations in the wishes and feelings of individuals with mental impairments, and of identifying what level or nature of fluctuation would require a conclusion that valid consent was no longer present; and the real risks of acquiescence (perhaps out of a fear of the consequences of non-compliance), masking and suggestibility among people with mental disorders and disabilities.

31. According to the Charities, article 5 requires that safeguards be in place for those who are, in an objective sense, deprived of their liberty, so as to ensure that their confinement has a lawful basis (under article 5(1)(e)) and is not arbitrary, and that an individual has a right of access to court to challenge their detention under article 5(4). The Charities contend that to say that an individual who is deprived of their liberty in an objective sense is, for subjective reasons, not so deprived as a matter of law, does not reduce any restrictions on them in reality. It simply removes the safeguards the individual has against arbitrary or unlawful detention, including access to independent representation and access to a court to challenge the lawfulness of that detention. It follows that narrowing the scope of the subjective element of article 5 in the way proposed by the Attorney will significantly reduce existing legal protections for disabled people to their detriment.

32. The Mental Welfare Commission for Scotland also intervened. It has the overarching function to act in a manner which seeks to protect the welfare of persons in Scotland who have a mental health disorder: section 4(2A) of the Mental Health (Care and Treatment) (Scotland) Act 2003. The Commission's submissions explain in practical terms the powers that can be exercised under section 13ZA of the Social Work (Scotland) Act 1968 to enable a local authority to arrange for an adult to move to a care home or other suitable registered care setting if it is deemed necessary for their welfare

and they lack capacity to consent to the move; and how consent to care arrangements currently operates in Scotland including how, as part of the exercise of obtaining consent, the views and wishes of the adult, as a unique individual, are required to be taken into account.

33. In short, the Commission's position is that, if an adult can understand their situation and circumstances so as to express an opinion or feeling about them, that can and should be given significant weight in the determination of that individual's consent to the arrangements in their case. It submits that such expressions of view can clearly indicate valid consent in terms of the subjective element of the deprivation of liberty such that there would not, on a correct analysis of article 5 in the Strasbourg jurisprudence, be a deprivation of liberty. To the extent that it is suggested that *Cheshire West* requires those feelings and wishes to be disregarded, the Commission submits that this is contrary to the principle of encouraging those lacking capacity to take part as much as possible in the decision-making surrounding their lives and welfare and that it would be contrary to the appropriate balancing of the individual's article 5 and article 8 rights which is necessarily inherent in the application of those provisions to treat such expressions of view by them as irrelevant on a blanket basis. It follows that the Commission's submission is that the Revised Code (which it submits is broadly aligned with the use of section 13ZA in Scotland) would not involve a breach of Convention rights.

34. The Official Solicitor to the Senior Courts of England and Wales ("the Official Solicitor") has also been permitted to intervene. One of her primary functions is to act as litigation friend of last resort in civil, family and Court of Protection proceedings. It is this function that is relevant for present purposes. The Official Solicitor accepts that the court can clarify the subjective element of the deprivation of liberty test (in particular, the meaning of valid consent) and determine the question raised in the reference by the Attorney. She also submits that the court can do so without reference to the objective element and without the need to interfere with or depart from the decision in *Cheshire West* because in that case this court simply did not consider the subjective element at all. However, the Official Solicitor has raised a series of concerns should the court consider departing from *Cheshire West*. These include the fact that the reference concerns a point of law which is being determined in the absence of any concrete factual matrix and in circumstances where there may be considerable practical repercussions across the United Kingdom. Substantively, she points to risks in adopting the valid consent approach for this cohort of people. Based on evidence provided by herself and by the Charities of the likely impact on individuals who lack capacity to consent to their care arrangements, she submits there is a risk that where such individuals are nonetheless perceived to consent to their confinement, and thereby cease to qualify as being subject to a deprivation of liberty under article 5, they will be prevented from having access to the courts by virtue of article 5(4) to challenge what is, in objective terms, their detention.

2. An ab ante (prospective) review of the lawfulness of the Revised Code

35. It is in the nature of the case presented by the Attorney on the reference that this court is called upon to scrutinise the compatibility of the Revised Code with the Convention rights of individuals under article 5 in advance of that revision being brought into effect and applied in concrete cases. That is to say, this court has to conduct what is called an ab ante (prospective) review in order to determine whether it is within the competence of the Minister under section 24 of the Northern Ireland Act 1998 to introduce that revision and thereby affect decision-making by persons who are required to have regard to the Revised Code.

36. The Revised Code is not legislation to be passed by the Northern Ireland Assembly in the exercise of its legislative competence under the devolution regime in the Northern Ireland Act 1998. It is guidance issued by a Minister in the exercise of a public law discretion to indicate how other decision-makers should behave. A question therefore arises regarding the test to be applied to determine whether the issuing of the Revised Code would be lawfully within the discretionary power, and hence the competence, of the Minister.

37. In the case of legislation to be enacted by a devolved legislature such as the Northern Ireland Assembly which is said to be outside competence because it will lead to violation of Convention rights, it is established that the test to be applied is whether the legislation would violate Convention rights in all, or almost all, cases in which it will fall to be applied: see *Christian Institute v Lord Advocate* [2016] UKSC 51; [2017] SC (UKSC) 29; *In re Abortion Services (Safe Access Zones) (Northern Ireland) Bill* [2022] UKSC 32; [2023] AC 505, paras 12–19; and *In re JR123* [2025] UKSC 8; [2025] AC 1256, paras 87–90. The application of that highly deferential test is justified by the need to accord full respect to the legislative competence of a devolved legislature: see *In re JR123*, paras 88–90 and 92. That is not a feature of the present case, which is concerned with the discretionary powers of the Minister rather than the legislative competence of the Assembly.

38. Further, the Revised Code just gives guidance as to how various decision-makers should proceed, to which they are required to have regard but with which they are not obliged to comply. They are subject to legal obligations under the general law and are bound by that law rather than the guidance in the Revised Code. So even if the Revised Code gives advice which is inconsistent with the requirements of article 5 under the general law, it does not override those requirements. The issue is whether the Revised Code would mislead decision-makers and distract them from proper compliance with their legal duties.

39. In this case, the appropriate test to be applied is that discussed in *R (A) v Secretary of State for the Home Department* [2021] UKSC 37; [2021] 1 WLR 3931 to assess the lawfulness of policies or statements of practice issued by a Minister to give direction to decision-makers, namely “does the policy in question authorise or approve unlawful conduct by those to whom it is directed?” (para 38). If it can be seen that a policy or statement of practice will do that in a significant number of cases, that will be a ground for quashing it: paras 77–78. Transposing that test for the purposes of assessing whether the Minister has competence to act under the Northern Ireland Act 1998, the question is whether the Revised Code authorises or approves unlawful conduct in a significant number of cases in the form of a breach of Convention rights of individuals.

40. As we explain below, if the decision of the majority in *Cheshire West* is good law regarding the interpretation of deprivation of liberty in article 5, the Revised Code is inconsistent with it and would involve authorisation or approval of treatment of persons with impaired mental capacity by care providers in settings which in many cases would constitute an unlawful deprivation of liberty contrary to that provision. It would be outside the competence of the Minister to issue a Code of Practice which did that. This makes it imperative that this court should examine the compatibility of the Revised Code with the Convention rights set out in article 5 and the analysis of the Strasbourg jurisprudence in the judgments in *Cheshire West*.

3. Precedent and the 1966 Practice Statement

41. There is an issue regarding the true ratio decidendi in *Cheshire West*. We address what that case decided in section 6 below. As we explain, we consider that the majority in *Cheshire West* gave an authoritative interpretation of the meaning of deprivation of liberty under article 5 which is inconsistent with the view of that concept which underlies the Revised Code. If that interpretation is not changed by this court, the conclusion must be that the Revised Code is incompatible with the meaning of deprivation of liberty in article 5. However, the Attorney and the Secretary of State squarely contend that *Cheshire West* was wrongly decided and went well beyond the caselaw of the European court in the interpretation given to that concept in article 5. Two questions therefore arise: (i) did the majority in *Cheshire West* err in their interpretation of article 5? And, if so, (ii) should this court correct that interpretation?

42. As regards the first of these questions, as we explain below, we consider that the majority in *Cheshire West* did err in their analysis of the Strasbourg jurisprudence regarding the meaning of deprivation of liberty in article 5 and in the interpretation they gave to that term. Therefore, we must answer the second question.

43. The judgments in *Cheshire West* were based on an analysis of the jurisprudence of the European court regarding the interpretation of article 5. Even if there had been a significant change in the interpretation of deprivation of liberty in the judgments of that court delivered after *Cheshire West* was decided, the majority judgment in *Cheshire West* would constitute binding authority of this court in so far as the interpretation of deprivation of liberty in that judgment constitutes part of the ratio decidendi: see *Kay v Lambeth Borough Council* [2006] UKHL 10; [2006] 2 AC 465, paras 40–45. It is only open to this court to depart from such authority by application of the principles set out in the House of Lords’ 1966 Practice Statement (Judicial Precedent) ([1966] 1 WLR 1234), which continues to govern the practice of this court: see *Austin v Southwark London Borough Council* [2010] UKSC 28; [2011] 1 AC 355, para 25.

44. As a general rule this court is very circumspect about accepting an invitation to invoke the 1966 Practice Statement. As Lord Bingham explained in *Horton v Sadler* [2006] UKHL 27; [2007] 1 AC 307, para 29, “Over the past 40 years the House has exercised its power to depart from its own precedent rarely and sparingly. It has never been thought enough to justify doing so that a later generation of Law Lords would have resolved an issue or formulated a principle differently from their predecessors.” It is important not to undermine the role of precedent and the certainty which it promotes: *Henderson v Dorset Healthcare University NHS Foundation Trust* [2020] UKSC 43; [2021] AC 563, para 87; and *In re Dalton* [2023] UKSC 36; [2025] AC 235, para 47.

45. However, as Lord Bingham explained in *Horton v Sadler*, para 29, while former decisions of the House of Lords or the Supreme Court are normally binding, “too rigid adherence to precedent may lead to injustice in a particular case and unduly restrict the development of the law”; see also *R v National Insurance Comr, ex p Hudson* [1972] AC 944, 966 (Lord Reid).

46. The 1966 Practice Statement may more readily be applied in relation to a decision of the House of Lords or this court where, subsequent to that decision, there have been judgments of the European court which are inconsistent with it. In such a case the proper development of the law is likely to require that this court should follow any settled interpretation of the Convention rights derived from the Convention and incorporated into domestic law by virtue of the Human Rights Act, in accordance with the guidance given by the House of Lords in *R (Ullah) v Special Adjudicator* [2004] UKHL 26; [2004] 2 AC 323 and by this court in *Manchester City Council v Pinnock* [2010] UKSC 45; [2011] 2 AC 104, *R (AB) v Secretary of State for Justice* [2021] UKSC 28; [2022] AC 487 and *R (Elan-Cane) v Secretary of State for the Home Department* [2021] UKSC 56; [2023] AC 559. That is particularly so in the present context, since the meaning of “deprivation of liberty” is directly tied to its meaning in article 5: see section 306 of the MCA 2016 and section 64(5) of the MCA 2005 (para 2 above). That linkage is even stronger than that under the Human Rights Act (section 2 of which only requires a domestic court to take account of the Strasbourg jurisprudence).

47. However, as it transpires in this case, no one contends that there has been any relevant change in the jurisprudence of the European court since *Cheshire West* regarding the meaning of deprivation of liberty in article 5. There is therefore no scope for this court to justify a departure from the majority judgment in *Cheshire West* on the footing that it has been superseded by developments in the Strasbourg jurisprudence. The submissions made by the Attorney and the Secretary of State require this court to assess whether the majority in *Cheshire West* were right or wrong in their analysis of the Strasbourg jurisprudence as it stood at the time of that decision and as it continues to apply now and to decide whether the 1966 Practice Statement should be applied.

48. By reason of the direct definitional link in the MCA 2016 and the MCA 2005 between deprivation of liberty and its meaning in article 5, it is that meaning, on which the European court provides authoritative guidance, which governs the operation of the relevant parts of the statutory regimes. If there is a significant divergence between the Strasbourg jurisprudence on article 5 and what was declared to be its meaning in *Cheshire West*, considerable confusion will result. The range of submissions received on this reference tends to illustrate this. The problem is likely to become worse in the future, as the European court may be expected to continue to follow its established

caselaw in this area and the application of the principles it has identified to new cases as they arise will tend to expose the divergence in approach that has occurred. Parties will be left in a quandary whether to follow *Cheshire West* or the Strasbourg jurisprudence as it continues to develop, which would require them to take on the burden of litigation which would be necessary to correct the position in domestic law.

49. Moreover, if the Attorney and the Secretary of State are correct in their submission that the decision in *Cheshire West* gives an overbroad interpretation to deprivation of liberty under article 5, there will not be scope for that to be corrected in a direct manner by the European court, because the public authorities affected by that interpretation do not have a right to apply to that court to challenge that interpretation: see *R (AB) v Secretary of State for Justice*, paras 56–57. This means that the Supreme Court has a particular responsibility to ensure that the interpretation of the Convention rights in article 5 is properly in line with the Strasbourg jurisprudence, in order to ensure that the legislative objective of the MCA 2016 and the MCA 2005 to align their application with article 5 is respected by the courts and is given effect throughout the administrative regimes created by those statutes.

50. We also explain (section 7 below) the considerable practical difficulties and unjustified cost and expense to which the decision in *Cheshire West* has given rise. The decision has had wide ramifications across the whole of the care sector in all the nations of the United Kingdom. The administrative difficulties which have arisen from the decision are a further ground for application of the 1966 Practice Statement, justifying this court in departing from that decision: see *R v National Insurance Comr, ex p Hudson* [1972] AC 944, 1024 (Lord Simon of Glaisdale).

51. For the reasons set out below, we conclude that it is important for the proper application of the Convention rights given domestic effect by the Human Rights Act, the MCA 2016 and the MCA 2005 and for the proper development of the law in this area that the error in *Cheshire West* should be corrected. Therefore, this is a case in which it is appropriate to apply the 1966 Practice Statement and for this court to depart from *Cheshire West*.

4. Summary of conclusions on the scope of the reference and the question posed

52. The question on this reference is directed at and invites consideration only of the subjective element (concerning lack of valid consent to confinement) in article 5. However, the fundamental question is whether the individual has been “deprived of his liberty” as that expression is used in article 5. We agree with the Secretary of State that this requires consideration of all three elements of the deprivation of liberty test taken together. It is not possible to consider the concept of absence of valid consent in isolation. As we explain below (para 126), “valid consent” for these purposes is distinct from consent to an infringement of Convention rights as required for a waiver of rights. Valid consent in the present context is an aspect of the assessment whether the relevant parts of article 5 predicated on there being a deprivation of liberty are applicable at all. In that context the starting point must be to identify to what an individual is or is not consenting, and that inevitably requires consideration of the objective element, regarding the circumstances of the confinement. To do otherwise risks developing domestic law by building on what may be a wrong approach to the objective element. This would be contrary to sections 306 of the MCA 2016 and section 64(5) of the MCA 2005, which define deprivation of liberty by reference to its meaning under article 5 and, if the Attorney and the Secretary of State are correct in their submissions, could lead to an even greater departure from the authoritative interpretation of that concept given by the European court. It follows, in our view, that the reference requires us to consider all three elements of the article 5 test.

53. For the reasons explained in detail below, we would answer the referred question in summary as follows:

- (i) The starting point in assessing whether someone has been deprived of liberty within the meaning of article 5 is the specific situation of the individual concerned, and the assessment is multifactorial, with account taken of a whole range of factors including the type, duration, effects and manner of implementation of the measure in question. This was the

approach set out in *Engel v The Netherlands* (1979–80) 1 EHRR 647 (“*Engel*”) and *Guzzardi v Italy* (1981) 3 EHRR 333 (“*Guzzardi*”) and it has been consistently applied by the European court since then, and in many different contexts, including the one with which we are here concerned. The judgments of the European court show that no single factor is determinative.

(ii) In addition to the objective element of confinement in a restricted space for a significant period, an individual will only be considered to be deprived of liberty if, as an additional subjective element, they have not validly consented to the confinement in question (*Storck*). Valid consent is therefore a powerful factor in the assessment. It is an autonomous concept and not to be equated with the concepts of consent for the purpose of waiver of rights under the Convention or of legal capacity in domestic law. The fact that an individual lacks legal capacity to decide on their living and care arrangements does not necessarily mean that they are de facto unable to understand and consent to those arrangements in a manner that prevents those arrangements from becoming a deprivation of liberty (see *Stanev, HL* and the other judgments of the European court considered below). On the contrary, an individual without legal capacity under domestic law, but who is conscious of their environment and has a basic understanding of their living circumstances so that they can express their view about their situation, who manifests their acceptance of the situation they are in, should have their opinion respected when an assessment is made of whether they are deprived of liberty under article 5.

(iii) Although the objective and subjective elements of deprivation of liberty are often considered sequentially by the European court in its assessment of an applicant’s specific situation, there is an overlap. The requirement to take account of the “type” and “effects and manner of implementation” of the measure in question means that the assessment of the objective element can take account of the specific context and circumstances of restrictive measures that are different from the paradigm of confinement in a cell.

(iv) The approach of the European court means that the effect of restrictions on an individual, including their compliance and the lack of objection if they are capable of objecting or giving tacit agreement, is relevant in assessing the objective element of confinement. The relative normality of the placement is also a relevant factor in this assessment. Similarly, in situations that are far from the paradigm of confinement in a cell, the purpose for which a measure has been taken is a factor to be considered.

(v) The European court has recognised that the process of assessing whether there has been a deprivation of liberty is no easy task in some contexts and may give rise to difficulties, especially in borderline or marginal cases. Equally, it may sometimes be difficult to ascertain the true feelings or preferences of vulnerable individuals who do not have mental capacity to decide on their living arrangements. The approach should be practical and realistic. Where there is serious doubt, no inference of valid consent should be drawn.

(vi) It follows from the analysis of the Strasbourg jurisprudence in section 8 below that, in setting out the acid test, the majority decision in *Cheshire West* departed from the longstanding multifactorial approach to determining whether a person is deprived of liberty within the meaning of article 5 and is wrong (as we explain in section 9 below).

(vii) For the reasons given in section 3 above, we have concluded that the 1966 Practice Statement should be applied and that *Cheshire West* should be overruled.

(viii) The Minister would not be acting incompatibly with article 5 in issuing the Revised Code and it is therefore within competence for him to proceed to issue it.

54. In reaching these conclusions we acknowledge the fact that this reference concerns a group of people who lack the mental capacity under domestic law to consent to their care arrangements. Moreover, as the evidence of the Charities makes clear, people with mental health problems or

learning disabilities and autistic people have a wide range of abilities and care needs. Some can communicate through speech, some are non-verbal and use “Makaton” or assistive technology, and some communicate through sounds or gestures. Some can understand the different possible options for their care but cannot weigh them up to make a choice; others are unable to understand what their support needs are, let alone the different ways and means in which they could be met. There is also a wide spectrum of care arrangements in the community for disabled people who lack capacity to decide on their residence and care. Some live in their own homes which they own or rent, or with parents or foster parents in the family home. Some live in supported living placements (with a tenancy agreement signed on their behalf) which have communal areas and shared staff, or they may live in a care home with other residents. There is similarly a wide spectrum of care arrangements for those who are detained in institutional settings and hospitals, ranging from those who are detained in “open” hospitals to those who are confined to a small space under close supervision. Care plans, even for those who live in their own homes in the community, can involve a wide range of restrictive measures that are considered to be in the individual’s interests (for example, the use of sedative medicines, physical restraint devices, electronic and other monitoring) but which have the potential to be overused, misused or abused. Put another way, even a domestic setting can involve a deprivation of liberty.

55. We do not assume that because an individual is cared for in a community setting, their care arrangements are necessarily less restrictive than in a psychiatric hospital, nor that an individual subject to restrictive care arrangements would inevitably object to them or indicate that they were not happy to live in the particular setting. Nor do we underestimate the difficulty of identifying whether a disabled or mentally impaired individual subject to such measures is agreeing to them, objecting to them, or otherwise has a “positive attitude to the care arrangements” (see para 2.12 of the Revised Code), as demonstrated by the evidence submitted by the Charities. These points will require careful consideration in finalising the Revised Code and in the further guidelines we understand will be produced. Moreover, although the Attorney’s written case suggests that the Revised Code would not apply to mental health hospitals in Northern Ireland, the approach we consider correct in relation to the subjective element of valid consent would, as a matter of logic, potentially affect all settings, including hospitals, care homes, children’s homes, hostels, supported living arrangements and people’s own private homes. This too will require further consideration to ensure appropriate provision is made.

56. To explain the conclusions we have reached, it is necessary by way of background, first to set out the relevant legislation dealing with mental capacity and deprivation of liberty in England and Wales, Northern Ireland and Scotland: section 5. We will then describe the judgments in this court in *Cheshire West* and summarise the effect of that decision: section 6. In section 7 we describe the practical consequences of the majority decision in *Cheshire West*. In section 8 we analyse the Strasbourg jurisprudence on the meaning of deprivation of liberty in article 5. In section 9 we explain why *Cheshire West* is wrong and what this court can and should do about it.

5. The legal framework dealing with mental capacity and deprivation of liberty

(a) England and Wales: the MCA 2005

57. In England and Wales, the MCA 2005 sets out the legal framework for determining a person’s capacity to make decisions. The MCA 2005 is complemented by a Code of Practice (issued under section 42 of the MCA 2005) which gives guidance on the application of the Act. There is a separate Code of Practice for Northern Ireland, issued under section 288 of the MCA 2016. Both codes are currently under review.

58. Section 1 of the MCA 2005 sets out the general principles which apply for the purposes of the Act. It provides, among other things, that a person is presumed to have capacity unless it is established that they lack capacity (section 1(2)); that they are not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success (section 1(3)); and that they are not to be treated as lacking capacity merely because their decision is unwise

(section 1(4)). Thus, although a person's wishes and feelings are stipulated as a matter to be considered when deciding what is in their best interests (section 4(6)), the section 1 principles make it clear that their wishes and feelings are considered from the outset.

59. Sections 2 and 3 together define the circumstances in which a person lacks capacity in relation to a particular matter. Section 2(1) provides that:

“For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.”

The question is not whether the person's ability to take the decision is impaired but rather whether the person is rendered unable to make the decision by reason of that impairment or disturbance. Capacity determinations are specific to particular matters that arise for decision at the time a determination is required to be made.

60. Section 3(1) provides that a person is unable to make a decision in relation to a matter if they are unable to understand, retain or use or weigh the information relevant to that decision, or are unable to communicate the decision. Section 3(2) provides that the information relevant to the decision is required to be presented to the person in a way that is appropriate to their circumstances. Section 3(3) provides that the fact that the person may be able to retain the information for a short time only does not prevent a finding of capacity. Section 5 enables decision-makers to carry out acts in connection with personal care, health care, or treatment of a person who lacks capacity to make their own decisions about the same, by conferring protection from liability (as long as the act is done in the reasonable belief that capacity is lacking and that the act is in the person's best interests). As originally enacted, section 6(5) included a limitation to section 5, and provided no protection for action that amounted to a deprivation of liberty for the purposes of article 5.

61. The current DOLS scheme in England and Wales is contained in Schedules A1 and 1A to the MCA 2005. As explained above, it provides an administrative process for the authorisation of deprivation of liberty in hospitals and care homes only, in cases where an adult (a person aged 18 or over) lacks capacity to consent to being accommodated there for care or treatment. In cases where a deprivation of liberty is proposed or taking place in the “community” (in other words, not in a hospital or care home), or where the person is aged 16 or 17 (and lacks capacity to consent to confinement applying the MCA 2005) an authorisation from the Court of Protection is required. In rare cases, the High Court's inherent jurisdiction may be invoked in this regard: see for example *A NHS Trust v A* [2013] EWHC 2442 (Fam); [2014] Fam 161. The safeguards available to a person during the DOLS scheme process have been summarised above.

(b) Northern Ireland: the MCA 2016

62. The provisions for determining capacity in Northern Ireland are materially the same. The MCA 2016 also applies a decision-specific test (sections 3 and 4). The test considers whether the person is able to understand, retain, appreciate, use and weigh the information relevant to the decision, and communicate their decision; and, if they are unable to do so, whether that inability is caused by an impairment or disturbance in the functioning of their mind or brain.

63. The provisions authorising deprivation of liberty for those lacking capacity to consent to arrangements for their care or treatment under the MCA 2016 have been in force since December 2019. Unlike the position in England and Wales, the MCA 2016 does not seek to define in detail those to whom the deprivation of liberty safeguards apply. Instead, section 24(1) of the MCA 2016 provides that a person is only protected from liability in carrying out an act which amounts to or is one of a number of acts that together amount to, a deprivation of a person's liberty if specific statutory conditions (including appropriate authorisation) are met: section 9 of the MCA 2016.

64. In Northern Ireland, authorisation for confinement amounting to deprivation of liberty for those aged 16 and over (in a hospital, a care or nursing home, day centre, respite facility, any other

health or social care setting or in a private home) can be sought in two ways under the MCA 2016: trust panel authorisation and short-term authorisation (although there are also provisions relating to emergency deprivation of liberty and related detention). These provisions are contained primarily in Schedules 1 to 3 of the MCA 2016. In both cases there must be a medical report from an independent practitioner unconnected with the person. The criteria for authorisation in both cases are that appropriate care or treatment is available for the person in the place in question; the prevention of serious harm condition is met (namely, that failure to detain the person would create a risk of serious harm to the person or risk of serious physical harm to others; and the likelihood of harm and the seriousness of the harm must be proportionate to the detention); the person lacks capacity in relation to the detention; and it would be in the person's best interests to be detained. A trust panel authorisation can last for a maximum of six months and may be extended, following further medical examination and other assessments, initially for six months and then for one year at a time. Short-term detention in hospital can be authorised by an appropriate healthcare professional for up to an initial 14 days which can be extended for another 14 days. There are requirements for a nominated person to be consulted when best interests are considered (at various points in the authorisation and any extension process) in relation to a deprivation of liberty and the affected person may (if they have capacity to do so) choose and appoint a nominated person. Both a short-term and a trust panel authorisation can be reviewed by the Review Tribunal, whose remit includes both deprivation of liberty cases as well as detention under the Mental Health (Northern Ireland) Order 1986.

(c) Scotland

65. In Scotland, the relevant legislation includes the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003. The Adult Support and Protection (Scotland) Act 2007 amended the 2000 Act and makes standalone provision for the temporary protection of certain vulnerable adults at risk of harm. All three pieces of legislation apply to individuals who have attained the age of 16 years (as well as, in certain limited respects, to those under 16). The 2003 Act makes provision in relation to the "detention" for treatment in hospital of persons who have a mental disorder, either by the issuing of an emergency detention certificate or a short-term detention certificate by a medical professional (Parts 5 and 6), or the making of a compulsory treatment order or an interim such order by the Mental Health Tribunal for Scotland (Part 7). These interventions are all predicated on the patient's ability to make decisions about the provision of medical treatment being significantly impaired and are subject to certain overarching general principles (sections 1 and 2(5)(a) where the patient is under the age of 18) and certain procedural safeguards. The general principles include the requirement to have regard to present and past wishes and feelings of the patient. The procedural safeguards include duties and powers of revocation; rights of appeal; and duties and rights of review.

66. A summary of the scope, the safeguards provided and the broad differences between the schemes in the different parts of the United Kingdom is set out in a table in annex 2 to this judgment.

(d) The Code of Practice in Northern Ireland

67. In Northern Ireland, section 288(1) of the MCA 2016 requires a code of practice to be issued by the Department of Health (in practice, on the direction of the Minister) to accompany the MCA 2016. Such a code may be revised under section 288(4), which is the power which the Minister is proposing to use to produce the Revised Code. Any such code has statutory force, in that various persons (including those acting in a professional capacity) who take decisions in relation to a person who is aged 16 or over and lacks capacity for purposes of the MCA 2016 "must have regard" to it: section 289(1) and (2)(a) of the MCA 2016.

68. To recap, the current Code of Practice accompanying the DOLS scheme in Northern Ireland is based on the decision of this court in *Cheshire West* and purports to reflect the link between the statutory definition of deprivation of liberty in section 306(1) of the MCA 2016 and article 5. The Revised Code (as currently drafted) is inconsistent with the approach assumed to be required by *Cheshire West* in providing that an individual without mental capacity under domestic law to make

decisions about their care arrangements can nonetheless give what is taken to be valid consent (as that concept has been articulated in the Strasbourg jurisprudence) to confinement through the expression of wishes and feelings that go beyond mere acquiescence in relation to the circumstances of their confinement. In the case of such individuals without mental capacity who nonetheless give valid consent, if the Revised Code is adopted, and if England and Wales and Scotland adopt similar guidance, there will be no need for the person proposing to take measures which amount objectively to detaining the individual, to obtain authorisation under Schedules 1 to 3 of the MCA 2016, Schedules A1 or 1A to the MCA 2005, or the Scottish legislation as applicable. It is therefore necessary to consider the conclusions reached by this court in *Cheshire West* and whether they are correct.

6. *Cheshire West*

69. On 19 March 2014 the Supreme Court gave judgment in the two conjoined appeals in *Cheshire West*. The cases of the three individuals in those appeals were considered by the Court of Protection, the statutory court established to oversee the MCA 2005 (in England and Wales) with power to authorise deprivation of liberty (by operation of section 4A(3) read together with section 16(2)(a) of the MCA 2005). (As explained above, the Court of Protection also serves as the route for the purposes of article 5(4) of the Convention for challenging administrative authorisations under the DOLS scheme in England and Wales.)

(a) The decisions in the Court of Protection and the Court of Appeal

70. *Cheshire West* concerned the cases of two sisters aged 15 and 16 when care proceedings started (but 17 and 18 by the time of the judgment of Parker J in the Court of Protection: [2010] EWHC 785 (Fam); [2011] MHLR 108) and a 38-year-old man (at the time of the judgment of Baker J in the Court of Protection: [2011] EWHC 1330 (Fam)). The sisters are referred to in the judgments in the Supreme Court as MEG and MIG, respectively, and the man is referred to as P.

71. MIG, the older of the two sisters, had a moderate to severe learning disability. She had very limited cognitive ability, experienced problems with her sight and hearing, communicated with difficulty and required help crossing the road because she was unaware of danger. She was living with a foster mother in her private home and regarded the foster mother as “Mummy”. Her foster mother provided her with intensive support in most aspects of daily living. MIG was not on any medication. She was not restrained or locked in. She had never attempted to leave the home by herself and showed no wish to do so, but, if she had done so, her foster mother would have restrained her. MIG attended a further education college daily during term time and was taken on trips and holidays by her foster mother.

72. MEG had mild learning disabilities, and her cognitive ability was limited. She lived with three others in a small NHS residential home for learning disabled adolescents with complex needs. She had occasional outbursts of challenging behaviour towards the other three residents and sometimes required physical restraint. MEG was prescribed (and administered with) tranquilising medication to control her anxiety. She was not in a locked environment but had one-to-one and sometimes two-to-one support. Continuous supervision and control were exercised to meet her care needs. MEG was accompanied by staff whenever she left the home. She attended the same further education college as her sister during term time and had a full social life. She showed no wish to go out on her own, and so there was no need to prevent her from doing so, but Parker J concluded that if she had tried to leave, she would have been restrained or brought back for her own safety.

73. In a careful judgment, Parker J held that neither MIG nor MEG had been deprived of their liberty within the meaning of article 5. Their situations were, she concluded, very far from the “paradigm” of imprisonment (para 235). She had not met MIG and MEG but concluded that their “wishes and feelings are manifest and clearly expressed. They plainly have no subjective sense of confinement. In a non-legal sense, they have the capacity to consent to their placements.” She had not visited their placements but concluded that no visitor “would gain any sense of confinement or

detention” (para 234). Parker J placed considerable emphasis on the purpose of the measures applied to them (to provide them with a safe environment) and on the nature of the intentions (which were benevolent) of their caregivers. In relation both to MIG and MEG, she held that “[e]ach lacks freedom and autonomy dictated by their own disability, rather than because it is imposed on them by their carers” (para 233).

74. Parker J’s decision in both cases was upheld by the Court of Appeal: [2011] EWCA Civ 190; [2012] Fam 170. Wilson LJ gave the lead judgment, with which Mummery and Smith LJ agreed. He discussed three factors relevant to the assessment of whether a person is, in an objective sense, subject to what can be regarded as confinement: whether or not the person objects to the confinement imposed on them; the administration of medication that suppresses the ability to express wishes and feelings; and the “relative normality” of their situation (paras 25–26 and 28–30). He explained that lack of valid consent was relevant to the objective element of confinement because it could lead to arguments, the stress of objections being overruled, and perhaps even restraint and forcible returns to confinement. On the other hand, the absence of objections “generates an absence of conflict and thus a peaceful life” which points away from a deprivation of liberty. Medication that has a sedative or tranquilising effect is liable (at least potentially) to suppress objections and was therefore relevant to the enquiry. As for normality, he referred to the wide spectrum of living arrangements which might require assessment. At one end of the spectrum is “the most normal life possible” with a person living with their natural family, and “not much less normal” is life with a foster carer. At the other end of the spectrum are institutions designed for compulsory detention, with small children’s homes or nursing homes falling in between. The enquiry into normality also involved consideration of daily activities and occupations such as attending college or a day centre, and the availability of outside social contact.

75. The case of P involved a 38-year-old man born with cerebral palsy and Down’s syndrome. Since 2009 he had lived in a staffed bungalow (referred to as Z House) with two other residents, near his mother’s home. P could walk short distances but otherwise required prompting and help with all activities of daily living, getting about, eating, personal hygiene and continence. He sometimes required intervention (amounting at times to physical restraint) when he exhibited challenging behaviour but was not prescribed any tranquilising medication. He was found by Baker J in the Court of Protection to be “completely under the control of the staff” and unable to “go anywhere or do anything without their support and assistance” (para 59 of the judgment of Baker J, [2011] EWHC 1330 (Fam)).

76. At para 53, Baker J recorded it as being common ground that the second and third elements of the deprivation of liberty test were satisfied: the subjective element was satisfied because P lacked the capacity to give his consent, and the state was responsible, as both the local authority and the court were engaged in determining where P should live. The question in dispute, accordingly, was limited to whether his circumstances objectively amounted to a deprivation of liberty.

77. Baker J’s reasoning, leading to his conclusion that P was being deprived of his liberty, is set out in paras 58–61 of his judgment. The judge found that the council and the home “have taken very great care to ensure that P’s life is as normal as possible” (para 58). P did not live in accommodation designed for compulsory detention and had regular contact with his family, attendance at a day centre five days a week, and a good social life with other residents and staff and in the community. As the judge said, “these features help to give his life a strong degree of normality”. Against that however, the judge held:

“his life is completely under the control of members of staff at Z House. He cannot go anywhere or do anything without their support and assistance. More specifically, his occasionally aggressive behaviour, and his worrying habit of touching and eating his continence pads, require a range of measures, including at times physical restraint, and, when necessary, the intrusive procedure of inserting fingers into his mouth whilst he is being restrained” (para 59).

The judge concluded that the steps required to deal with his challenging behaviour led to a clear conclusion that, looked at overall, P was being deprived of his liberty (para 60).

78. The Court of Appeal allowed the appeal: [2011] EWCA Civ 1257; [2012] PTSR 1447. Munby LJ gave the lead judgment, with which Pill and Lloyd LJ agreed. The court held that Baker J had applied the wrong test by comparing P's life to the life of an able-bodied man and never comparing "P's situation in the Z House with the kind of life P would have been leading as someone with his disabilities and difficulties in what for such a person would be a normal family setting. He never grappled with the question whether the limitations and restrictions on P's life at Z House are anything more than the inevitable corollary of his various disabilities" (para 110). P was inherently restricted in the kind of life he could lead. The fact that he could not go anywhere or do anything without support and assistance of staff was dictated by his various disabilities and would have been the case wherever he was living and in whatever kind of setting (para 111). Moreover, the measures described by the judge as applied from time to time to P were far removed from the physical or chemical restraints sometimes found and far removed from anything that approached a deprivation of liberty (para 114). On this analysis, Munby LJ concluded that none of the matters that tipped the balance for Baker J were capable of doing so and P was not deprived of liberty.

79. As we have indicated, the appeals in all three cases were heard together by the Supreme Court. The court held (unanimously) that P was deprived of his liberty, and (by a majority of four to three) that MIG and MEG were also deprived of their liberty. The lead judgment for the majority was given by Baroness Hale, with whom Lord Sumption agreed. Lord Neuberger and Lord Kerr also agreed with Baroness Hale and gave concurring judgments.

(b) The majority judgment in Cheshire West

80. At para 19,
Baroness Hale, for the majority, identified that:

"In cases under the Human Rights Act 1998, the courts have frequently to consider how far their duty, in section 2(1), to 'take into account' the jurisprudence of the European Commission and Court of Human Rights ... goes. That problem does not trouble us in this case. Section 64(5) of the Mental Capacity Act states that: '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'. As the object was to avoid the violation identified in *HL* ... it seems clear that we are expected to turn to the jurisprudence of the Strasbourg Court to find out what is meant by a deprivation of liberty in this context."

81. Baroness Hale
defined the issue for consideration at para 32 as follows:

"The Strasbourg case law, therefore, is clear in some respects but not in others. The court has not so far dealt with a case combining the following features of the cases before us: (a) a person who lacks both legal and factual capacity to decide upon his or her own placement but who has not evinced dissatisfaction with or objection to it; (b) a placement, not in a hospital or social care home, but in a small group or domestic setting which is as close as possible to 'normal' home life; and (c) the initial authorisation of that placement by a court as being in the best interests of the person concerned. The issue, of course, is whether that authorisation can continue indefinitely or whether there must be some periodic independent check upon whether the placements made are in the best interests of the people concerned."

82. At para 37, Baroness Hale described the three elements of deprivation of liberty for article 5 purposes as follows: “(a) the objective component of confinement in a particular restricted place for a not negligible length of time; (b) the subjective component of lack of valid consent; and (c) the attribution of responsibility to the state” (see para 4 above). She said that the second and third elements were not in issue on the appeals but that the first element, the objective component, was in issue.

83. It was common ground that all three individuals lacked mental capacity under domestic law to make relevant decisions about where they lived and the care and treatment they received there, so that under the MCA 2005 they did not have the mental capacity to consent to the arrangements amounting to a confinement. It appears therefore to have been common ground by the time these cases reached the Supreme Court that, because they lacked that mental capacity to consent, the individuals concerned could not give valid consent for the purposes of the subjective element of the article 5 test. As we have explained, this element was addressed in both first instance judgments and by the Court of Appeal in both appeals. But the focus of the case in the Supreme Court was on the objective element and the question of consent was simply not argued.

84. This was both unfortunate and confused. Deprivation of liberty under article 5 is an autonomous concept (meaning it arises under the Convention and is governed by principles laid down by the European court in its jurisprudence, rather than by national law in a Contracting State), and the subjective element in that concept and the notion of valid consent are likewise autonomous concepts. Therefore it in no way followed from the fact that the individuals did not have legal capacity in domestic law under the MCA 2005 to decide about their living arrangements that they could not give valid consent, in terms of the law under the Convention, in relation to those arrangements for the purposes of determining whether the subjective element of deprivation of liberty was made out or not.

85. Nonetheless, Baroness Hale referred to the European court’s approach to “tacit acceptance” of a care placement as discussed in *Mihailovs v Latvia* [2014] MHLR 87 (“*Mihailovs*”) (see further paras 170–172 below). Moreover, in her discussion of the objective element, Baroness Hale distinguished *Mihailovs* on the basis that the applicant in that case had a “level of de facto understanding which had enabled him to express his objections to his first placement.” She continued, “[t]he Strasbourg court accepts that there are some people who are not capable of expressing a view either way and this is probably the case with both MIG and MEG” (para 55). Baroness Hale appears therefore to have accepted that those with a “level of de facto understanding” could give tacit acceptance to the placement, although we consider that if this was her conclusion, it is difficult to reconcile with her categorical statement in para 50 that “lack of objection” is never relevant in the assessment regarding deprivation of liberty. More fundamentally, we respectfully consider that, without the assistance of argument on this point, in para 55 she got the analysis on this point the wrong way round. It appears that she thought that if someone is not capable of expressing a view about their position, that means that the subjective element of a deprivation of liberty is established; but according to the Strasbourg jurisprudence, this would indicate that it is not established: see paras 142, 164–167, 171 and 176 below. Baroness Hale ultimately acknowledged that none of the suggested distinctions (it is assumed between the situation in *Mihailovs* and the situations of MIG and MEG) were very satisfactory (para 56).

86. Baroness Hale held that in the Strasbourg jurisprudence, the context of the measures was relevant but the following factors were not relevant: the fact that the confinement was imposed in the best interests of the individual concerned, the fact that she did not object or was compliant, the relative normality of the care arrangements and the reason or purpose of the confinement: see paras 42, 43, 47 and 50.

87. Baroness Hale held that it is axiomatic that people with disabilities (both physical and mental) must have the same human rights as others and that those rights include the right not to be deprived of one's physical liberty. Moreover, she observed that the meaning of deprivation of liberty must be the same for everyone. In this regard, the fact that the arrangements are comfortable and make the life of the person concerned enjoyable makes no difference. She held, at para 46:

“Those rights include the right to physical liberty, which is guaranteed by article 5 of the European Convention. This is not a right to do or to go where one pleases. It is a more focused right, not to be deprived of that physical liberty. But, as it seems to me, what it means to be deprived of liberty must be the same for everyone, whether or not they have physical or mental disabilities. If it would be a deprivation of my liberty to be obliged to live in a particular place, subject to constant monitoring and control, only allowed out with close supervision, and unable to move away without permission even if such an opportunity became available, then it must also be a deprivation of the liberty of a disabled person. The fact that my living arrangements are comfortable, and indeed make my life as enjoyable as it could possibly be, should make no difference. A gilded cage is still a cage.”

88. Baroness Hale then formulated what she described as the “acid test” for determining whether someone is deprived of their liberty. She held, at paras 48 and 49:

“48. So is there an acid test for the deprivation of liberty in these cases? I entirely sympathise with the desire of Munby LJ to produce such a test P, MIG and MEG are, for perfectly understandable reasons, not free to go anywhere without permission and close supervision. So what are the particular features of their ‘concrete situation’ on which we need to focus?

49. The answer, as it seems to me, lies in those features which have consistently been regarded as ‘key’ in the jurisprudence which started with *HL v United Kingdom* (2004) 40 EHRR 32: that the person concerned ‘was under continuous supervision and control and was not free to leave’ (para 91). I would not go so far as Mr Gordon, who argues that the supervision and control is relevant only in so far as it demonstrates that the person is not free to leave. A person might be under constant supervision and control but still be free to leave should he express the desire so to do. Conversely, it is possible to imagine situations in which a person is not free to leave but is not under such continuous supervision and control as to lead to the conclusion that he was deprived of his liberty. Indeed, that could be the explanation for the doubts expressed in *Haidn v Germany* [2013] MHLR 13.”

89. Baroness Hale also explained, in agreement with submissions made by the National Autistic Society and Mind, that the following are *not* relevant to the question whether a person is deprived of liberty: “the person’s compliance or lack of objection”; the “relative normality of the placement (whatever the comparison made)”; and the “reason or purpose behind a particular placement”: para 50.

90. Baroness Hale held that on the facts the three individuals were not free to leave and in all the circumstances had been deprived of their liberty. The practical effect of this conclusion was that all three would be entitled to regular (at least annual) reviews of the continued necessity for the

arrangements which deprived them of their liberty, and the continued aptness of the assessment under which their needs were met, including participation in the review by independent advocates on their behalf. Baroness Hale explained (para 57) the policy reason for erring on the side of caution in identifying the relevant cohort of people as “deprived of their liberty”:

“Because of the extreme vulnerability of people like P, MIG and MEG, I believe that we should err on the side of caution in deciding what constitutes a deprivation of liberty in their case. They need a periodic independent check on whether the arrangements made for them are in their best interests. Such checks need not be as elaborate as those currently provided for in the Court of Protection or in the deprivation of liberty safeguards (which could in due course be simplified and extended to placements outside hospitals and care homes). Nor should we regard the need for such checks as in any way stigmatising of them or of their carers. Rather, they are a recognition of their equal dignity and status as human beings like the rest of us.”

91. Lord Neuberger and Lord Kerr gave short concurring judgments agreeing with Baroness Hale’s acid test. Lord Neuberger set out a list of the factors that divided the minority judgment by Lord Carnwath and Lord Hodge (with the agreement of Lord Clarke of Stone-cum-Ebony) from those of the majority. Those points included the fact that the regime was no more intrusive or confining than is required for the protection and well-being of the person concerned, which the minority considered was significant but the majority thought was irrelevant.

92. Lord Neuberger also observed, at para 66, that in *Austin v United Kingdom* (2012) 55 EHRR 14, GC (“*Austin*”), para 58, the European court made it clear:

“that the fact that ‘the object is to protect, treat or care in some way for the person taken into confinement’ has ‘no bearing on the question whether that person has been deprived of his liberty, although it might be relevant to the subsequent inquiry whether the deprivation of liberty was justified ...’ To the same effect, the Grand Chamber said in *Creanga v Romania* (2012) 56 EHRR 11, para 93 that ‘the purpose of measures by the authorities depriving applicants of their liberty no longer appears decisive for the court’s assessment of whether there has in fact been a deprivation of liberty’, on the basis that the purpose is to be taken ‘into account only at a later stage of its analysis, when examining the compatibility of the measure with article 5.1 ...’”

93. At para 67 Lord Neuberger rejected the idea that, “if certain conditions amounted to a deprivation of liberty in the case of a person who had the capacity to object and did object, they may, or—even worse—would, not do so in the cases of a person who lacked the capacity to object”. We observe that Lord Neuberger’s approach has the effect of substantially downgrading the significance of, if not altogether eliminating, the subjective element of deprivation of liberty identified in *Storck*. Also, as with Baroness Hale’s judgment, it is inconsistent with the approach adopted by the European court (paras 142, 164–167, 171 and 176 below).

94. At para 68 Lord Neuberger said that “the notion that the absence of objection can justify what would otherwise amount to a deprivation of liberty is contrary to principle”. In our view this

confuses the concept of justification of deprivation of liberty (which is relevant to the application of article 5(1)(e), where a deprivation is identified as occurring) with the criteria for identifying a deprivation in the first place. He then said that “a person’s consent (provided that it is freely and properly given)” may defeat a contention that they have been deprived of their liberty. This seems to us to confuse valid consent (in the sense in which we are using that term), as an aspect of the criteria for identifying whether a deprivation exists, with the quality of consent required for a waiver of rights, which is a completely different concept: see para 126 below. And then he stated that “it involves turning that principle on its head to say that the absence of objection will justify what would otherwise be a deprivation of liberty—save in those rare circumstances where the absence of objection can be said to amount to consent, as in *Mihailovs* ... paras 138–139”. As to which we observe (i) the confusion with justification is again evident; (ii) this approach reverses the proper order of analysis as appears from the Strasbourg jurisprudence (see paras 135–142, 151 and 161–169 below); and (iii) the position in *Mihailovs*, discussed at paras 170–172 below, is by no means a rare case. Lord Neuberger did not explain what those cases might be.

95. In his concurring judgment, Lord Kerr emphasised (paras 76–77 and 80) the objective approach to deprivation of liberty and the question whether a person is restricted, and substantially downgraded the significance of the subjective element despite the emphasis it was given in *Storck* and other leading Strasbourg cases such as *Stanev*: see para 120 below. He acknowledged the subjective element but considered that deprivation of liberty is determined “primarily” on an objective basis, is not “solely dependent” on the reaction or acquiescence of the individual whose liberty has been curtailed, and “contentment ... does not determine whether she is restricted in her liberty”; “[l]iberty means the state or condition of being free from external constraint. It is predominantly an objective state”.

96. Neither Lord Neuberger nor Lord Kerr addressed the question of what might constitute valid consent, as an autonomous concept, in the context of a person lacking capacity to give consent applying the test under domestic law in the MCA 2005.

97. In our view, although the argument in *Cheshire West* was presented on the basis that the case was only concerned with the objective element of deprivation of liberty, by reason of the way in which the majority analysed the position, the decision stands as binding authority that the acid test for deprivation of liberty under article 5 as described by Baroness Hale governs the whole operation of that provision, including in relation to its subjective element. As a corollary of that, it is binding authority that (i) an individual who is unconscious but who would be confined if they awoke is subject to deprivation of liberty; (ii) there is a deprivation of liberty even when a person with mental impairment (who would for that reason be confined if they tried to leave) gives every sign of being content with their living arrangements, in anything other than rare and exceptional cases of undefined ambit; (iii) the purpose for which confinement is imposed is irrelevant in making the assessment whether there is a deprivation of liberty; and (iv) the normality of the arrangements to which the individual in question is subject is also irrelevant.

98. Lord Carnwath and Lord Hodge gave a joint dissenting judgment. They considered that the European court deals with the question of deprivation of liberty on a case specific basis involving a range of criteria: para 94. They did not consider that the Strasbourg jurisprudence provided sufficient support for Baroness Hale’s acid test. In their view the degree of constraint was relevant to the existence, or not, of a deprivation of liberty, and they considered it relevant that the care regimes in question were no more intrusive or confining than was required for the protection and well-being of the persons concerned. Lord Clarke agreed with them and held in addition

that there was no basis for interfering with the judgments of the trial judges in each of the three cases.

7. The consequences of *Cheshire West*

(a) Administrative and resource implications

99. Dr Lucy Series (Associate Professor in Social Care Law and Policy at the University of Bristol) has described the practical consequences of the Supreme Court’s decision in *Cheshire West* in England and Wales (*Deprivation of Liberty in the Shadows of the Institution* (Bristol University Press, 2022), p 186) as follows:

“The volume of applications to authorize deprivation of liberty after *Cheshire West* overwhelmed the systems’ administrative and judicial safeguards. The DOLS were designed to process relatively few applications; the Department of Health (2007) had estimated 21,000 in the first year, falling to 5,000 annually. In fact, applications started around 7,000 annually but rose slowly, reaching 14,346 in 2013–14 (Health and Social Care Information Centre, 2014; Care and Social Services Inspectorate Wales and Health Inspectorate Wales, 2015).

After the Supreme Court’s ruling, this increased tenfold to 148,221 (Health and Social Care Information Centre, 2015b; Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales, 2016) and continued to rise, reaching 255,836 applications in 2018–19 (NHS Digital, 2019b; Care Inspectorate Wales and Healthcare Inspectorate Wales, 2020). Factoring in deprivation of liberty outside the DOLS scheme, the government estimated a new scheme might need to process 304,132 applications annually (Department of Health and Social Care, 2019a). To put this in perspective, the annual number of detentions under the [Mental Health Act 1983 for England and Wales] is estimated to be around 50,000 (NHS Digital, 2019c).”

(The equivalent figures in Northern Ireland are 4,116 under the Northern Ireland DOLS scheme and 998 under the Mental Health Order 1986 in 2023–2024. There are no comparable figures for Scotland, as there is no equivalent to the DOLS scheme in Scotland.)

100. These implications became apparent soon after the decision. As Baroness Hale observed extra-judicially (in *Psychiatry and the Law: An enduring interest for Lord Rodger* (October 2014)) the judgment had had “alarming practical consequences. It means that a great many elderly and mentally disabled people, wherever they are living, must have the benefit of safeguards and reviews, to ensure that their living arrangements are indeed in their best interests.”

101. More recent statistics continue to support that conclusion. In the year before this court’s judgment in *Cheshire West*, 13,700 referrals were made for a DOLS authorisation. By contrast, in 2023/24, there were 332,455 referrals for a DOLS authorisation in England, and by then there was a backlog of 123,790 cases. A further 19,337 applications were made for a DOLS authorisation in Wales over the same period. (See *Mental Capacity Act 2005, Deprivation of Liberty Safeguards, 2023–24; Official Statistics* (August 2024) and *Deprivation of Liberty Safeguards Annual Monitoring Report for Health and Social Care 2023–2024* (2024), issued by Care Inspectorate Wales). These figures do not capture the large numbers of people who are deprived of liberty in settings not covered by the DOLS scheme, including supported living, shared lives and private and domestic settings. The Secretary of State submitted that a best estimate is that there are around 60,000 cases of deprivation of liberty in these other settings, according to the criteria laid down by the majority judgments in *Cheshire West*. If *Cheshire West* is correct, then backlogs in the processing of DOLS authorisations and applications for court orders mean that hundreds of thousands of people are being deprived of their liberty unlawfully. (b) Practical consequences

102. The assessments required of an individual for the purposes of the DOLS scheme, which often have to be repeated periodically, can be both intrusive and distressing for them and their families. Where the individual is deprived of their liberty, the assessment process must comply with article 5 and is plainly warranted. However, in a case where the affected individual is being cared for at home or in a care home in accordance with their expressed wishes and feelings, these assessments will not generally have any therapeutic or other intrinsic benefit for the person. They may well require disclosure of sensitive personal data such as diagnoses, medication, descriptions of behaviour that is considered challenging, risks posed, and family relationships. Disclosure of this information will be required if confinement, even though in line with the individual's own wishes and feelings, is held to be a deprivation of liberty. For the purposes of article 5 compliance, such data must be shared (without the consent of the individual or family members) with the relevant panel authorising the deprivation of liberty for the individual concerned and with staff associated with the authorisation and judicial scrutiny process. This too can be distressing.

103. If the submissions of the Attorney and the Secretary of State are correct, it also follows that limited public funds and staff resources, including those needed to carry out the clinical assessment by medical practitioners as required by article 5, are being expended on authorising situations which do not, in fact, amount to a deprivation of liberty for the purposes of article 5. This inevitably diverts scarce resources away from carrying out assessments for individuals who clearly are subject to measures which amount to a deprivation of liberty and who need to have their cases dealt with promptly so that the measures imposed on them can be reviewed and perhaps improved.

(c) Consultation and reform proposals

104. In England and Wales, the issue of mental capacity and deprivation of liberty was referred to the Law Commission (though, in light of the then recent decision in *Cheshire West*, it was not asked to examine the meaning of the term “deprivation of liberty”). It produced a final report in March 2017 entitled *Mental Capacity and Deprivation of Liberty* (Law Com No 372). The Law Commission commented on the widespread reports of backlogs, breaches of statutory timescales and increased workloads in this area:

“2.23 The official figures also show an increasing number of DOLS referrals being left unassessed and statutory time-scales being routinely breached; in England, only 43% of the 195,840 DOLS cases referred to local authorities for [assessment] during 2015–16 were completed during the year, and of those only 29% were completed within the 21-day time limit set in regulations.

2.24 Our impact assessment estimates that the cost of full compliance with the DOLS regime following *Cheshire West* would be £2.2 billion per year – approximately two per cent of the entire budget of NHS England.”

105. Indeed, the Law Commission reported that, following *Cheshire West*, it was common for the supervisory body to have failed to arrange the requisite assessments for a standard authorisation within the maximum 14-day period even for urgent authorisations.

106. The strain on resources was such that it was necessary to prioritise certain cases over others, for example giving lower priority to “end of life care and intensive care situations which may meet the acid test but where the safeguards will bring no benefit to the person from the safeguards.” The Law Commission reported that, “in many cases, this meant that the assessment process had not even started before the person had died, been discharged, or moved out of the place in which they were deprived of liberty” (paras 4.18 and 4.19). This was of obvious concern because deprivation of liberty without lawful authority violates article 5, thus leaving the individual potentially unlawfully deprived of liberty and those responsible for care and treatment at risk of violating the applicable regulatory standards and breaking the law.

107. Parliament’s Joint Committee on Human Rights (“JCHR”) considered the Law Commission’s recommendations in a report entitled *The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards*, 2018 HC 890, HL Paper 161 (“the JCHR Report”). The JCHR received submissions from stakeholders and specialists in the area, including two High Court judges of the Family Division (one of whom was retired) who were critical of the decision in *Cheshire West* and suggested that it should be revisited, from family members of those now found to be deprived of liberty despite their living arrangements reflecting their wishes and feelings and from academics.

108. The JCHR Report acknowledged Baroness Hale’s “strong policy reasons for adopting a wide definition of deprivation of liberty, based on the vulnerability of the cohort of people who lack mental capacity and the need to ensure decisions are made in their best interests”, but considered nevertheless that “this judgment has led to an unsustainable situation and has captured many people within the definition who may object to being categorised as deprived of their liberty” (para 35). It referred to this cohort as including many people whose lives are enriched by the care and treatment provided to them, who are happy and fulfilled in the place where they live, and do not object to the restrictions that may be in place (paras 35, 38–39 and 41).

109. In that sense, *Cheshire West* has been described as creating the “paradoxical outcome” that a person who is positively happy with their living arrangements, and has no desire to leave them, has ended up in a situation where they are characterised as being deprived of liberty by the state (see *Deprivation of Liberty in the Shadows of the Institution* by Dr Lucy Series, cited above, p 30). They face significant state intrusion into their lives and those of their families, through the perceived need for mental capacity assessments and deprivation of liberty review processes to authorise their deprivation of liberty. This can lead to distress, the waste of precious time and unnecessary expense for all involved. As the JCHR Report states at para 41:

“This has led to some families feeling distressed that their loved ones are considered deprived of their liberty as a result of their care plans, as well as leading to substantial resourcing issues. This approach also sits at odds with the UNCRPD [the United Nations Convention on the Rights of Persons with Disabilities], which emphasises respecting the autonomy and wishes of those with disabilities.”

110. Against this background, the JCHR Report emphasised the importance of resources being directed as far as possible to the delivery of care rather than to legal and bureaucratic processes.

111. It considered that an alternative approach to re-visiting the interpretation of “confinement” would be to reconsider the meaning of valid consent (as part of the subjective element of the test for deprivation of liberty). As it explained,

“‘valid consent’ could be construed more widely than the current position, which would recognise that there are ways in which an individual, whilst lacking mental capacity, may nevertheless be capable of expressing consent to specific care or treatment arrangements.” (para 44)

112. The JCHR Report recommended that Parliament should set out a statutory definition of deprivation of liberty which clarifies the application of the acid test by extending “safeguards only to those who truly need them, whilst respecting the right to personal autonomy of those who are clearly content with their situation, even if they are not capable of verbalising such consent” (see paras 1, 35 and 45). It considered that it was possible to do so in a Convention-compliant way.

113. Some attempt was then made to introduce a new statutory definition, but this failed because of concern about inconsistency with *Cheshire West*: see Notices of Amendments, 9 January 2019. The Law Commission’s recommendations for reform were adopted in the Mental Capacity (Amendment) Act 2019 (“the 2019 Act”) which inserted a new schedule AA1 into the MCA 2005, introducing a

new streamlined procedure for authorising deprivation of liberty: “the Liberty Protection Safeguards”. However, the Liberty Protection Safeguards have not yet been brought into force in England and Wales and are currently the subject of review.

(d) *Courts narrowing the application of the acid test*

114. It is also significant that since *Cheshire West*, the courts have sought to distinguish it to avoid or narrow the effect of the acid test. For example, in *R (Ferreira) v Inner South London Senior Coroner* [2017] EWCA Civ 31; [2018] QB 487 (“*Ferreira*”), the Court of Appeal held that *Cheshire West* is not a test of universal application in the context of those with impaired decision-making capacity. The case concerned an individual, M, with severe mental-health impairment who was admitted to hospital suffering from breathing difficulties which required intubation and sedation. Subsequently, she suffered a heart attack and died in the intensive care unit of the hospital. The court held that it was not bound by *Cheshire West* to apply the acid test to determine whether there had been state detention requiring an inquest (which was not exactly the same concept as deprivation of liberty) in her case. Applying Strasbourg jurisprudence, it held that the administration of life-saving treatment which interfered with an individual’s liberty of movement would not amount to a deprivation of liberty within the meaning of article 5, provided that their condition was not the result of action wrongly inflicted by the state and the treatment could properly be given to an individual of sound mind in that condition. M was physically restricted in her movements by her physical infirmities and by the treatment she received (which included sedation), but the cause of any loss of liberty was not any restrictions imposed by the hospital amounting to detention but rather her own physical condition.

115. Arden LJ
further observed (paras 98–99):

“98 ... the two-part acid test formulated by Baroness Hale DPSC in *Cheshire West* in my judgment was designed to apply only where the second element—lack of freedom to leave— was the consequence of state action, particularly state action consisting of the continuous supervision and control constituting the first element of the test.

99. In the case of a patient in intensive care, the true cause of their not being free to leave is their underlying illness, which was the reason why they were taken into intensive care. The person may have been rendered unresponsive by reason of treatment they have received, such as sedation, but, while that treatment is an immediate cause, it is not the real cause. The real cause is their illness, a matter for which (in the absence of special circumstances) the state is not responsible. It is quite different in the case of living arrangements for a person of unsound mind. If she is prevented from leaving her placement it is because of steps taken to prevent her because of her mental disorder. *Cheshire West* is a long way from this case on its facts and that, in my judgment, indicates that it is distinguishable from the situation of a patient in intensive care.”

116. Although Arden
LJ’s attempt to distinguish *Cheshire West* in a case like that is understandable, the suggestion that the element of state control provides a suitable point of differentiation is not persuasive. Albeit the Strasbourg jurisprudence on article 5 makes it clear that a state party to the Convention is only responsible for a deprivation of liberty if there is a relevant element of state responsibility in relation to the situation, in the care context it is relatively easy to identify factors giving rise to such responsibility, including where public officials are on notice that an individual is subject to a deprivation of liberty at the hands of a private party: see *Re A* [2010] EWHC 978 (Fam); [2010] 2 FLR 1363, paras 95–96 (Munby LJ). In this

court it is appropriate to engage in a more fundamental and principled examination of the criteria for a deprivation of liberty under article 5. Similar comments apply in relation to the observations by King LJ in *In Re Briggs (Incapacitated Person)* [2017] EWCA Civ 1169; [2018] Fam 63, para 105, to the effect that, in light of *Ferreira*, a patient kept in hospital and “being cared for in a minimally conscious state” is not subjected to a deprivation of liberty. In our view, King LJ’s conclusion is correct, but it turns on the fundamental question about how a case involving an unconscious individual should be analysed: see paras 142–145 below.

117. We note that there have also been first instance decisions in England and Wales in which judges have sought to limit the application of *Cheshire West* by redefining the objective element. These include three decisions of Mostyn J (*Rochdale Metropolitan Borough Council v KW* [2014] EWCOP 45; [2015] 2 FCR 244; *Bournemouth Borough Council v PS* [2015] EWCOP 39; (2015) 18 CCL Rep 486; *A Hospital Trust v CD* [2015] EWCOP 74; (2015) 149 BMLR 137); a decision of Bodey J (*W City Council v L* [2015] EWCOP 20; (2015) 18 CCL Rep 350); and a decision of Lieven J in *Re SM (Deprivation of Liberty; Severely Disabled Child)* [2024] EWHC 493 (Fam); [2024] 2 FLR 896 (“*SM*”). Such efforts by experienced judges to distinguish a major decision of this court provide evidence that the decision has not provided appropriate guidance and is impeding the proper development of the law.

8. The Strasbourg jurisprudence on article 5

(a) Introduction and overview of the applicable principles

118. Article 5 of the Convention is entitled, “Right to liberty and security”. In proclaiming the “right to liberty”, article 5(1) “is contemplating individual liberty in its classic sense, that is to say the physical liberty of the person. Its aim is to ensure that no one should be dispossessed of this liberty in an arbitrary fashion ... it does not concern mere restrictions upon liberty of movement”: *Engel*, para 58; *Guzzardi*, para 92; also see, among many authorities, *Stanev*, para 115; *Creanga v Romania* (2013) 56 EHRR 11, GC (“*Creanga*”), para 92; *De Tommaso v Italy* (2017) 65 EHRR 19, GC (“*De Tommaso*”), para 80; *Ilias and Ahmed v Hungary* (2020) 71 EHRR 6, GC (“*Ilias and Ahmed*”), para 211. The starting point in assessing whether someone has been deprived of their liberty within the meaning of article 5(1) is their “concrete situation”—sometimes referred to as their “specific situation” or “specific situation in reality” (as in *De Tommaso*, para 80, and *Ilias and Ahmed*, para 212, respectively)—and “account should be taken of a whole range of factors such as the nature, duration, effects and manner of execution of the penalty or measure in question”: *Engel*, para 59; *Guzzardi*, para 92; *Stanev*, para 115; *De Tommaso*, para 80; *Creanga*, para 91; *Ilias and Ahmed*, para 212. It is necessary to look beyond appearances “and concentrate on the realities of the situation”: *Creanga*, para 91.

119. The difference between deprivation and restriction of liberty is one of degree or intensity, and not one of nature or substance: *Guzzardi*, para 93; *Stanev*, para 115; *De Tommaso*, para 80; *Creanga*, para 91; *Ilias and Ahmed*, para 212. Where there are a number of restrictions involved in the treatment of an individual, it is necessary to consider them “cumulatively and in combination” to assess their overall effect on the individual: *Guzzardi*, para 95; *De Tommaso*, para 80. The context in which the measure is taken is an important factor in assessing how close the measure in question is to the paradigm of deprivation of liberty, which is confinement in a prison cell: *De Tommaso*, para 81. In *Guzzardi* the European court found, on balance, that there was a deprivation of liberty in relation to a preventive measure involving confinement of a mafioso on a tiny island, who was subject to strict and constant supervision, including an almost complete impossibility for him to make social contacts. But in cases involving other forms of preventive orders including special supervision, night curfews and so on, it has held that there was no deprivation of liberty: *De Tommaso*, paras 84–89.

120. In *Storck*, para 74, the European court held that the notion of deprivation of liberty in article 5(1) contains (i) an objective element, involving confinement in a particular restricted space for a material period of time and (ii) an additional subjective element: “Individuals can only be considered

as being deprived of their liberty if, as an additional subjective element, they have not validly consented to the confinement in question”. This formula was repeated in *Stanev*, para 117.

121. Factors relevant to the objective element include the possibilities available to the individual to leave the restricted area, the degree of supervision and control over their movements, the extent of isolation and the availability of social contacts: *Guzzardi*, para 95; *HM v Switzerland* (2004) 38 EHRR 17, para 45; *HL*, para 91; *De Tommaso*, para 88; *Storck*, para 73.

122. As regards the subjective element, the European court has observed that the right to liberty is too important in a democratic society for an individual “to lose the benefit of Convention protection for the single reason that he may have given himself up to be taken into detention”, especially when he is “legally incapable of consenting to, or disagreeing with, the proposed action”: *Stanev*, para 119, referring to *De Wilde v Belgium (No 1)* (1979–80) 1 EHRR 373, paras 64–65; *HL*, para 90; and *Storck*, para 75.

123. On the other hand, the fact that an individual lacks legal capacity does not necessarily mean that they are unable to understand and consent to their situation in a manner that prevents it from becoming a deprivation of liberty: see, in particular, *Shtukurov v Russia* (2012) 54 EHRR 27 (“*Shtukurov*”), para 108, and further authorities discussed below. The degree of understanding an individual in fact has regarding their circumstances, even though they lack legal capacity, is an important part of their concrete situation.

124. In *HM v Switzerland*, the European court found that there was no deprivation of liberty where the applicant, who suffered from mental health problems and lacked legal capacity, was placed in a secure nursing home, where she said that she had no reason to be unhappy, and, after her arrival there, agreed to stay (see para 150 below). This analysis was endorsed in *Stanev*, para 131.

125. This is to be contrasted with the situation in *Stanev* itself. The applicant, who suffered from mental impairment and lacked legal capacity, was placed in a secure care home with the consent of his guardian. Despite his mental impairment, “he was well aware of his situation” (para 130). He made it clear in various ways, such as by failing to return from leave of absence, by expressing to psychiatrists his desire to leave the care home and by making applications to have his legal capacity restored, that he objected to being kept at the home (*ibid*). In light of the objective conditions in which he was kept at the home and his “lack of consent”, the court found that there was a deprivation of liberty: para 132.

126. The form of consent which is relevant to the subjective element of an assessment whether a deprivation of liberty under article 5(1) has occurred, as discussed in *HM v Switzerland* and *Stanev*, is different from that which is relevant in applying the distinct substantive doctrine that an individual with knowledge of their rights under the Convention (including their rights under article 5) is capable of waiving those rights by consenting to the treatment in question. The consent required for a waiver of rights has to be free and fully informed: see, eg, *Natsvlishvili v Georgia* (2014) 37 BHRC 593, paras 90–97. Also, application of the doctrine of waiver would ordinarily require the individual concerned to have legal capacity to make that decision.

127. The European court acknowledges that the process of distinguishing between a deprivation of liberty and a mere restriction on liberty of movement can sometimes be “no easy task”, particularly in borderline or marginal cases: *Guzzardi*, para 93; *Stanev*, para 115; *Ilias and Ahmed*, para 211 (a case concerned with measures confining asylum seekers in a transit zone located on the national border between Hungary and Serbia while relevant checks were carried out, which were held not to constitute a deprivation of liberty). In *Ilias and Ahmed* the European court said that “its approach should be practical and realistic, having regard to the present-day conditions and challenges” and should take account of states’ rights to control their borders: para 213. In our view, the same practical and realistic approach is required in the present context, and the assessment should take account of the rights of the individuals affected to have their own views respected and recognised so far as possible, as we explain below.

128. In *Creanga*, in which a deprivation of liberty was found in relation to an individual questioned at a police station but not subject to formal arrest, the European court explained that, in relation to individuals attending police stations, “the purpose of measures by the authorities depriving applicants of their liberty no longer appears decisive for the Court’s assessment of whether there has in fact been a deprivation of liberty” (para 93). The court explained that this reflected an evolution in the caselaw in this context. In one of the previous cases referred to, and not followed, the Commission had attached decisive weight to the fact that an applicant had never intended to leave the courtroom where he was taking part in a hearing (*EG v Austria* (Application No 22715/93) (unreported), decision of 15 May 1996). Although the context in which the Revised Code will operate is materially different, it is not a sufficient answer to the claim that it encourages the imposition of measures amounting to deprivation of liberty within the meaning of article 5 to say that detention of individuals in care settings is for their own good (eg to prevent them from leaving a care home for their own safety), nor that they may initially have accepted the confinement: see also *Stanev*, para 119 (there is no loss of Convention protection under article 5 “for the single reason that [the applicant] may have given himself up to be taken into detention”); *Ilias and Ahmed*, para 221; and *Storck*, para 75. Even measures intended for the protection of or taken in the interest of the person concerned may be capable of being regarded as a deprivation of liberty: *Khlaifia v Italy* (Application No 16483/12) (unreported), judgment of 15 December 2016, GC, para 71. Thus, for example, it is accepted that enforced admission of an individual to hospital under the Mental Health Act 1983 for the purposes of in-hospital medical assessment can constitute a deprivation of liberty: *MH v United Kingdom* (2014) 58 EHRR 35; see also *M v Ukraine* [2013] MHLR 255, para 54 (where compulsory hospitalisation for treatment in a mental health facility amounted to deprivation of liberty within article 5).

129. However, in situations which are different and far removed from the sort of case in contemplation in *Creanga*, para 93 (in which the analogy to the paradigm of detention in a prison cell is close), the fact that the individual has chosen or has willingly accepted the measures in question is a relevant factor to be taken into account in determining whether they constitute a deprivation of liberty: see *Ilias and Ahmed*, paras 220–223, discussed at paras 133–137 below.

130. The general jurisprudence of the European court makes it clear that the statement in *Creanga*, para 93, has to be read with reference to the particular context described in that paragraph (presence at a police station for questioning) and that in other, more marginal situations, the purpose for which a measure has been taken is a factor to be taken into account. When assessing whether there is a deprivation of liberty, the required focus on the “concrete situation” of the individual and “the realities of the situation”, taking account of the type of measure in question, means that it is in fact relevant to have regard to the purpose of the measure, even though this is not decisive by itself: see, eg, *Munjaz v United Kingdom* [2012] MHLR 351 (“*Munjaz*”). In *Munjaz*, having regard to the general guidance referred to above, periods of preventive seclusion for safety reasons of a patient detained at the secure psychiatric hospital at Ashworth were held not to amount to a deprivation of liberty. The purpose of the seclusion measure was treated as a significant factor: para 70 (“it is clear that seclusion, though coercive, was not imposed on the applicant as a punishment ... the aim of seclusion at the hospital is to contain severely disturbed behaviour which is likely to cause harm to others”). Indeed, it is difficult to see how, in more marginal or borderline cases, the purpose of the measure could fail to be a potentially relevant factor, albeit not decisive in itself. If a restrictive measure is imposed with the aim of punishment or coercion against someone’s will, it will more closely approximate to the paradigm of imprisonment in a prison cell. Conversely, if it is imposed for different (eg protective) reasons, the further it may be from that paradigm.

131. Thus, in *Austin*, in which a police measure to “kettle” protesters in what had become a violent demonstration was held not to amount to a deprivation of liberty, the European court had regard to the purpose of the measure, to protect the public, when making its assessment. At para 58, the court noted the general point that “an underlying public interest motive, for example to protect the community against a perceived threat emanating from an individual, has no bearing on the question whether that person has been deprived of his liberty”, although it might be relevant to justification under one of the subparagraphs of article 5(1), and said “[t]he same is true where the object is to protect, treat or care

in some way for the person taken into confinement, unless that person has validly consented to what would otherwise be a deprivation of liberty”. But this has to be read in context as meaning that an underlying public interest motive is not of itself a sufficient answer, because the court went on to say (para 59) that the requirement to take account of the “type” and “manner of implementation” of the measure “enables it to have regard to the specific context and circumstances surrounding types of restriction other than the paradigm of confinement in a cell”; and this led it to say that the restrictions on movement involved in the “kettling” measure in the case, “so long as they are rendered unavoidable as a result of circumstances beyond the control of the authorities and are necessary to avert a real risk of serious injury or damage, and are kept to the minimum required for that purpose”, did not constitute a deprivation of liberty. The specific context in which the kettling technique was deployed had to be taken into account, as well as “the responsibilities of the police to fulfil their duties of maintaining order and protecting the public”: para 60. The purpose of the measure was, therefore, a significant factor in leading to the court’s conclusion that there was no deprivation of liberty: “the measure was imposed to isolate and contain a large crowd, in volatile and dangerous conditions” and the police acted “to avert a real risk of serious injury or damage”: para 66. The police kept the position under review, which meant that the continuation of the measure was throughout directed to that purpose: para 67.

132. Similarly, there is no deprivation of liberty for the purposes of article 5(1) where a passenger is stopped by border officials when entering a country at an airport in order to check their status, provided the element of restriction of movement has not exceeded the time strictly necessary to comply with the relevant formalities normally associated with airport travel: *Gahramanov v Azerbaijan* (Application No 26291/06) (unreported), decision of 15 October 2013, para 41; *OM and DS v Ukraine* (Application No 18603/12) (unreported), judgment of 15 September 2022, paras 113–120; cf *Kasparov v Russia* (2018) 66 EHRR 21, where a deprivation of liberty was found when the restrictive measures at the border went far beyond the time strictly necessary for such formalities.

133. In *Ilias and Ahmed* the European court summarised the effect of these cases as follows (para 217):

“In determining the distinction between a restriction on liberty of movement and deprivation of liberty in the context of confinement of foreigners in airport transit zones and reception centres for the identification and registration of migrants, the factors taken into consideration by the Court may be summarised as follows: (i) the applicants’ individual situation and their choices, (ii) the applicable legal regime of the respective country and its purpose, (iii) the relevant duration, especially in the light of the purpose and the procedural protection enjoyed by applicants pending the events, and (iv) the nature and degree of the actual restrictions imposed on or experienced by the applicants.”

(This guidance has been reiterated in other authorities, including *ZA v Russia* (2020) 70 EHRR 24, GC, para 138, and *RR v Hungary* (Application No 36037/17) (unreported), judgment of 2 March 2021, para 74.)

134. Accordingly, in the marginal cases which arise in that area, to determine whether such confinement amounts to a deprivation of liberty or a restriction on liberty of movement, it is again the case that relevant factors include the purpose of the application of the measures in question (that is, in that context, the purpose of the legal regime which is applied to the applicants and whether the duration of confinement corresponds to that purpose). The European court in *Ilias and Ahmed* considered that such factors were relevant, *mutatis mutandis*, in the somewhat different case before it (confinement at a national border for asylum checks): para 218. This indicates that they are capable of providing guidance in other marginal situations as well. The European court reviewed the duration of the restrictions to ensure that it corresponded with the implementation of the public policy purpose for which they were imposed: para 233. It held that, albeit involving a significant restriction on the

freedom of movement of the asylum seeker applicants, the restrictions did not limit their physical liberty unnecessarily or to an extent or in a manner unconnected to the examination of their asylum claims so that there was no deprivation of liberty in the circumstances of that case.

135. Where an individual lacks full mental awareness (in a factual sense) in relation to their circumstances, so that they cannot be regarded as someone with full ability to decide how they wish to be treated for all purposes, they may nonetheless be sufficiently aware of the circumstances in which they are maintained in confinement as to be able to register whether they are happy or unhappy with those circumstances and to enter protests against their treatment if they are unhappy with them. As the authorities discussed below make clear, for such individuals this is the dividing line between cases in which they consent to their confinement and those in which they do not, for the purposes of an assessment of whether there is a deprivation of liberty under article 5. It is an important line in Convention terms, since choices made by individuals with impaired understanding should be respected where possible, as an aspect of respecting their dignity as human beings. Whether someone experiences the situation in which they are being kept and cared for as amounting to detention contrary to their wishes or as constituting a broadly supportive home environment where they are content to live their life is a basic aspect of human experience, and there is accordingly no good reason to disregard or discount the individual's own evaluation of their position. They may have impaired understanding of many things and may lack capacity in a full legal sense, but they may nevertheless have a fundamental understanding of whether they are broadly happy or unhappy about something so basic, and their understanding of and choices regarding that should be accorded respect.

136. This approach also accords with the guidance provided by the European court's jurisprudence in the marginal cases concerned with confinement when crossing national borders, referred to above. The assessment whether such confinement constitutes a deprivation of liberty takes into account:

- (i) Other relevant rights in play in the context in question: *Ilias and Ahmed*, para 213, referring to the rights of state parties (para 127 above). In our view, this is a still more significant factor when it is the rights of the individual him- or herself which should be taken into account.
- (ii) The applicant's "individual situation and their choices": *ibid*, para 217 (para 133 above). In our view, this is a still more significant factor when it is the individual's own choices about such fundamental matters as where and how they should live, as expressed or indicated by them, which are in issue.
- (iii) The duration of the measure, in light of its purpose and the procedural protections enjoyed by the individual: *ibid*. In our view, in the present context, whilst the duration of the measures in question will often be long, it is significant that they are specifically taken in the individual's own interests, to care for them and to keep them well and safe (consistently with safeguarding others against harm they might cause, if that is an issue), which again is a factor of greater weight than was the position in *Ilias and Ahmed* and such border-control cases. Also, it is important to recognise that individuals in care enjoy a range of personal protections under the regimes applicable to them, including rights to independent external reviews and audits by qualified professionals (see para 10 above) and to express their own views and preferences and have them taken into account. This helps ensure that the measure is applied only for as long as necessary.
- (iv) The nature and degree of the actual restrictions imposed on or experienced by the individual: *ibid*. In many cases of those in care, the restrictions imposed may be fairly limited (eg locking the doors of a care home to stop individuals who are not capable of looking after themselves from wandering into the streets), may allow for social contacts to be maintained, and in all cases are required to be in line with the purpose referred to in subpara (iii) above. Where restrictions become progressively more intrusive, it will be relevant to consider whether they are imposed in response to an increase in the need in a particular case to protect

the individual and/or the interests of others. As *Ilias and Ahmed*, para 217, makes clear, the subjective experience of the individual affected is relevant. If they do not experience a restriction as a major intrusion in their life, that tends to indicate a classification as a restriction on liberty of movement rather than as a deprivation of liberty.

137. In relation to factor (ii) above, in its assessment in the particular circumstances in *Ilias and Ahmed* the European court treated the choice of the applicants to enter the territory of Hungary, as an expression of their own free will, as a significant factor to be taken into account: paras 220–223. At para 221, the court distinguished the specific type of situation addressed in *Creanga*, para 93 (para 128 above), where it had said that detention might involve a deprivation of liberty even though the individual agreed to it, on the ground that this concerned “situations where the law provided for deprivation of liberty or situations where the applicants had complied with an obligation, such as, among others, to enter a prison or a police station or submit to house arrest” and the situation in *Ilias and Ahmed* where the starting point for analysis was “entirely different”. In our view, the concrete or specific situation of individuals in care is also very different from the type of case referred to in *Creanga*, so the starting point for analysis of whether there is a deprivation of liberty is also very different.

138. In *Fernandes de Oliveira v Portugal* (2019) 69 EHRR 8 (“*Oliveira*”), GC, a case concerning the obligations of a secure mental health hospital arising under article 2 of the Convention (right to life) to take protective measures in relation to a patient with suicidal tendencies, the European court affirmed that “the very essence of the Convention is respect for human dignity and human freedom”: para 112. It referred in that regard to, in particular, the Convention rights in article 3 (prohibition of inhuman or degrading treatment), article 5 and article 8 (right to respect for private life). This meant that the hospital authorities had to discharge their duties “in a manner compatible with the rights and freedoms of the individual concerned and in such a way as to diminish the opportunities for self-harm, without infringing personal autonomy”: *ibid*. The judgment in *Oliveira* was reviewed in detail by this court in *R (Maguire) v Blackpool and Fylde Senior Coroner* [2023] UKSC 20; [2025] AC 63, paras 52–59. At para 59 its effect was summarised as follows: “A theme which emerges in the *Oliveira* judgment is that in assessing the application of the [hospital authorities’ duties under article 2 in relation to a vulnerable person] it is relevant to take into account the wider interests of the vulnerable person who is said to be at risk, in terms of promoting their autonomy, integration into society and relationships of trust with those caring for them: paras 112–113, 121–122, 125 and 130–132”. This approach underlines the importance of according respect to the views of vulnerable individuals about how they should be treated when analysing the application of article 5, as set out above.

139. The basic and fundamental nature of the issue of whether someone is happy or unhappy about their care and living arrangements means that it is precisely the sort of matter about which the individual concerned is likely to have views which are meaningful, and which should be sought and should carry weight, even if the individual is mentally incapacitated in other respects. We do not consider that there is any sound reason to discount their expressions of view in that regard when assessing whether there is a deprivation of liberty under article 5, particularly when it is borne in mind that negative consequences for them may follow from such an assessment. In *Stanev*, at para 153, in the context of assessing whether a deprivation of liberty could be justified under one of the subparagraphs of article 5(1), the European court stated that “the objective need for accommodation and social assistance must not automatically lead to the imposition of measures involving deprivation of liberty. The Court considers that any protective measures should reflect as far as possible the wishes of persons capable of expressing their will”. In our view, that approach accords with what was said in *Oliveira* and has general application, so that it is relevant to the assessment of whether there is a deprivation of liberty in the first place. The subjective element in that assessment, as set out in *Storck*, para 74, and *Stanev*, para 117 (para 120 above), should give effect to this principle of respect.

140. There will be many cases where it is implausible to conclude that someone with impaired understanding cannot subjectively appreciate to a sufficient degree whether they are happy or unhappy about such a basic feature of their life as the circumstances in which they are living. It will

also have the consequence that they will have to be subjected to periodic assessments by psychiatrists and other care professionals to determine whether those professionals, rather than the individual concerned, think that what they themselves might regard as their home is the right place for them to be. This process of assessment is likely to be intrusive and potentially upsetting for the individual, constituting an interference with their right to respect for their private life and (in some cases) for their right to respect for their family life or their home within the meaning of article 8(1): see, eg, K Reid et al, *A Practitioner's Guide to the European Convention on Human Rights*, 7th ed (2023), para 46–009 (“Forcible examination for psychiatric purposes constitutes an interference with private life within the scope of article 8”, even though it is done in order to protect the individual’s own health). It is also liable to leave the individual feeling disempowered and possibly disrespected by those around them, which may disrupt the stability and supportive nature of the relationship their carers have with them, thereby undermining rather than enhancing their quality of life. Of course, sometimes such professional assessments may need to take place in order to protect an individual’s rights under article 8 and other provisions of the Convention, including articles 2 and 3; but that is not a reason to jump to the conclusion that other aspects of their rights under article 8 (regarding minimisation of interference by state officials and others and according respect to their own choices and preferences) have no bearing on the application of other Convention rights, including in assessing whether they are subject to a deprivation of liberty under article 5.

141. At this point in the analysis, another important feature of the context deserves emphasis. The due protection of an individual’s interests does not require that an extended interpretation be given to the concept of deprivation of liberty under article 5, contrary to the opinion of Baroness Hale in *Cheshire West* at para 57. She said that there was a policy reason to adopt an extensive view of deprivation of liberty under article 5 because, having regard to the extreme vulnerability of people like P, MIG and MEG, it was necessary to “err on the side of caution” in deciding what constitutes a deprivation of liberty in cases like theirs, since “[t]hey need a periodic independent check on whether the arrangements made for them are in their best interests”. But an individual in care has other relevant Convention rights, including most prominently those under articles 2, 3 and 8, which mean that they cannot be left unprotected and without appropriate review of their interests on a continuing basis. In our view, in light of these other protections, the policy reason given by Baroness Hale is overstated. Their interests and rights under those provisions may be capable of being protected effectively in less intrusive ways than under article 5. In any event, that policy reason does not justify the approach Baroness Hale adopted to the assessment of whether a deprivation of liberty exists.

142. We should also mention two particular kinds of case which are relevant to this discussion. First, at the extreme end of the spectrum of people in care, an individual may be catatonic, eg due to severe dementia or in the aftermath of suffering a stroke or traumatic head injury, and unable to express any view at all about what should happen to them, whether verbally or by physical manifestations of contentment or discontent. Where an individual is in such a state, they do not have control over their body such as would give the concept of deprivation of liberty under article 5(1), which refers to “the physical liberty of the person”, any sensible meaning in their case. Their “concrete” or “specific” situation is such that, by virtue of their physical condition, they do not have any possibility of exercising physical control over their body, either by means of engaging their own motor skills or by being able to request others to help them to move. Hence, they do not have any bodily, physical liberty to exercise, irrespective of the circumstances in which they are being cared for. Also, since there is no possibility of anyone contradicting their will in that regard, it cannot sensibly be said that anyone is subjecting them to treatment which constitutes a “deprivation” in relation to their physical or bodily liberty. For both reasons, the situation of such an individual is far removed from the paradigm of imprisonment in a prison cell. The concept of “deprivation of liberty” is inapt and inapplicable. In terms of the *Storck* criteria and the guidance in *Ilias and Ahmed*, para 217, there is no objective element of deprivation and also no subjective element of an appreciation of being subjected to a deprivation.

143. Second, what is the position where an individual is temporarily unconscious (or unable to form coherent thoughts) because of their physical condition as a result of injury or disease or because

they have been given drugs in the course of being provided with medical treatment? In our view, in such a case it is relevant to take into account the individual's potential to regain consciousness by recovering or if treatment is withdrawn, judged realistically, and to make an assessment in the light of that. It is clearly appropriate to say that an individual may continue to suffer a deprivation of liberty while they are asleep, eg someone serving a term of imprisonment or who has been compulsorily admitted to and detained in hospital under mental health legislation. Similarly, such an individual continues to suffer a deprivation of liberty while in custody even though they are temporarily unconscious through injury or illness or as a result of medical treatment administered to them.

144. In such cases an objective element of deprivation of liberty is present, in that when they regain consciousness they will be prevented from leaving. The requisite subjective element is also present, where the context is such that they clearly do not, or would not (when they regain consciousness), consent to the background circumstances of their confinement: see *HL*, discussed at paras 152–156 below, and *Storck*, paras 76–77, discussed at paras 157–158 below. The analogy with the paradigm of imprisonment in a prison cell is then clearly very close. In that regard, it would clearly be a relevant factor if an individual was medicated to put them in a state of unconsciousness, or near unconsciousness, for the purpose of keeping them compliant, in order to obviate the need to apply other forms of restraint to which they would be likely to object.

145. But the closeness of that analogy varies greatly with context and the concrete situation of the individual. The purpose of holding them in one place and (if necessary) preventing them leaving if they regain consciousness may be important in making the assessment whether there is a deprivation of liberty. In ordinary circumstances, an individual in hospital to receive treatment (and who, for their own protection, would be prevented from leaving while, say, confused and unable to think because of medication) would not be regarded as suffering a deprivation of liberty within the meaning of article 5. Ordinary expectations and the ordinary conduct of life play a significant role in the assessment whether there is a deprivation of liberty: see, eg, *Austin*, para 59 (referring to temporary restrictions on freedom of movement in certain contexts, such as travel by public transport and crowd control, the court said that it “does not consider that such commonly occurring restrictions on movement, so long as they are rendered unavoidable as a result of circumstances beyond the control of the authorities and are necessary to avert a real risk of serious injury or damage, and are kept to the minimum required for that purpose, can properly be described as ‘deprivations of liberty’ within the meaning of article 5(1)”). The presumption is that a person who is unconscious and kept in care to have medical treatment administered does not suffer a deprivation of liberty, unless there is evidence that they are in fact in detention or there is an established pattern of behaviour to show that they clearly do (or would) object to being cared for in this way.

146. Also, as the European court observed in *Firat v Turkey* (Application No 34010/06) (unreported), judgment of 10 September 2013, para 35, “[a]ccording to the Court’s established case-law, coercion is a crucial element in its examination of whether or not someone has been deprived of his or her liberty with the meaning of article 5(1)”. In light of *Creanga*, para 93, this perhaps overstates the position to a degree, but it serves as a reminder that the focus should be on the closeness of the situation to the paradigm case of detention in a prison cell. In the two kinds of case to which we have referred in paras 142–143 above, there is no element of coercion, since the individual’s will is not being overridden. By contrast, in *HL* there was an element of coercion, as we explain below. That is also true of the other cases where a deprivation of liberty has been found by the European court.

147. Although *Firat v Turkey* provides guidance which is of assistance in the present context, we should say that we did not find another authority relied upon by Mr McGleenan KC for the Attorney to be helpful: *Rooman v Belgium* [2020] MHLR 1, GC. In the context of a discussion about whether treatment of prisoners violated their rights under article 3 of the Convention, the European court observed (para 141) that a relevant factor is whether the purpose of the treatment in question is to humiliate or debase, but the absence of such a purpose does not conclusively rule out a violation of

article 3. Then it said (para 142) “Measures depriving persons of their liberty inevitably involve an element of suffering and humiliation”.

148. Mr McGleenan sought to turn this observation into a positive test for what treatment will count as a deprivation of liberty, and submitted that confinement for their own benefit of individuals who cannot look after themselves does not involve an element of suffering or humiliation. But in our view in para 143 the European court was simply amplifying the view it had expressed in para 142, to explain why the very fact of deprivation of liberty may be relevant to an assessment of whether there is a violation of article 3. It was not seeking to limit or qualify its existing caselaw on article 5. We agree that it might be difficult to say that some situations involving confinement of incapacitated individuals for their own protection involve suffering or humiliation, but that does not necessarily prevent them from constituting a deprivation of liberty within the meaning of article 5 according to the caselaw dealing with that provision.

(b) Review of the caselaw on deprivation of liberty in circumstances of mental impairment

149. The analysis above, based on Grand Chamber decisions, is supported by *Nielsen v Denmark* (1989) 11 EHRR 175 (“*Nielsen*”). In that case the applicant, a 12-year-old boy, was placed, at his mother’s request, in the secure psychiatric ward of a hospital for fiveand-a-half months. It was held that there was no deprivation of liberty under article 5. The European court emphasised (para 70) that he needed medical treatment and that the treatment administered was for a therapeutic (“curative”) purpose, and the period of time involved was consistent with this purpose. Further, the restrictions on his freedom of movement and contacts with the outside world “were not much different from restrictions which might be imposed on a child in an ordinary hospital: it is true that the door of the ward, like all children’s wards in the hospital, was locked, but this was to prevent the children exposing themselves to danger or running around and disturbing other patients”. The applicant was allowed to leave the ward with permission or under supervision for various activities and could visit his parents and friends; and “in general, conditions in the ward were said to be ‘as similar as possible to a real home’”. The intervention of the police when he ran away, “which would have been appropriate for the return of any runaway child of that age even to parental custody”, did not alter the characterisation of his situation.

150. *Nielsen* was cited with approval and followed in *HM v Switzerland*, paras 40–49. That case concerned an elderly woman subject to a guardianship arrangement, who was unable to care for herself. An order was made to place HM in a care home, despite an initial objection by her (para 17), in view of the need to provide her with care in her own interests because she was suffering from serious neglect (paras 44 and 46). She had freedom of movement and was able to maintain social contacts (para 45). After the placement took effect, the applicant broadly accepted it in that she did not clearly reject it (paras 21 and 46), and, subjectively, she “hardly felt the deprivation of liberty” or “the effects of her stay” in the home (paras 24 and 46). The European court held that there was no deprivation of liberty within the meaning of article 5(1), either in relation to the initial period of the placement or later, when the applicant agreed to stay at the care home.

151. The discussion above assists us to analyse the series of Strasbourg cases which were particularly relied upon by the parties to this reference. The principle which emerges from the authorities is as follows. An individual without legal capacity, but who is conscious of their environment and has a basic understanding of their living circumstances in a secure care environment, so that they can in some suitable way express their view about their situation, who manifests their acceptance of that situation, should have their opinion respected when an assessment is made whether they are suffering a deprivation of liberty under article 5. Their subjective attitude, as so expressed, carries significant, indeed usually decisive weight, according to the criteria set out in *Storck*. Conversely, if such a person manifests a view that they do not accept that situation, that opinion should also be respected and will usually lead to the conclusion (if the objective circumstances indicate that they are detained) that they are subject to a deprivation of liberty.

152. *HL* concerned an autistic adult who was unable to consent or object to medical treatment, who in July 1997 was confined in a secure psychiatric hospital after becoming agitated and engaging in violent behaviour and self-harm. The applicant “was compliant and never attempted, or expressed the wish, to leave” (para 90). Accordingly, at the commencement of his confinement it was unnecessary for him to be compulsorily detained under the Mental Health Act 1983. In fact, initially his compliance was secured by his being sedated: paras 11–12 and 46. He was also maintained in a tractable state while in hospital by regular sedation: para 46. He was kept in the hospital as an informal (or voluntary) patient, although it was recognised throughout that if necessary he would immediately be detained under the Act (and indeed he was so detained in October 1997 when it appeared that, by reason of a court decision in his case, he might otherwise have to be released): paras 12, 17, 46 and 91. In September 1997 the applicant, represented by a family member, launched proceedings for judicial review of the decision to admit him, for habeas corpus and claiming damages for false imprisonment and assault. He was eventually released back into the care of his usual carers in December 1997. In due course the House of Lords held that he had not been unlawfully detained but was lawfully admitted to the secure hospital as an informal patient on the basis of the common law doctrine of necessity.

153. The applicant made an application to the European court complaining that, among other things, his rights under article 5(1) had been violated. In the relevant part of its judgment the court found that he had suffered a deprivation of liberty. The judgment preceded *Storck* and did not follow precisely the same analytical framework as was laid down in that case. However, the court emphasised the objective features of the applicant’s case, which involved particularly strict measures of confinement and denial of access to the applicant’s carers in the period between July and October 1997, when the applicant was compulsorily detained (para 91).

154. This way of addressing the issue is significant: the court treated it as axiomatic that compulsory detention would constitute a deprivation of liberty (ie in line with the approach in *MH v United Kingdom*, para 128 above), and then it was a matter of evaluation (of his “specific situation” taking account of the “whole range of factors ... such as the type, duration, effects and manner of implementation”) whether the “informal” detention until October 1997 was more akin to compulsory detention or to voluntary detention. Since the power of compulsory detention was kept in mind by the authorities throughout as an option to be used immediately if *HL* ever showed signs of wanting to leave it is unsurprising that the court regarded compulsory detention as the relevant analogy, rather than voluntary acceptance of his situation: see also *M v Ukraine*, paras 71–74 (discussed at paras 168–169 below). In psychiatric practice an effort is usually made to persuade someone who needs intensive treatment to enter hospital voluntarily, in order to avoid stigmatisation and to foster good relations between them and those treating them with a view to improving therapeutic outcomes; but the debate with the individual to try to persuade them to do this typically occurs against a background, understood by both sides, that compulsory powers will be used immediately if needed. In *HL* this was part of the case presented by the applicant: para 86 (referring to “psychological detention” and “potential detention (perceived threat of restraint)”); also, his compliance was secured by his being sedated for much of the time.

155. Since that was the situation, it is again unsurprising that the court in *HL* should apply the formula that the right to liberty is too important “for a person to lose the benefit of Convention protection for the single reason that he may have given himself up to be taken into detention, especially when it is not disputed that that person is legally incapable of consenting to, or disagreeing with, the proposed action”: para 90 (and see para 122 above). The reference to “legally incapable” here is not to an absence of capacity in domestic law, which was not a concept on which the judgment focused, but to capacity as recognised for the purposes of application of the legal regime in the Convention, which essentially means the capability of the individual *de facto* to agree or object himself.

156. At para 93 of *HL*, the court also distinguished *HM v Switzerland* (on the basis of a combination of elements that (a) the applicant in that case had sufficiently expressed consent to her

treatment and (b) the regime had been entirely different, in that the care home had been an open institution which allowed freedom of movement and encouraged contacts with the outside world) and *Nielsen* (on the basis that the applicant had been a minor committed to an institution by his mother in the exercise of her parental rights, who could have removed him at any time in exercise of those rights: that is to say, her decision amounted to valid consent to his treatment). By contrast, the hospital in *HL* had to rely on state legal powers to justify the applicant's detention: *ibid*.

157. In *Storck* the European court held there was a deprivation of liberty where the applicant was held in the locked ward of a psychiatric clinic and forcibly medicated. She had neither expressly nor implicitly consented to her stay there: para 72. She attempted to escape but was fettered to prevent this, and on another occasion was returned to the clinic by the police; she was also not able to maintain regular social contacts with the outside world, and these features satisfied the objective element of deprivation of liberty: para 73. The "key factor" in the case was that the applicant had tried to flee on several occasions: para 76. Therefore, even if it was presumed that she had "capacity to consent", she had not agreed to her stay in the clinic: *ibid*. It appears from para 75 that the court was using this term in the sense of both legal and factual capacity to consent, since it referred to the fact that the applicant had attained majority at the time of her initial admission to the clinic and had not been placed under guardianship. Although she had initially presented herself to the clinic, accompanied by her father (who wished to have her detained there), that was not enough on its own to show that she consented to her treatment, because the right to liberty was too important and an individual should not lose the benefit of protection under article 5(1) "for the single reason that they may have given themselves up to be taken into detention" (para 75).

158. At para 76 of *Storck* the European court also said: "In the alternative, assuming that the applicant had no longer been capable of consenting following her treatment with strong medicaments, she could, in any event, not be considered as having validly agreed to her stay in the clinic". That is to say, she had sufficiently manifested her objection to her situation by attempting to flee, so her temporary inability to manifest objections after her treatment with drugs could not be regarded as significant: see para 145 above. This finding was confirmed (para 77) by reference to *HL*. The finding of a deprivation of liberty in *Storck* was a fortiori (para 77), because in *HL* there had been no attempt to leave the hospital. Also, in para 77 the court distinguished *HM v Switzerland*, because in that case the applicant, "who had been legally capable of expressing a view, had been undecided as to whether or not she wanted to stay in the [care] home", so that the conclusion could be drawn that she did not object. The court referred to the applicant's legal capability notwithstanding that she was subject to a guardianship arrangement. Accordingly, as in *HL* the reference is to legal capability in the sense of mental capability recognised under the Convention, which focuses on the individual's de facto ability to express their own view.

159. In *Shtukurov* the applicant had a history of mental illness, including schizophrenia, with periods of in-patient psychiatric treatment. His mother applied to the court for a guardian to be appointed, and this was done without notice to the applicant, with his mother assuming that role. On 2 November 2005 the applicant sought the assistance of a lawyer to lodge an application to have his legal capacity restored. However, on 4 November his mother, as guardian, had him confined in a psychiatric hospital, with the applicant claiming that this was against his will. The hospital treated his confinement as voluntary, since his mother had legal power to consent to it on his behalf. The applicant's lawyer made claims on his behalf to restore his legal capacity and have him released, even though he was refused access to his client. The lawyer made an application to the European court and sought an interim measure to have him released, which eventually happened. After that, the court proceeded to examine the merits of the applicant's case under a number of provisions of the Convention.

160. The court held that there had been a deprivation of liberty under article 5(1). The objective element of the test for deprivation of liberty was clearly made out (the applicant was confined for several months, not free to leave and his contacts with the outside world were seriously restricted). As regards the subjective element, the respondent government maintained that the applicant's detention

had been voluntary, because his legal guardian had consented to it, whereas the applicant “referred to his own perception of the situation” (para 107). The court recognised that the applicant lacked *de jure* capacity to decide for himself, but found that he was *de facto* able to understand his situation, as his own behaviour showed, and judged by reference to that he had not validly consented to his confinement and there had been a deprivation of liberty: paras 108–109.

161. In *Stanev*, the applicant was diagnosed with schizophrenia in 1975. In 2000 a social worker was appointed as his guardian, who arranged for him to live in a secure care home where he was subject to confinement and a range of restrictions. The European court referred (para 118) to examples of situations in which a deprivation of liberty had been found: *Shtukurov*, *Storck* and *HL*. It described the last case as one “where the applicant was an adult incapable of giving his consent to admission to a psychiatric institution which, nonetheless, he had never attempted to leave”. This simple description slightly obscures the reasoning in the case, but the court did not suggest in *Stanev* that it was seeking to re-analyse the reasoning in *HL*. As explained above (paras 152–156), there were particular reasons why the applicant in *HL* was regarded as incapable of giving his consent to his confinement. As appears from the reasoning in *Stanev* itself and from later cases which refer to it, discussed below, the court was not seeking to establish a principle that an individual who is in some way incapacitated and is confined in a care setting which they do not attempt to leave must always be regarded as being subjected to a deprivation of liberty within the meaning of article 5(1). The position is far more nuanced than that.

162. In *Stanev* the applicant was not consulted about being placed in the care home, “even though he could have expressed a valid opinion” (para 122). This was a reference to his factual ability to express a view, rather than to his having legal capacity to do so (his legal capacity had been removed because of the guardianship arrangement). The court also distinguished *Nielsen*, on the basis that it was a case where the mother had committed her son to a secure care institution, who was a minor “who was not capable of expressing a valid opinion”. The applicant in *Stanev* was under constant supervision and required the permission of the director of the care home to leave it; his stay was sufficiently lengthy for him to have felt the full adverse effects of the restrictions imposed, and the court found that the objective aspect of a deprivation of liberty was established: paras 124–129.

163. As regards the subjective aspect, the court observed (para 130) that “there are situations where the wishes of a person with impaired mental faculties may validly be replaced by those of another person acting in the context of a protective measure and that it is sometimes difficult to ascertain the true wishes or preferences of the person concerned. However ... the fact that a person lacks legal capacity does not necessarily mean that he is unable to comprehend his situation [citing *Shtukurov*, para 108]”. Mr Stanev was in fact well aware of his situation; he explicitly expressed his desire to leave the care home both to the psychiatrists treating him and by making a number of unsuccessful applications to vary the terms of his guardianship in order to secure his release from the home. Accordingly, at para 131, the court distinguished *HM v Switzerland* and concluded that the applicant had not consented to the placement, nor had he “accepted it tacitly”. The court therefore held that there was a deprivation of liberty for the purposes of article 5(1). The importance of the views expressed by the applicant was further emphasised at para 153 (see para 139 above).

164. Two comments should be made about the important judgment in *Stanev*. First, the Grand Chamber accepted that if an individual is in a condition where their wishes cannot be ascertained, in an appropriate case their views may “validly be replaced by” those of someone acting to protect their interests (see also the explanation of the *Nielsen* judgment given in *HL*, para 93; para 156 above). This indicates that, when assessing whether there is a deprivation of liberty under article 5, the mere fact that the individual concerned is incapable of expressing any view does not lead to the conclusion that the subjective element of a deprivation of liberty is made out. On the contrary, in an appropriate case it may lead to the conclusion that the subjective element is assessed by reference to the view of the person with authority to make decisions for the individual, in their best interests. The court’s analysis of the *Nielsen* judgment confirms this. Secondly, in analysing the subjective element, it is the

factual capacity of the individual to understand their situation sufficiently to express a view about it which is important, not their legal capacity.

165. Further cases in the line of relevant Strasbourg authority to which we were taken confirm this analysis. In *DD v Lithuania* [2012] MHLR 209, the applicant had a history of mental illness and was diagnosed with schizophrenia. At the request of her adoptive father, a court declared that she was legally incapacitated and in due course he was appointed as her legal guardian. At his request the applicant was confined in a psychiatric hospital for treatment. She ran away from the home on two occasions, brought proceedings to challenge the guardianship order in her case and engaged in correspondence to protest at her confinement. She made an application to the European court complaining, among other things, that she had suffered a deprivation of liberty contrary to article 5(1).

166. The court held that there had been a deprivation of liberty. It found that the objective element of a deprivation of liberty was made out and addressed the subjective element at para 150. Whilst *DD* lacked de jure capacity, this did not necessarily mean that she was de facto unable to understand her situation (citing *Shtukatur*, para 108); she “subjectively perceived” her confinement as a deprivation of liberty and sought to bring it to an end; “In sum, even though the applicant had been deprived of her legal capacity, she was still able to express an opinion on her situation”, and had done so in a way which showed she had not agreed to being placed in the care home or her continued residence there. The court also commented (para 150), “[w]hilst accepting that in certain circumstances, due to [the] severity of his or her incapacity, an individual may be wholly incapable of expressing consent or objection to being confined in an institution for the mentally handicapped or other secure environment, the Court finds that this was not the applicant’s case”. This indicates that for an individual at that extreme end of the spectrum, the absence of any response at all to their situation is taken to mean that there is no deprivation of liberty in the requisite sense, which supports the analysis in para 142 above.

167. *Kędzior v Poland* [2013] MHLR 115 (“*Kędzior*”) is similar. The applicant, who suffered from mental ill-health, had his legal capacity under domestic law removed and was then subjected to confinement in a secure care home. He objected to his confinement and sought to have his legal capacity restored in order to bring it to an end. The European court held that he had suffered a deprivation of liberty under article 5(1). The objective element of deprivation of liberty was made out. The court addressed the subjective element in para 58 in terms materially identical to para 150 in *DD v Lithuania*, above.

168. In *M v Ukraine* the applicant was compulsorily admitted to a psychiatric hospital on account of her mental ill-health on several occasions. For two of her admissions, it was straightforwardly accepted on all sides that she was deprived of liberty under article 5(1) (para 54). On a further occasion (the fourth hospitalisation), however, the state submitted that there had been no deprivation of liberty because the applicant was admitted on the basis of her own application, which showed that the hospitalisation was voluntary: para 68. The pattern for such an admission was the same as that in *HL*, namely engagement with the mentally ill individual to try to persuade them to admit themselves, in the interests of avoiding the stigma of a compulsory admission and promoting therapeutic outcomes, but with the prospect that discharge may be refused by the authorities if the individual does not cooperate, by relevant compulsory admission procedures being “immediately applied”: para 71. As the European court noted (para 71), this approach is recognised in principle 15 (and also, we observe, by principle 16) of the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care adopted by General Assembly resolution 46/119 of December 1991.

169. Although admitted as a voluntary patient, but against the background of being vulnerable to immediate detention should she not cooperate, the applicant in *M v Ukraine* was not free to leave the hospital and was subjected to the same restrictive regime as involuntary patients; and the conclusion was drawn that throughout the period of the fourth hospitalisation she was deprived of liberty within the meaning of article 5(1): paras 72–74. Having reached that conclusion, the court then proceeded to

address the distinct question which arises when it is established that a deprivation of liberty has occurred, namely whether the deprivation is lawful for the purpose of the Convention according to the requirements of article 5(1): paras 70, 75–79 and 90 (did the applicant’s consent to her admission to the hospital for psychiatric treatment mean that her hospitalisation was to be viewed as “valid and lawful” for the purpose of the Convention, that is, under article 5(1)(e)? The answer given was no, because her consent to treatment was not free and informed, since it was not based on full, accurate and comprehensible information about her condition and the treatment proposed) and paras 80–90 (was the retention of the applicant in hospital thereafter justified under article 5(1)(e)? Again, the answer was no, because there were insufficient procedural protections in place).

170. In *Mihailovs* the applicant complained that he had been held against his will in a state care home, at the request of his wife, who had been appointed as his legal guardian in 2000 pursuant to a psychiatric examination. In 2002 he was placed in a care home called the Ile Centre. He could not leave or receive visitors without the consent of his wife. In 2007 he applied to the domestic court for restoration of his legal capacity with a view to securing his release and complained that he had been placed in the Ile Centre against his will (paras 32–34), but his application was unsuccessful. In 2009 he asked for the appointment of another guardian, with the same object (para 38), initially without success. In 2010 the applicant was moved to another care home in Lielberze, and when his wife proposed that he be moved somewhere else he objected to that on the grounds that he was satisfied with his stay at the Lielberze home (para 26). In 2010 he commenced proceedings in the European court complaining of, among other things, a violation of his rights under article 5(1). In 2011, another person was appointed as the applicant’s guardian in accordance with his wishes (para 45). However, his residence at the Lielberze home continued.

171. The European court in *Mihailovs* referred (para 128), in particular, to the principles laid down in *Stanev* and *Storck*. It found that the conditions of the applicant’s confinement at the Ile Centre constituted the objective element for a deprivation of liberty (referring also, in that regard, to *HL, DD v Lithuania* and *Kędzior*): paras 131–133. As regards the subjective element, the court found that this was made out as well, since de facto the applicant understood his situation and objected to it. At paras 134–135 it repeated in near identical terms what had been said in *DD v Lithuania*, para 150, and *Kędzior*, para 58, and, as in *Stanev*, the court distinguished *HM v Switzerland*.

172. Turning to the applicant’s confinement at the Lielberze home from 2010, the court held that his situation there did not amount to a deprivation of liberty within article 5(1). By contrast with his period of confinement at the Ile Centre, the applicant acknowledged that the home was an open institution (and he had been able to leave it for periods of time); he had refused to move from it in 2010 because he said he was satisfied with his stay there; and, unlike his position in relation to the Ile Centre, he had not approached any domestic authority with a view to obtaining his release from it: para 138. These factors led the court to consider that “the applicant had tacitly agreed to stay” in the home: para 139. In other words, it was by reference to the subjective element that the court concluded that there was no deprivation of liberty. Accordingly, *Mihailovs* makes it clear that if an individual is placed in a secure care home, has de facto understanding of their situation and does not express or manifest any objection to staying there despite having a realistic opportunity to do so, they can be taken to have given tacit consent sufficient to negative the subjective element required for a finding that there has been a deprivation of liberty.

173. In *Stankov v Bulgaria* (Application No 25820/07) (unreported), judgment of 17 March 2015 (“*Stankov*”), the applicant, who suffered from mental health problems, was declared legally incompetent by a court on the application of his mother, who was made his guardian. At her request he was placed in a care home. He was later transferred to another care home in 2004, because the first home was being closed and he could not be sent home, and it was alleged that he had signed contracts agreeing to this, which he disputed. After his admission to the second home, he asked to be released from it. His attempts to have his legal capacity restored were unsuccessful.

174. The respondent government contended, among other things, that there had been no deprivation of liberty under article 5(1) and also that the six-month time limit for an application to the

European court had commenced in 2004 when the applicant was alleged to have signed the contracts, and so had expired before his application was made, “because the applicant had consented to the measure and had therefore lost his status as a victim [at that time]”: para 79. Since the question of whether Mr Stankov had expressed a wish to live in the care home was central to his allegation that he had suffered a deprivation of liberty, the court said it would consider the questions of the time limit and victim status together with that issue: *ibid*.

175. The European court found that both Mr Stankov’s placements involved a deprivation of liberty under article 5(1): paras 81–91. In doing so, it also rejected the respondent’s objections based on the time limit and loss of victim status: para 91.

176. As to the subjective element in relation to deprivation of liberty, the court said (para 89) that “there are situations in which the will of a person whose mental capacity is impaired may validly be replaced by that of a third party acting within the framework of a protective measure” (thereby confirming the relevance of the analysis at para 164 above); noted “that it is sometimes difficult to ascertain the true will or preferences” of such a person, but the fact that they are deprived of legal capacity does not necessarily mean that they are incapable of understanding their own situation (citing *Shtukatorov*, para 108, and *Stanev*, para 130); observed that Mr Stankov did understand his situation and had made it clear that he did not agree to his placement at the first home, because he tried to escape from it, and he had made express requests to leave the second home. The court therefore found that he had not validly consented to his confinement or accepted it later: first sentence of para 90. This part of the court’s reasoning simply involves an application of the standard approach set out in its previous caselaw, as reviewed above. *Storck* and *DD v Lithuania* were also referred to earlier in the judgment.

177. However, later in para 90 of *Stankov* the court expressed itself in a manner which might be capable of giving rise to confusion, if it is not properly understood in context. It is important to recall that in this part of its reasoning the court was dealing not just with whether there was a deprivation of liberty, but also with the issue of the time limit, which depended on the question whether the applicant had lost his victim status under article 34 of the Convention in 2004 by consenting to his treatment at that time. The test for an applicant to lose their status as a victim in relation to a violation of the Convention simply by consenting to the treatment being accorded to them is a demanding one, since it is akin in its effect to a waiver of a procedural right. The test applied by the European court for a waiver of procedural rights under the Convention is that the applicant must be fully aware of the facts and consequences and, in light of that, must have given their consent freely to being treated in that way. See, eg, *Natsvlshvili v Georgia*, para 91 (“any waiver of procedural rights must always, if it is to be effective for Convention purposes, be established in an unequivocal manner and be attended by minimum safeguards commensurate with its importance”). This is different from the established approach to assessment of the subjective element in relation to determining whether there is a deprivation of liberty.

178. Having indicated in the opening sentence of para 90 of the judgment that there was no valid consent and (by implication) there was a deprivation of liberty by application of its standard approach to that question, the European court in *Stankov* continued by saying that in relation to the issue whether the applicant consented to or accepted his placements in the care homes, it “recalls ... that a person’s consent to admission to a mental health institution for treatment can only be considered valid under the Convention if there is sufficient and credible evidence suggesting that the capacity to consent, and to understand the consequences of that act, have been established in a fair and appropriate procedure, and that all necessary information concerning the placement and the proposed treatment has been adequately provided to the interested party [citing *M v Ukraine*, para 77]”. The court continued as follows: “The court considers that this principle is also applicable when it comes to obtaining consent for the placement in a social care home of a person whose legal capacity is impaired due to their mental health, as in the present case.” It then noted that Bulgaria had not demonstrated that the applicant’s consent had been sought “in accordance with an appropriate procedure or that the necessary information was provided to the applicant”. At para 91 the judgment

continued: “In view of the above, the Court rejects the objection relating to the six-month time limit and the loss of victim status (para 79 above)”. The conclusion that, “as in the *Stanev* case”, there had been a deprivation of liberty within the meaning of article 5(1) was then recorded in the later part of that paragraph.

179. In our view *Stankov*, para 90, cannot be read as qualifying the standard approach to assessment of whether there is a deprivation of liberty as set out in *Stanev* and the consistent line of authorities reviewed above: (i) *Stanev* was expressly referred to in the court’s conclusion on the deprivation of liberty issue set out in para 91; (ii) para 89 of the judgment repeats the standard approach taken from other leading authorities in respect of the meaning of the subjective element of deprivation of liberty in article 5(1) and there is no indication by the court that it intended to depart from or qualify that well-established line of cases or that approach; (iii) the court’s cross-reference in para 90 to *M v Ukraine*, para 77, is not to the part of the judgment in that case dealing with deprivation of liberty, but to the part dealing with justification of a deprivation of liberty which has been established (see para 169 above); (iv) the discussion in *Stankov*, para 90, deals both with deprivation of liberty (where the relevant conclusion on that issue is covered by the first sentence) and with the time limit and linked victim status points, and it is the latter points to which the later part of that paragraph relates, in applying the different test of informed consent which is appropriate in the context of consideration of loss of victim status; (v) this is underlined by the way those points are directly reflected in the first sentence of para 91; and (vi) later authorities, below, continue to apply the standard approach and the standard authorities on the meaning of the subjective element of deprivation of liberty, without any suggestion that the law has been affected by *Stankov*.

180. In *Červenka v Czech Republic* [2017] MHLR 195 the applicant, who suffered from alcoholic dementia, had his legal capacity removed by an order of a court, which appointed a guardian for him. He applied unsuccessfully to reverse this. The applicant was placed in a secure care home, initially without clear disagreement, but he soon made it clear that he did not wish to remain there. He brought proceedings to challenge the lawfulness of his detention there, but without success. The European court referred to its previous jurisprudence, in particular *Stanev*, *Shtukatur* and *DD v Lithuania*, and had no difficulty in finding that the objective and subjective elements of a deprivation of liberty were made out: paras 102–104.

181. The Charities also made reference to *N v Romania* [2018] MHLR 288. In that case a court issued a medical detention order against the applicant in 2007. He was detained in psychiatric hospitals. The applicant appealed unsuccessfully against the detention order. Eventually, however, on 29 August 2016 a court directed that the hospital where he was confined should arrange for him to be transferred to an institution which could provide him with appropriate living conditions in the community (paras 61–64). However, there was a delay before an appropriate placement could be found, and the applicant asked to remain in the psychiatric hospital until that was sorted out (para 73). It was not in dispute that the applicant was subject to a deprivation of liberty under article 5(1) throughout the period he spent in psychiatric hospitals. The issue was whether that deprivation was justified under article 5(1)(e). In discussing that issue, the European court reiterated the point made in *Stanev*, para 153, that “any protective measure should reflect as far as possible the wishes of persons capable of expressing their will”: para 146. This supports the analysis at para 139 above. The court also observed (para 165) that “even though the applicant agreed to remain confined until the welfare services found a solution appropriate to his situation ... he ought to be granted adequate safeguards for his protection, which should, in particular, lead to his release without unjustified delay”. In other words, in those circumstances the Romanian government could not justify his continued detention under article 5(1)(e). Accordingly, the court’s conclusion (para 168) was that there was a violation of article 5(1)(e) as regards, in particular, his continued detention after 29 August 2016. Contrary to the submissions of Ms Victoria Butler-Cole KC for the Charities, para 165 does not shed light on the meaning of deprivation of liberty. It was not concerned with that issue.

182. In *Kaganovskyy v Ukraine* (2023) 76 EHRR 30 the applicant, who had chronic paranoid schizophrenia, was admitted on a voluntary basis to a social care institution. His condition

deteriorated and he was placed in a closed unit in the institution, for those dangerous to themselves and others. The applicant complained that although his presence in the care institution was voluntary, he had never agreed to be placed in the closed unit.

At paras 80 and 83 the European court referred to the approach set out in *Stanev, Storck and M v Ukraine* (notably, at para 69, in which *Storck* was referred to, not para 77—see para 169 above). It held that his confinement in the closed unit constituted a deprivation of liberty, with both the objective and subjective elements being present: paras 82–87. As to the subjective element, it was common ground that his placement in the unit was against his will, and there was “nothing to suggest that he could have freely decided not to go with the male nurse to the unit when the nurse came to him and told him to go there”: para 85. That is to say, the position was equivalent to that in *HL* and *M v Ukraine*, discussed at paras 154 and 168–169 above. The court went on to hold that the deprivation of liberty was not justified under article 5(1), because it was not lawful under domestic law: paras 89–104.

9. Is *Cheshire West* correct?

183. The Strasbourg jurisprudence to which we have referred confirms that the European court has continued to apply the multifactorial test in determining when an individual is deprived of liberty and provides a clear indication of the nature and extent of restrictions that are required before a “person of unsound mind” will be found to be detained in the relevant sense in a psychiatric hospital or social care institution. It has never adopted an acid test, either generally or in the more limited context of the living arrangements for those who lack legal capacity. We have some sympathy with the desire to establish a universally applicable bright-line test to assist decision-makers (albeit a bright-line test would have the negative feature of failing to be appropriately responsive to the justice of particular situations arising across the whole field of its application). Further, although understandable in context, the underlying policy concern of the majority in *Cheshire West*, that it is only by treating the vulnerable individual as being deprived of their liberty that one can be confident that there will be regular reviews of the suitability of their placement and an independent person appointed with a duty to pursue the individual’s best interests, is also not a good reason for extending the definition of deprivation of liberty (see para 141 above). In setting out the acid test the majority decision in *Cheshire West* went beyond the Strasbourg jurisprudence and departed from the long-standing multifactorial approach to determining when a person is deprived of liberty. We respectfully consider that the majority decision in *Cheshire West* was wrong in the following respects.

184. First, while the acid test formulated in *Cheshire West* refers to elements which are relevant as part of the multifactorial test set out in *Engel and Guzzardi*, application of the acid test is not sufficient by itself to show that there is a deprivation of liberty according to the Strasbourg jurisprudence. Put another way, it may well be that an individual cannot be subject to a deprivation of liberty under article 5 without the acid test being met, but this is not sufficient. To determine whether an individual is subject to such deprivation, a court must focus on their concrete situation and must take account of the whole range of factors in the particular case, including the type, duration, effect and manner of implementation of the measures in question.

185. *Cheshire West* creates a bright-line test which is too crude in its application and which leads to an over-extensive interpretation of deprivation of liberty on the basis of a misplaced policy concern that safeguards in relation to vulnerable people have to be provided pursuant to article 5. In our view, this policy-driven approach puts the cart before the horse. A crude application of article 5 cannot be a cure for the problems posed by caring for vulnerable adults with mental health or other cognitive disabilities. Nor is it necessary to adopt that interpretation of article 5 to safeguard the interests of such individuals, since other legal regimes and Convention rights apply in their case: see para 10 above.

186. Moreover, the judgments of the European court show that no single factor is determinative. As was explained in *Guzzardi* and has been affirmed many times, the difference between deprivation of liberty and restriction of liberty is one of degree or intensity and not one of nature or substance. So

it is possible in an appropriate case to conclude that a deprivation of liberty results from the manner of implementation of the measure in question. Whilst it might not be possible to conclude on the strength of one of the elements comprising the implementation of the measure that there has been a deprivation of liberty, it is possible that cumulatively and in combination the elements comprising the implementation of the measure will amount to a deprivation of liberty for the purposes of article 5. The approach of the European court emphasises the importance of taking all relevant factors into account, whereas the decision in *Cheshire West* abandons that. By adopting two factors as an acid test, the majority in *Cheshire West* wrongly isolated a small sub-set of factors and elevated it to a universal test that ignores all other potentially relevant factors.

187. Secondly, in our judgment the majority was wrong to conclude (para 50) that a “person’s compliance or lack of objection” is never legally relevant to the question of objective confinement. As the Strasbourg jurisprudence shows, confinement must be established as an objective fact and subjectively there must be an absence of valid consent: *Storck*, para 74. Moreover, the Strasbourg jurisprudence shows that these are not hermetically sealed concepts and there is inevitably some overlap. Thus, factors considered relevant in determining whether there is confinement are the “effects and manner of implementation” of the arrangements or restrictions in question (see para 118 above). The effect of restrictions on an individual is liable to differ according to whether they are content with or object to their living arrangements, and it is therefore relevant to consider the effect of the living arrangements on them: see, for example, *W City Council v L* [2015] EWCOP 20; (2015) 18 CCL Rep 350. If an individual objects to the arrangements, this is likely to result in conflict. There may be arguments, attempts to leave a particular place, expressions of a wish to leave, or conduct showing a wish to leave. The resulting stress for the individual in having their objections overruled may lead to suffering and result in the use of physical force or physical restraint. These features of the individual’s concrete situation are likely to be clear indicators that they are being confined, in the sense of suffering a deprivation of liberty. The necessary element of coercion is present because the individual is being compelled to live somewhere they do not want to live. Conversely, the absence of objections is likely to result in an absence of conflict which is equally capable of being relevant. If the arrangements for an individual’s care and treatment accord with their known wishes and feelings, and they are happy with them, it may be difficult to conclude that they are subject to a deprivation of liberty. There is unlikely to be any element of coercion present in that situation.

188. Depending on the circumstances, mere compliance or acquiescence may carry little weight in determining whether there is confinement, particularly if it is accompanied by the administration of sedative medication which is capable of suppressing objections: see for example, *HL* paras 90–91 (paras 152–156 above). The administration of medication (including antipsychotic drugs or tranquilisers) is likely to be highly relevant in supporting the existence of the objective element of confinement because it suppresses the ability and freedom to express wishes and feelings. Its relevance is increased if the administration of it is accompanied by force. But again, the absence of medication may be a relevant factor pointing in the opposite direction.

189. However, if an individual is able to, and does, express their wishes and preferences about their living arrangements, and is happy with them, it will ordinarily be difficult to see how they are being coerced. This view is supported by Eldergill et al, *European Court of Human Rights and Mental Health* (2024) at para 3.91:

“... the objective and subjective conditions overlap. The disadvantage of the *Storck* approach ... is that ... it risks artificially separating out the relevant facts, by placing them in one of two columns (objective, subjective), when a particular factor may be relevant to both conditions.

A person’s wishes and feelings, the existence of objections, their agreement or tacit agreement, and the absence of objections from someone capable of objecting, are always relevant to the objective condition, not just the subjective condition. All of these things are part of the ‘whole range of criteria’ that help to establish the breadth and

intensity of any supervision and control, and also whether the person is being prevented from doing what they can do and what they wish to do ...”.

190. In borderline cases, the Strasbourg jurisprudence makes reference to the closeness of the situation to the paradigm case of deprivation of liberty, which is confinement in a prison cell: para 119 above. This again indicates the importance of adopting a multifactorial approach in assessing whether a deprivation of liberty has occurred. In our view, the majority judgments in *Cheshire West* lost sight of this basic point of orientation for the interpretation of article 5.

191. We recognise that there may be considerable evidential difficulties in ascertaining whether a person who is severely autistic or who has other profound cognitive disabilities is content with and not objecting to their living arrangements. Inevitably there will be a wide spectrum of cases, with cases at one end where eliciting evidence of positive expressions of wishes and feelings about the care placement will be impossible, and at the other end, cases (like MIG’s and MEG’s in *Cheshire West*, and the applicant’s attitude to the Lielberze home in *Mihailovs*) where a tacit positive indication of wishes and feelings showing contentment with the arrangements can be ascertained. In the latter cases, such evidence is relevant and should not be excluded from consideration. The cases between the two ends of the spectrum will create varying degrees of difficulty and will require anxious consideration to determine what effect the applicable restrictions are having and what attitude the affected individual has to them. As we have said, it may be that if nothing more than mere compliance or acquiescence is a feature of the case, that is not enough. If the individual is capable of expressing a view and there is serious doubt about their attitude, no inference should be drawn.

192. A theme of the Charities’ case is that because this exercise of evaluating the wishes of an individual who lacks legal capacity to consent to their care arrangements is going to be difficult or impossible in some cases, possibly even many cases, there should be no attempt to consider lack of objection or wishes and feelings in any case at all. We do not accept this. It is contrary to the fundamental principle underlying the Convention that individuals should be treated with due regard to their dignity as persons and that their own views should be accorded respect: paras 138–139 above. It is also too crude as an approach in this area, where sensitive judgments are required. The argument that, because *some* adults will find it difficult to communicate and express views and feelings about their placement, the views of *no* adults should be capable of vouching consent creates an arbitrary threshold and may lead to unnecessary and intrusive interference with the private lives of those adults with impaired mental capacity who *are* able to express views and feelings.

193. Thirdly, the European court has emphasised that article 5 is concerned with the physical liberty of the person and is not concerned with mere restrictions on the liberty of movement: para 118 above. Yet the acid test takes no account of the type of setting where an individual receives care and treatment and draws no distinction between the position of an individual in, say, a category A prison or a high security psychiatric hospital on the one hand, and a person supported to live as independently as possible in their own accommodation or in their family home. The effect of the restrictions on an individual living in their family home with their family, or living in their own home, with opportunities for leaving the place of residence for recreation, education or social contact, is likely to be very different from the effect on an individual held in a psychiatric hospital or a prison. The normality of the circumstances in which an individual is cared for is a relevant factor: see para 145 above. Moreover, the parties identified no decision of the European court to date which has held that an individual living in their own home is deprived of liberty. And although the majority in *Cheshire West* discounted the point, because it had not been argued, we think it is noteworthy that the European court in *HL* focused on the applicant’s position in the hospital (finding that to involve a deprivation of liberty), by contrast with his position when being cared for in the community (which the court did not suggest would involve such deprivation). This does not mean that an individual living in their own home could *never* be subject to a deprivation of liberty. However, if an individual is living in their own home, in accordance with their wishes and feelings, it makes it less likely that the individual is being subject to a deprivation of liberty within the meaning of article 5. Put another

way, the restrictions imposed would need to be more severe or extensive to amount to such a deprivation, such as, for example, a combination of restraint, medication, and seclusion.

194. Whether a placement amounts to a deprivation of liberty as opposed to involving only a restriction on the freedom of movement of an individual is plainly fact sensitive and a question of degree. The European court has repeatedly said that each case must be decided by reference to its own particular “range of factors”. In *HL*, for example, the court contrasted the circumstances of HL’s case with those of the applicant in *HM v Switzerland*. The court referred to the fact that HM was legally incapable of expressing a view on her position but had sufficiently indicated that she was willing to stay at the care home: para 156 above. Also, the court emphasised that the regime at the care home was entirely different from that applied to HL. This analysis also illustrates the way in which the subjective and objective elements inherent in deprivation of liberty may interact with each other.

195. Fourthly, the Strasbourg jurisprudence reflects the need for coercion or some externally imposed restrictions on an individual that prevent them from exercising their fundamental right to physical liberty. However, the acid test in *Cheshire West* takes no account of the innate limitations to which an individual may be subject by reason of their own physical or mental condition. To the extent that the majority assumed that such a person would be subject to a deprivation of liberty under article 5 (see, eg, para 67), we disagree: see paras 145, 164–167, 171 and 176 above.

196. Take the case of *SM*, for example. Lieven J recognised that SM (a 12-year-old with profound cognitive and physical disabilities, who responded like a child of a few months old) was under constant supervision and control, but this was because her condition was such as to require this by way of care, not to prevent her from leaving her placement. In fact, SM was wholly incapable of leaving, both because of physical inability and because she was unable to form any desire or intention to leave. In our view, the judge was right to conclude that this situation did not involve a deprivation of liberty within the meaning of article 5. Difficult issues could arise regarding the possibility that a state (under the Convention) or a public authority (under the Human Rights Act) might owe a physically disabled but mentally alert individual a positive duty under any of articles 3, 5 and 8 of the Convention to assist them to be physically mobile, but we do not seek to address them in this judgment.

197. Our view accords with the analysis of Professor Eldergill, discussing the position of a person in the final sad stages of dementia, confined to bed and so cognitively impaired as to be unable to form the idea of swallowing, let alone moving about. In this situation, no one is interfering with, limiting, or controlling their liberty to do anything they can do:

“Wishing or deciding to leave fall into the category of things which the person is now incapable of doing and one cannot properly speak of being prevented by others from doing something which one is incapable of doing. Nor can anyone possibly restrain a person from doing something which they do not have the ability to do at present. Mere inability is not lack of freedom.” (Eldergill, “Are all incapacitated people confined in a hospital, care home or their own home deprived of liberty?” (2019) 19 ERA Forum 511, p 527)

198. This does not result in “liberty” in article 5 meaning something less for those who, because of their impairments, are unable to enjoy that liberty. Nor does it mean that their human rights are in any way different from, or less than, those of an able-bodied person of sound mind. Liberty means the same thing for everyone. As explained in *Engel*, it means physical liberty, including the freedom to go where one pleases. For those who are unable to do this because they are unconscious, in a minimally conscious state, or so profoundly disabled that they cannot conceptualise leaving let alone physically achieve this, they are not being prevented by a third party from doing something and are not being deprived of anything. The state may in some circumstances be subject to positive obligations (as the Secretary of State accepts) to take reasonable steps to prevent a deprivation of liberty, by, for

example, providing a wheelchair or other aid to enable the individual to leave. But that is a wholly different point.

199. Nor does this amount to discrimination against those who are disabled. We agree with Lieven J that a disabled person in the position of SM is not in a “relevantly similar” situation to a non-disabled comparator (*SM*, paras 41–44). The non-disabled person is in a fundamentally different position from persons who are unconscious, or in a minimally conscious state, or profoundly mentally and physically disabled. The former is capable of leaving but prevented from doing so. The latter are simply, by reason of their condition, not capable of leaving. It follows that there is no less favourable treatment of people in a materially similar position.

200. Fifthly, the majority in *Cheshire West* were wrong to discount the potential relevance of the purpose for which measures of confinement were imposed: see paras 130–134 above.

201. Sixthly, the approach taken by the majority in *Cheshire West* equates lack of legal capacity with lack of valid consent (as part of the subjective element of the article 5 test); and this appears to have led them to treat the subjective element as not being in play in the three cases. This is wrong. Lack of valid consent as the subjective element of deprivation of liberty is an autonomous Strasbourg concept. It is separate from and not tied to the question of legal capacity in a domestic law context. Instead, it is more concerned with a person’s de facto understanding of their situation and how they experience it. The European court treats lack of valid consent as part of the definition of deprivation of liberty. To treat the lack of legal capacity as an inability to express valid consent confuses the analysis. A person may not have mental capacity to make decisions about their care and residence arrangements, but if they have a basic level of awareness and consciousness of their living arrangements that is sufficient to enable them to know and communicate whether they are happy or unhappy with them, they may be treated as able to give or withhold valid consent to confinement by an expression of their wishes and feelings.

202. As we have explained, the question whether an individual in care is subject to a deprivation of liberty depends on the factual circumstances of their particular case. It may assist and provide guidance if we indicate our view of the position of MIG, MEG and P in *Cheshire West*.

203. In our view, in the circumstances described by Parker J and reviewed in this court, MIG was not subject to a deprivation of liberty. We consider that there were sufficient indications of her being happy with her living arrangements to amount to valid consent, in accordance with *Storck*, para 74. Her living arrangements were as close to normal as possible and such minimal element of confinement as existed was for her benefit and protection; so in our opinion the objective element of confinement was not present either. Overall, her situation was very far removed from the paradigm case of confinement in a prison cell.

204. We also consider that MEG was not subject to a deprivation of liberty. There were sufficient indications that she was happy living in the NHS facility where she was placed as to amount to valid consent to being there. She showed no wish to leave the facility or go out on her own. Although she received tranquillising medication, that was not administered with a view to disabling her from forming a view about her living circumstances and does not seem to have had such an effect. The basic pattern of MEG’s response to her living environment was that she was happy to be there, even if there were occasional upset outbursts from time to time. We also consider that the objective element of a deprivation of liberty was not present. The living arrangements were as normal as possible in the circumstances, and the continuous supervision and control to which she was subject were directed to meeting her care needs rather than to making her a prisoner. Although she was physically restrained on occasion, that was done for her own protection or for the protection of others, and not with a view to punishing her. Overall, again, her situation was far removed from the paradigm case of confinement in a prison cell.

205. We would prefer to reserve our opinion about the situation of P. We have not heard argument about his case, and we note that this court in *Cheshire West* came to the unanimous view that he was

subject to a deprivation of liberty. We are not in a position specifically to overrule that part of the judgment. Nonetheless, it seems to us that there were many features of his case, as described by Baroness Hale at para 17, which would tend to indicate that he was not subject to a deprivation of liberty. We would be doubtful that when P was living at home with his mother, as he did until the age of 37, that constituted a deprivation of liberty. When he moved to Z House, the basic arrangements continued and everything was done to provide care for him in a similar way and in as normal an environment as possible. It is not obvious that P's case bore any real similarity to confinement in a prison cell. It suffices here to say that we have some sympathy with the view of Munby LJ in the Court of Appeal that he was not subject to a deprivation of liberty.

206. We have come to the clear conclusion, with respect, that the majority in *Cheshire West* erred in their interpretation of the Strasbourg jurisprudence in relation to the meaning of deprivation of liberty in article 5. Moreover, because the jurisprudence of the European court is clear in adopting the multifactorial approach and giving weight to valid consent, this is a further reason why that reasoning should not be followed: see *R (ElanCane) v Secretary of State for the Home Department*, above; and *R (AB) v Secretary of State for Justice*, above, paras 54–59. On such a fundamental issue regarding the proper interpretation of the Convention, it is for the European court to give the lead in laying down the approach to be followed.

10. Conclusion

207. For the reasons we have given, we decline to follow *Cheshire West* and would overrule it. The so-called acid test has never been adopted by the European court and is wrong in principle.

208. In our view, the Minister would not be acting incompatibly with article 5 in issuing the proposed Revised Code. The Revised Code neither authorises nor approves unlawful conduct in the form of a breach of Convention rights of individuals to whom it is applied. The Minister would be acting within competence in issuing it.

209. We note that the draft Revised Code has not been fully worked through and in any event, it will require revision in the light of this judgment.

ANNEX 1

THE REVISED CODE

(Chapter 2 of the proposed revised Statutory Code to be issued pursuant to section 288(4) of the Mental Capacity Act (Northern Ireland) 2016)

CHAPTER 2: DEPRIVATION OF LIBERTY

Introduction

2.1 Depriving a person of his or her liberty is one of the most serious infringements on a person's human rights. The Act therefore treats detention amounting to deprivation of liberty ("DOL") as one of the most serious interventions that can be done to a person who lacks capacity ("P").

2.2 To ensure that P's human rights are protected, the Act defines DOL as having the same meaning as within Article 5(1) of the European Convention on Human Rights ("ECHR") which provides that:

Everyone has the right to liberty and security of person. No one shall be deprived of his liberty [unless he or she is of an unsound mind] and in accordance with a procedure prescribed by law.

- 2.3 What this means is that a person can only ever be deprived of his or her liberty in a care or treatment context if he or she is deemed to be of unsound mind. A person who lacks capacity to make a decision about care arrangements that would amount to a deprivation of liberty is of unsound mind and is deprived of liberty if any act or intervention which fits the test below occurs unless they express their consent. The only way to be protected from liability when carrying out the act in such circumstances is to follow the statutory procedures and have regard to this Code.
- 2.4 Conversely, anyone who has the relevant capacity cannot be deprived of their liberty unless expressly provided for under other legislation (e.g. criminal legislation permitting imprisonment for committing offences).
- 2.5 This chapter sets out what a DOL is, where a DOL can take place and how DOL interacts with other interventions. In this chapter references to capacity are in regards to a person's capacity to make decisions in relation to their care arrangements which may amount to a deprivation of liberty.

Testing if a person is subject to a DOL

- 2.6 To test if a person who lacks capacity is deprived of his or her liberty the following questions must be asked:

- a. _____ is P under continuous supervision and control?
- b. _____ is P free to leave?
- c. _____ is P expressing consent to the arrangements for their care?

2.7 _____ If P is under continuous supervision and control and is not free to leave and not consenting then P is subject to a DOL.

2.8 _____ A DOL must be considered on individual merit and on the particular circumstances of each case; blanket assumptions must not be made. Account must be taken of a whole range of criteria such as type, duration, effect and manner of implementation of the measure. This includes the possibility to leave a restricted area, the degree of supervision and control over the person's movements, the extent of isolation and the availability of social contacts. Bear in mind that whether or not an act amounts to a DOL does not depend on its duration alone. However, an act that is short, timebound and reactive to an immediate event is likely not to be a DOL but restraint, which is not covered under the first phase of commencement of the Act.

2.9 _____ Being under **continuous supervision and control** depends on the particular circumstances but may include control over who P can have contact with, control over P's activities or supervision over P's health and actions.

2.10 _____ Not being **free to leave** may include locked doors that are not unlocked on P's request, physically preventing P from leaving, not being able to leave the place without supervision and not being free to permanently move residence.

2.11 P can **consent** to the arrangements for their care if P has the capacity to understand, retain, appreciate, use and weigh the fact that they are being confined, and can communicate their agreement to that confinement.

2.12 P can also be regarded as consenting even if he or she does not have that capacity, but they actively express positive wishes and feelings about the arrangements in place. It is not enough that P does not express objection, there must be evidence of a positive attitude to the care arrangements. For example, P could be regarded as consenting if he or she

- a. regularly says that they like where they live
- b. or appears keen to return to their home after a trip away

and in either case, there is no evidence of resistance or objection to the arrangements in place.

2.13 The responsibility lies with those who are confining P to be able to explain at all times how P can be regarded as consenting. If they cannot do so, then the arrangements must be taken to be a deprivation of P's liberty, and the safeguards of the Act must immediately be put in place.

2.14 If a person has capacity to and does consent, they can be subject to any arrangements, including those of a similar nature to DOL, on a voluntary basis. However, a person who has capacity cannot consent pre-emptively to a DOL for a time in the future when they may no longer have capacity. If they lose capacity, then their position must be assessed following the approach set out above.

2.15 Examples of where P, if not expressing a positive attitude to their care arrangements, *may* be subject to DOL include, but are not limited to:

- a. an acute hospital where P is receiving treatment, is not bed bound, and is prevented from leaving by locked doors or forcibly by staff (see below for exceptions for some persons in hospital);
- b. an acute hospital where P is receiving treatment and is bed bound but would be prevented from leaving if he or she attempted to or had the ability to (even if he or she does not try to leave) (see below for exceptions for some persons in hospital);
- c. a care setting where P is subject to seclusion (that goes beyond the remit of restraint);
- d. a care home where P is resident and only allowed to leave under supervision;
- e. a nursing home where P is resident, the doors are locked with a key pad and P does not know the code or cannot understand that the numbers next to the door is the code;
- f. a day care facility which P is not allowed to leave;
- g. a setting where P is bed bound and not able to leave and family members (or others) are prevented from removing P [deleted: 'even though this is according to P's wishes'];

- h. in a private home where P is bed bound, receiving around the clock care (provided by the health and social care system) but would be prevented from leaving if he or she had the ability; and
- i. in supported living or a private home where P is cared for by a carer (who may be a relative) and is prevented from leaving (either by locks, persuasion or coercion) and the carer is financially compensated by the state (for example through direct payments or carers allowance).

2.16 The Courts have found that certain factors **are not relevant** when considering if P is subject to a DOL. This includes that it does not matter:

- a. if P can physically leave;
- b. if P is compliant or is not objecting;
- c. if the place where P is residing is “normal” for P; and
- d. what the reason or purpose for the DOL is.

Situations where P is unable to leave

2.17 Being unable to leave does not automatically mean that a person is prevented from leaving. That is the case even if the person’s inability to leave is due to treatment or actions by others.

2.18 For example, a person is receiving palliative care which involves strong pain killers. The effect of the pain killers is that the person is physically unable to leave as the medication has a strong sedative effect. The person is then under continuous control and supervision and unable to leave (due to the medication). However, this does not automatically mean the person is not free to leave. The question that must be asked is if the person was able to leave would the person be prevented from leaving. In settings such as palliative care, most people would be allowed to leave, and if the answer to the question is that the person would be allowed to leave there is no deprivation of liberty.

2.19 Similarly, if another person is receiving care and treatment and the person’s physical health has deteriorated to the extent that the person is unable to leave it does not automatically mean that the person is not free to leave. The question that must be asked is if the person could leave would they be allowed to. If the answer is yes, the person is not deprived of liberty.

2.20 The effect of this is that many people who are receiving care and treatment where their physical health has deteriorated to the extent that they are unable to leave are not deprived of liberty as they would be allowed to leave if they were able to.

2.21 This does, of course, not mean that all persons unable to leave are free to leave. Assessments must be made on individual circumstances with the question, if the person was able [to] leave would he or she be allowed to leave.

Exception for persons receiving life-saving treatment in hospital

2.22 In general there is no DOL where the person is receiving life-saving medical treatment in hospital. The courts have found that:

There is in general no need in the case of physical illness for a person of unsound mind to have the benefit of safeguards against the deprivation of

liberty where the treatment is given in good faith and is materially the same treatment as would be given to a person of sound mind with the same physical illness. The treatment is neither arbitrary nor the consequence of her impairment.

2.23 Therefore if a person is in hospital and is treated for a life-threatening illness, the person is not subject to a DOL if the circumstances of the treatment for the physical illness for the person who lacks capacity is the same as for a person who has capacity, even if the factual circumstances meet the DOL test.

2.24 For example, this may be a person in intensive care who is chemically restrained due to the physical illness they are being treated for, and thus not free to leave and is subject to continuous supervision and control. However, if the reason for the restraint is the physical illness and not the lack of capacity, the person is not deprived of his or her liberty and the additional safeguards outlined in this Code do not apply.

2.25 The Courts have explained that it is not the precise setting which is determinative, but the nature of the treatment. It may be that a person is getting that urgent lifesaving treatment outside Intensive Care, at which point there is most likely not a deprivation of liberty, unless there is some unusual feature about the person's care. Conversely, it may be that there are cases in Intensive Care where the arrangements go beyond those which would ordinarily be in place and the circumstances should be considered as a deprivation of liberty.

Detention amounting to DOL under the Act

2.26 In a situation where a person fulfils the test on DOL the Act applies if:

- a. P is 16 or over; and
- b. P lacks capacity in relation to the detention amounting to DOL

ANNEX 2

	Authorisation (England and Wales) (references to legislation are to the Mental Capacity Act 2005)	Authorisation (Northern Ireland) (references to legislation are to the Mental Capacity Act (Northern Ireland) 2016, and include prospective provisions)	Authorisation (Scotland) (references to legislation are to the Mental Health (Care and Treatment) (Scotland) Act 2003)
Age range	Aged 18 or over: statutory authorisation (Sch A1, para 12(1)(a)) and 13 16 and 17-year-olds: by application to the Court of Protection (ss 4A(3) and 16(2)(a))	Aged 16 or over (Sch 1, para 2(1); Sch 2, para 2(2))	Children and adults (ss 1, 2)
Care settings	Hospitals and care homes (Sch A1, para 1(2)) The Court of Protection can authorise a deprivation of liberty in other settings (ss 4A(3) and 16(2)(a))	A place where appropriate care or treatment is available for trust panel authorisations (“TPA”) concerning “deprivation of liberty” (Sch 1, para 2(2)(b)) Hospitals, for short-term authorisation (“STA”) (Sch 2, para 2)	Hospitals, for emergency detention certificates (“ED”) and short-term detention certificates (“SD”) (ss 36, 44) Hospitals and other settings for compulsory treatment orders (“CTO”) and interim compulsory treatment orders (“ICTO”) (ss 63, 65)
Arrangements	Standard authorisations (“SA”) and urgent authorisations (“UA”) apply in respect of a specific hospital or care home	TPA concerning “deprivation of liberty”, as well as STA, apply to a specified place or hospital (Sch 1, para 22(1); Sch 2, para 2(4)(e)) TPA can be “for a specified purpose in one place and for other specified purposes in another place” (Sch 1, para 16(3))	ED and SD apply in respect of a particular hospital (ss 36(8)(a), 44(5)(a)) CTO also apply in respect of a specified hospital or place of residence (s 66(1)(a) and (e))
Authorising body	For SA in respect of care homes in England and Wales, and in respect of hospitals in England: the local authority where the individual is ordinarily resident or, absent such residence, the local authority where the care home is situated (Sch A1,	For TPA: a panel of the relevant trust (Sch 1, paras 14, 15) The relevant trust for detention in a particular place “amounting to a deprivation of liberty”: the Health and Social Care Trust in whose area	ED and SD: a medical practitioner (ss 36(1), 44(1)) CTO and ICTO: Mental Health Tribunal (s 64(2) and 65(2))

	para 180(1), 180(4), 182(1), 182(3)) For SA in respect of hospitals in Wales, if the person is not resident in England: National Assembly, if the care is commissioned by it or by a Local Health Board commission (Sch A1, para 180(3)) For SA in other cases: the local authority for the area in which the hospital is situated (Sch A1, para 180(4)) For UA: the managing authority of the relevant hospital or care home (Sch A1, para 74)	the place is situated (Sch 1, para 2(4)(a)) For STA: an “appropriate healthcare professional” (Sch 2, paras 2(1)–(2), 3)	
Authorisation conditions	SA requires the satisfaction of six requirements concerning age; mental health; mental capacity; best interests; eligibility; and no refusals (Sch A1, para 12(1)) UA is to be made where a request is to be made for SA and the need for detention is sufficiently urgent (Sch A1, para 76) Authorisation may also be given where there is a question about whether a person is authorised to deprive another person of their liberty; the deprivation of liberty is wholly or partly for the purposes of, or consists wholly or partly of, giving the person life-sustaining treatment or doing any vital act; and the deprivation is necessary in order to give lifesustaining treatment or do the vital act (s 4B)	TPA “amounting to a deprivation of liberty” necessitates the satisfaction of five criteria: availability of appropriate care or treatment; risk of serious harm; proportionality; lack of capacity; and best interests (Sch 1, para 10) Interim TPA may be granted if there is good prospect of establishing the criteria for authorisation (Sch 1, para 20(1)(b)) STA may be granted for examination (and possible subsequent treatment or care) upon the satisfaction of five criteria: having or suspicion of having an illness; risk of serious harm; proportionality; lack of capacity; best interests (Sch 2, para 2(3))	ED and SD may be granted when specific requirements concerning the following are met: significant impairment due to mental disorder; necessity; significant risk; undesirable delay; and consultation of a mental health officer, insofar as practicable (ss 36, 44) CTO and ICTO require specific requirements concerning the following to be met: impairment; positive impact in respect of prevention or alleviation of a mental disorder; significant risk; and necessity (ss 57(3), 64(5))

Avoiding repeat assessments	A repeat assessment is unnecessary for a new SA if an “equivalent” assessment has already	Beyond the possibility of extending an authorisation (see below on duration), no	Beyond the possibility of extending an authorisation (see below on duration), no
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	been carried out, subject to certain conditions (Sch A1, para 49)	provision is made for avoiding repeat assessments	provision is made for avoiding repeat assessments
Duty to consult	The “best interests” requirement requires that, so far as reasonably practicable, the person is to be permitted and encouraged to participate, and to have his or her ability to participate improved, as fully as possible (s 4(4) and Sch A1, para 16)	The “best interests” requirement for authorisation requires that, so far as practicable, the person is encouraged and helped to participate as fully as possible in determining what would be in that person’s best interests (s 7(5)) Regard is to be had to past and present wishes and feelings, the beliefs and values that would be likely to influence that person’s decision if they had capacity, and other factors that person would be likely to consider if able to do so (s 7(6))	In exercising a function under the Act, regard is to be had to the relevant past wishes and feelings, as well as to the importance of the patient participating as fully as possible and of providing the maximum benefit to the patient, among other things (s 1(3), 2(5)(a)) Prior to SD, a mental health officer has a duty to interview the patient, unless impracticable to do so (s 45) Prior to CTO, a mental health officer has a duty to prepare a proposed care plan which assesses the needs of the patient (s 62(5)(c))

Role of independent assessor	A “best interests assessor” is to complete a “best interests” assessment in relation to each standard authorisation (Sch A1, para 39). There is also a requirement for an independent mental health assessment (Sch A1, para 35).	In taking the requisite reasonable steps to establish lack of capacity, a formal capacity assessment is to be carried out by a suitably qualified person (s 14)	ED requires the consent of a mental health officer, unless impracticable (s 36(3)(d) and 36(6)) SD requires the consent of a mental health officer (s 44(3)(d)) CTO requires two medical practitioners to carry out medical examinations (ss 57(2), 58) The medical practitioners who submit mental health reports are also to have an opportunity to participate in proceedings prior to an ICTO (ss 65(4)-(5))
Duration of authorisation	SA: one-year maximum (Sch A1, para 42(2)) UA: a period not exceeding seven days (Sch A1, para 78(2)); this can be extended for a further	TPA: six months (Sch.1 para 15(6)(b); it may be extended for six months (s 37(2)), and again for periods of one year thereafter (s 38(2)). See also Sch 3	ED: up to 72 hours (s 36(8)(b)) SD: for 28 days (s 44(5)(b)), and may be extended for five days or for the giving of medical
	seven days (Sch A1, para 85)	Interim TPA: up to 28 days (Sch 1, para 20) STA: expires if a person not already an in-patient at the specified hospital is not admitted within two days after the medical report or such longer period not exceeding 14 days as certified as necessary because of exceptional circumstances (Sch 2 para 9); in respect of an admitted person, STA ends if certain conditions are not met (Sch 2, paras 10–15)	treatment if an application for a CTO has been made (s 68) or for three days pending a CTO for the giving of medical treatment (s 47(4)) CTO: period of six months (s 64(4)) ICTO: period not exceeding 28 days (s 65(2)(a)) and not exceeding a continuous total of 56 days, taking due account of other ICTOs (s 65(3))

Appropriate person	SA: a “relevant person’s representative” must be appointed by the supervisory body (Sch A1, para 139) An independent mental capacity advocate must also be appointed in a number of circumstances (ss 39A, 39C, 39D)	A “nominated person” must be in place (s 15) An “independent mental capacity advocate” is also necessary (s 35)	A “named person” is to be identified (ss 250-254), subject to amendments in the Mental Health (Scotland) Act 2015 (Commencement No 4 and Transitional and Savings Provisions) Order 2017 Every person shall have a right of access to independent advocacy (s 259(1))
Role of the Court of Protection / Review Tribunal / Mental Health Tribunal	The Court of Protection can authorise the deprivation of liberty in settings other than care homes and hospitals, and in respect of 16 and 17 year-olds (ss 4A(3)-(4) and 16(2)(a)) Challenges to SA and UA may be made to the Court of Protection, which may vary or terminate the authorisation (s 21A)	On application or reference, the Review Tribunal may revoke, vary, or take no action in respect of TPA (s 51) and may revoke or take no action in respect of STA (s 52) In either case, the Review Tribunal may recommend specific actions and further consider the matter in the event of non-compliance (s 53)	On application, the Tribunal may revoke SD (s 50) Appeals may be made against the Tribunal’s decisions to authorise CTO and ICTO, and in respect of its refusal to revoke SD (s 320)

Safeguarding and Public Protection / Deprivation of Liberty Safeguards (DoLS) Team

The Supreme Court Judgment for DoLS 2026

Mental Capacity Act and Deprivation of Liberty Safeguards Action Plan 2026-2027

RAG Rating - Red ■ Out of Time Frame. Amber ■ Within Timeframe. Green ■ Completed.

	Recommendations	Action Required	Lead	Evidence of completion	Target Date	RAG
1.0	Implement immediate organisational response to ensure compliance with the Supreme Court judgment (AGNI) and minimise risk of unlawful deprivation of liberty	Amend all relevant paperwork to reflect the new legal threshold AGNI Review the DoLS pending list to establish priority cases Establish an urgent duty/screening system to triage and prioritise incoming DoLS applications Review all current Standard Authorisations prior to the date of the	DoLS/ MCA Manager	All current forms have been amended to reference the new supreme court judgment All applications on the pending list have been reviewed Duty rota in place and operational Audit report completed and actions logged.	Completed: 09.06.26 Completed: 08.06.26 Completed: 15.06.2026 Review completed on: 08.06.26	



		judgment to identify any unlawful deprivations of liberty Issue a briefing paper outlining changes and immediate expectations		Briefing paper developed and approved by the Executive Board. The briefing paper has been circulated throughout the Health Board, added to the Safeguarding website and bulletin board.	Completed: 13.07.2026	
		Develop and implement a decision-making flowchart to support clinical areas in identifying, assessing and escalating potential deprivations of liberty under the revised legal threshold.		A step-by-step flow chart has been developed. Once approved via the governance route the flow chart will be circulated.	Completed 30.07.26	
		Submit a paper to the Executive Board outlining the implications of the Supreme Court judgment, seeking endorsement of the interim operational approach, acknowledgement of associated legal and operational risks, and agreement on governance and oversight arrangements.		An Executive Board paper has been developed and will be presented at the next Executive Board meeting	01.07.2026	
		Update organisational risk register to reflect legal and operational risks arising from judgment		Risk logged and reviewed at governance forum	Completed 08.06.26	

		Monitor emerging national guidance and case law		Maintain liaison with Welsh Government, NHS Wales and legal advisors. Attend webinars and relevant training provided.	Review quarterly	
2.0	Embed the requirements of the Supreme Court judgment into organisational policy, training, and practice	Review and update all relevant DoLS policies and procedures Develop and deliver training programme for staff on new legal requirements Update practice guidance and tools to reflect new case law Establish ongoing audit process to monitor compliance	DoLS/ MCA Manager	Current Standard Operating Procedures (SOPS) are currently undergoing a review. Legal advice obtained, is to wait for official guidance before finalising and circulating. Initial amendments have been made to ensure the training package reflects the immediate changes required. No further amendments can be made until official guidance is received. A basic step-by-step DoLS Flow chart has been developed. Further detailed education material will be developed once official guidance has been received: Such as; further flow charts, leaflets, posters, guides. The DoLS data base has been updated to add additional data relating to the new judgment, required to monitor and review cases.	Q2/Q3 2026-27 TIMESCALE (please note: although a timescale is provided, as this is a change in law, we await official guidance from UK/Welsh Government and this may require additional activity) Completed: 13.07.26	AMBER

		Establish a communication and engagement programme		The data analyst will continue to audit on a monthly basis and provide a quarterly report to the MHLC committee. Re-advertise the MCA/DoLS training lead secondment post. Deliver briefing sessions to senior nurses, ward managers, safeguarding leads and operational managers	Rolling action, reviewed quarterly Q2 2026/27 Q2/Q3 2026/27	
3.0	Governance and Assurance: Provide assurance to organisational governance structures regarding implementation of the judgment.	Reporting to MHLC Committee. Compliance review. Monitoring of application volumes and backlog. Monitoring of unlawful deprivation risks. Reporting of significant incidents linked to the judgment	DoLS/ MCA Manager	Quarterly committee reports Audit reports Update the Risk register as and when required Develop a local improvement plan Complete escalation process	Q2 2026-27 Monthly Review quarterly Q2 2026-27 As and when required	Amber



Appendix 3

Safeguarding and Public Protection / Deprivation of Liberty Safeguards (DoLS)

Briefing on the Supreme Court Judgment: The Attorney General for Northern Ireland's Reference (Deprivation of Liberty) [2026] UKSC 16

Background: What was the position under Cheshire West?

For someone to be deprived of their liberty, the law, from a case: *Storck v Germany* (2005) 43 EHRR 6 identified that three elements must apply:

- An objective element: The person is confined to a restricted space for a non-negligible period of time.
- A subjective element: The person has not given valid consent.
- Imputability to the State: The state is aware of the confinement and is responsible for making sure the confinement does not take place without appropriate legal safeguards.

During this time, it was often difficult to determine the difference between a restriction and a deprivation of liberty.

In 2014, the *Cheshire West* ruling (*P v Cheshire West and Chester Council* [2014] UKSC 19) attempted to simplify this by introducing the 'acid test', by excluding the context of the situation or reasons for care and focus on two aspects:

- Are they under continuous supervision and control?
- Are they free to leave?

If both answers suggest restrictions, and the person lacks capacity to consent to the arrangements, there is likely to be a deprivation of liberty, requiring legal authorisation. This led to a large increase in DoLS and court applications and meant individuals residing in supportive living or family settings, who were often happy and settled, were often still considered legally deprived of their liberty, resulting in a formal legal authorisation.

As a result, the system became overloaded and resources were taken away from more serious restrictive cases.

The recent Supreme Court case, brought by the Attorney General for Northern Ireland (AGNI) asked a fundamental question:

Did *Cheshire West* move so far away from the original European Legal approach?

Introduction to the recent Supreme Court Judgment

On the 2nd June 2026, the Supreme Court made an important new decision about DoLS. All seven Justices of the Supreme Court agreed to overturn the 2014 *Cheshire West* ruling.

The new Supreme Court judgment does not remove safeguards or reduce human rights protections. Instead, it changes the legal test, bringing back what is viewed to be a more balanced and context-based approach, closely aligned with cases that have been heard in the European Court of Human Rights. Ultimately this new shift brings both opportunity and risk.



NOTE: 39 Essex Chambers: A summary of the judgment: [2026-UKSC-16-Summary-for-website-2-June.pdf](#)

The key message is that, this is not a reason to panic, but it is also not a reason to be complacent. The focus now is on careful, confident application of the new approach in practice.

The Ruling: What has changed?

The Supreme Court decided that the Cheshire West “acid test” was too rigid and highlighted, when deciding whether someone is deprived of their liberty, should not be based on one fixed test alone.

The court has introduced a multifactorial assessment and professionals are now expected to look at the whole situation (the context) including:

- The person’s living situation and care arrangements.
- Whether the care is normal for someone with their needs.
- The level of control or restriction being used (must be appropriate and proportionate).
- The person’s feelings, wishes, and experience (Does the patient have a basic understanding of the circumstances and express feelings of happiness to be able to give valid consent to those arrangements).

The Court made clear that supportive, caring environments (such as family homes or placements where the person appears settled) do not automatically rule out a deprivation of liberty. The key consideration remains whether the individual is subject to levels of supervision and control and restrictions placed to restrict movement, rather than how normal the setting appears or how well-intentioned the care is. However, this should not be interpreted as meaning that all such arrangements amount to a deprivation. The assessment depends on the specific level of control and restriction in each case and should not be assumed.

NOTE:

- Safeguards are still needed where someone is truly deprived of their liberty.
- The law still requires decisions to be necessary and proportionate.
- Focus attention on people in more restrictive or high-risk situation.
- Professionals must use more careful judgment, rather than relying on a simple test.

What this means in practice:

It is important to note that DoLS remains but staff can no longer rely on the ‘acid test’. The new test is that practitioners must consider the individual’s ‘concrete situation’ (first identified in *Engel v The Netherlands* (1976) and then expanded on in *Guzzardi v Italy* (1980)).

Practitioners must consider the following:

- Look at the whole situation.
- Consider whether the care provided is normal and appropriate for the person.
- Think about how restrictive the arrangements really are.
- The length of time they’ve been in place.
- The effect they are having on the individual.



- The manner in which they were implemented.

A key point of the judgment is what the Supreme Court calls the “prison cell” idea. The most obvious example of being deprived of liberty is being locked in a prison. The more a person’s care situation looks like this, the more likely it is to be a deprivation of liberty. The less it looks like this (such as care in a person’s own home, a family setting, or in the community) the less likely it is to meet that threshold.

This means that each situation needs careful consideration. The focus should be on why the person is being restricted and what those restrictions actually look like.

NOTE:

- Not every situation with supervision and control will need a DoLS authorisation.
- More professional judgment is required.
- Decisions must be clearly recorded and explained.
- Context and individual circumstances matter.
- Good record keeping and reasoning are essential.
- Safeguards must still be used where there is a clear deprivation of liberty.
- The Mental Capacity Act principles still apply.

What should you do now?

- Continue to apply for a DoLS where there is a clear deprivation of liberty.
- Start to consider context more carefully in each case.
- Ensure decisions are well documented and evidence-based.
- Start to consider the person’s ability to give valid consent to the current arrangements and clearly record the decision.
- Where the person is unable to give valid consent, ensure a mental capacity assessment is undertaken and recorded in full.
- Keep up to date with local and national guidance as it develops.
- Where there is doubt, staff should err on the side of identifying a potential deprivation of liberty and seek advice/authorisation.
- Seek advice from the DoLS Team or BCUHB Legal Services if you are unsure.

Mental Capacity Act (MCA):

NOTE: The Supreme Court judgment impacts Article 5 (DoLS/DoL scope only). It does not replace or override the wider MCA framework for day-to-day decision-making

The recent Supreme Court judgment relates specifically to Article 5 (deprivation of liberty). It remains essential to emphasise that all other decision-making must continue to follow the statutory principles of the MCA. Staff must still assess capacity and make best interest decisions in line with the MCA wherever a person lacks capacity in relation to care or treatment.

What is Valid consent?

This is one of the most important changes following the Supreme Court judgment. It means that a person might still be able to consent to their care arrangements for Article 5 purposes, even if they lack capacity under the Mental Capacity Act.



This is a change from previous practice and it is no longer correct to assume that “If a person lacks capacity, they cannot give valid consent”. A more individual and case-by-case approach is required.

Where an individual has a basic understanding of their situation and expresses acceptance or contentment, this may be relevant to the subjective element identified in *Storck v Germany*. However, it should not be treated as determinative and must be considered as part of a broader, context-based assessment alongside the overall level of control and restriction.

There must be clear evidence of what the person understands and how they express their views. Staff must record how the person shows acceptance or agreement (e.g. words, behaviour, engagement). If there is any doubt, you should not assume consent.

Where there is doubt as to whether the person is consenting, such as any indication of the following:

- Objection or resistance.
- Distress or upset.
- Fluctuating wishes and views.
- Compliance driven by fear means that consent cannot be inferred.

In these situations, consent is not valid and a DoLS may be required.

NOTE:

At present there is no clear guidance on how to tell the difference between genuine acceptance and simply going along with and accepting the circumstances.

Staff must proceed carefully and ensure all decisions are well reasoned and clearly recorded. It is also important to be aware that different people (family, professionals) may have different views, so clear documentation is essential. Any disagreements may lead to a safeguarding referral or an application to the Court of Protection. Clear and accurate records are essential and may be relied upon as evidence of how decisions were made.

Immediate changes:

While the judgment has immediate effect, in the absence of national guidance the Health Board should adopt a proportionate, risk-based interim approach rather than implying immediate wholesale change. Although full implementation cannot be achieved immediately, staff are expected to begin embedding changes in day-to-day practice, including a more multifactorial approach to assessment, while further guidance is awaited.

What happens now:

Managing Authorities (Hospital Wards)

- Automatic reliance on the old acid test must stop. Applications can no longer be made purely based on whether a person is under continuous supervision and control and not free to leave. Each case must now be considered individually and in context.
- Practitioners should focus on the person’s actual experience of care, not just the level of restriction.



- Greater emphasis must be placed on the persons wishes and feelings, level of understanding and acceptance (or otherwise) of the arrangements.
- Care plans must clearly evidence, what restrictions are in place, why they are necessary and how they are proportionate to the person's condition and risks.
- Staff should speak with the person to explore whether they are able to consent to the arrangements.
- Decisions must be clearly recorded, including the reasoning behind whether a deprivation of liberty is (or is not) occurring and evidence of the person's views and engagement.
- When submitting a DoLS application, ensure clear and detailed information outlining any distress, objections or resistance to care and treatment. Along with high levels of restraint or institutional control. Clearly record the patient's wishes and feelings and level of understanding of current circumstances.
- Where there is disagreement, uncertainty or borderline cases, staff should seek DoLS Team or Legal Services for advice.

Supervisory Bodies (DoLS Team):

A clear prioritisation strategy has been implemented, focusing on cases involving objection, distress, high levels of restraint or institutional control.

The role of the Best Interest Assessors (BIAs) and Mental Health Assessors is now more complex and decision making is no longer based on a simple fixed test and requires a balanced and professional judgment taking into account the full circumstances of each case.

Practitioners must carefully explore whether the person is consenting, identifying whether the person is genuinely agreeing or simply going along with care (passive objection).

The absence of objection must not automatically be taken as consent and greater emphasis must be placed on the persons:

- Experience of care.
- The persons wishes', feelings, and level of understanding.
- Whether any restrictions are necessary and proportionate.

When deciding whether a deprivation of liberty is taking place, Best Interest Assessors should now consider:

- Why the restrictions are in place (the reason for the confinement).
- What the restrictions look like in practice.
- How closely the situation reflects the "prison-style" level of control (the "prison cell" idea).

The more the arrangements resemble a highly controlled environment, the more likely they are to amount to a deprivation of liberty.

DoLS Authorisers:

Decisions must now clearly explain why Article 5 does or does not apply and this must be clearly articulated. Authorisers must show clear reasoning, including:

- Whether the person is consenting or appears to accept the arrangements.
- Whether there is any 'serious doubt' about that consent.
- The overall impact of the restrictions, rather than looking at them in isolation.



Authorisers must move away from relying on categories alone and instead provide clear, evidence-based reasoning for every decision.

Assuming someone is consenting because they are settled or not objecting. This must always be tested and evidenced.

Section 12(2) Doctor (Mental Health Assessor / Eligibility Assessor):

The Supreme Court judgment does not change the statutory role of Section 12(2) doctors. However, it has important implications for practice. Doctors should be aware that the threshold for what constitutes a deprivation of liberty remains widely drawn, meaning more individuals may now fall within DoLS. As part of the eligibility assessment, there is an increased need to give careful consideration to the interface with the Mental Health Act 1983, particularly in cases involving objection, fluctuating presentation or treatment for mental disorder. Assessors should ensure clear, well-reasoned decisions about whether the person is ineligible due to the MHA, recognising that borderline cases may arise more frequently.

While we do not request formal capacity assessments under DoLS, doctors should remain mindful of issues of valid consent and how these may inform the wider MCA/MHA interface in their reasoning. Robust recording of the rationale for eligibility decisions will be essential given the broadened application of DoLS following the judgment.

Common misunderstandings following the judgment:

“DoLS no longer applies” – This is incorrect. DoLS legal framework remains in place. What has changed is who may fall within it.

“If someone isn’t objecting, they are consenting” – This is incorrect. A lack of objection does not mean consent. People may appear to go along with care without truly agreeing. Consent must be shown through clear signs of understanding, engagement or contentment.

“Capacity assessments are no longer needed” – This is incorrect. The Mental Capacity Act has not changed. Capacity assessments remain essential. What has changed is that capacity and consent are not always the same thing.

“Providers can now use more restrictive care” – This is incorrect. In fact, the risk has increased. If consent is wrongly assumed, this could lead to unlawful deprivation of liberty and potential human rights breaches.

‘Roles’ like BIAs will become less important” – This is incorrect. Decisions are now more complex, which means there is a greater need for skilled, confident professionals to make and evidence them properly.

The key message is that practice must be more careful, evidence-based, and person-centred than ever before.

Useful Links:

[A Reference by the Attorney General for Northern Ireland of a devolution issue under paragraph 34 of Schedule 10 to the Northern Ireland Act 1998 - UK Supreme Court](#)



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board



Case ID Number:			
DEPRIVATION OF LIBERTY SAFEGUARDS			
BEST INTERESTS DUTY/SCREENING ASSESSMENT – NO DEPRIVATION			
This form is being completed in relation to a request for a standard authorisation where it is considered likely that the persons situation does not amount to a deprivation of liberty.			
This form is being completed in relation to a review of an existing standard authorisation that under Part 8 of Schedule A1 to the Mental Capacity Act 2005 because it is expected that the persons situation does not now amount to a deprivation of liberty.			
Full name of the person being assessed			
Date of birth (or estimated age if unknown)		Est. Age:	
Name and address of the care home or hospital where the person is, or may become, deprived of liberty (include the Ward if a hospital)			
The present address of the person being assessed if different from above.			
Name and address of the Assessor			
Profession of the Assessor			
Name of the Supervisory Body			
MATTERS THAT I HAVE CONSIDERED AND TAKEN INTO ACCOUNT			
Note: before embarking on the full best interests assessment consultation process, the Best Interests Assessor may first wish to check that there is prima facie evidence that a deprivation of liberty may be occurring, or is likely to occur, since, if it is apparent that there is no deprivation of liberty, the full best interests consultation process will be unnecessary.			
I have considered the views of the relevant person			
I have considered what I believe to be all of the relevant circumstances and, in particular, the matters referred to in section 4 of the Mental Capacity Act 2005			
I have considered any assessments of the person's needs in connection with accommodating the person in the hospital or care home			
I have considered any care plan that sets out how the person's needs are to be met while the person is accommodated in the hospital or care home.			
In carrying out this assessment, I have considered any information given to me, or submissions made, by any of the following:			
(a) any relevant person's representative appointed for the person			
(b) any IMCA instructed for the person in relation to their deprivation of liberty			



VIEWS OF THE PERSON, ANY OTHERS YOU HAVE CONSULTED AND THE MANAGING AUTHORITY

Please note this is not the full consultation process required for a Form 3 but a record of details which have helped you arrive at the conclusion that the person is not deprived of liberty.

BEST INTERESTS ASSESSMENT TO EVIDENCE WHY THE PERSON IS NOT DEPRIVED OF THEIR LIBERTY

Use a multifactorial approach to inform your analysis.

In my opinion although the person is, or is to be, kept in the hospital or care home for the purpose of being given care or treatment the circumstances do not amount to a deprivation of liberty for the following reasons

- Consider the concrete situation of the person including type, duration, effects and manner of implementation of the measures in question.
- Examine the person's awareness of the arrangements and their wishes and feelings in relation to them,
- Consider whether coercion is present or the use of sedative medication.
- Could the person physically leave, would a request to leave be facilitated.

(NB: If an objective deprivation of liberty is identified or indicated please do not use this form but continue assessing using a Form 3):

RECOMMENDATIONS

Having found the person is not subject to a deprivation of liberty, the Deprivation of Liberty Safeguards are not required. Have you identified any issues or areas of concern which need to be passed on to others

PLEASE NOW SIGN AND DATE THIS FORM

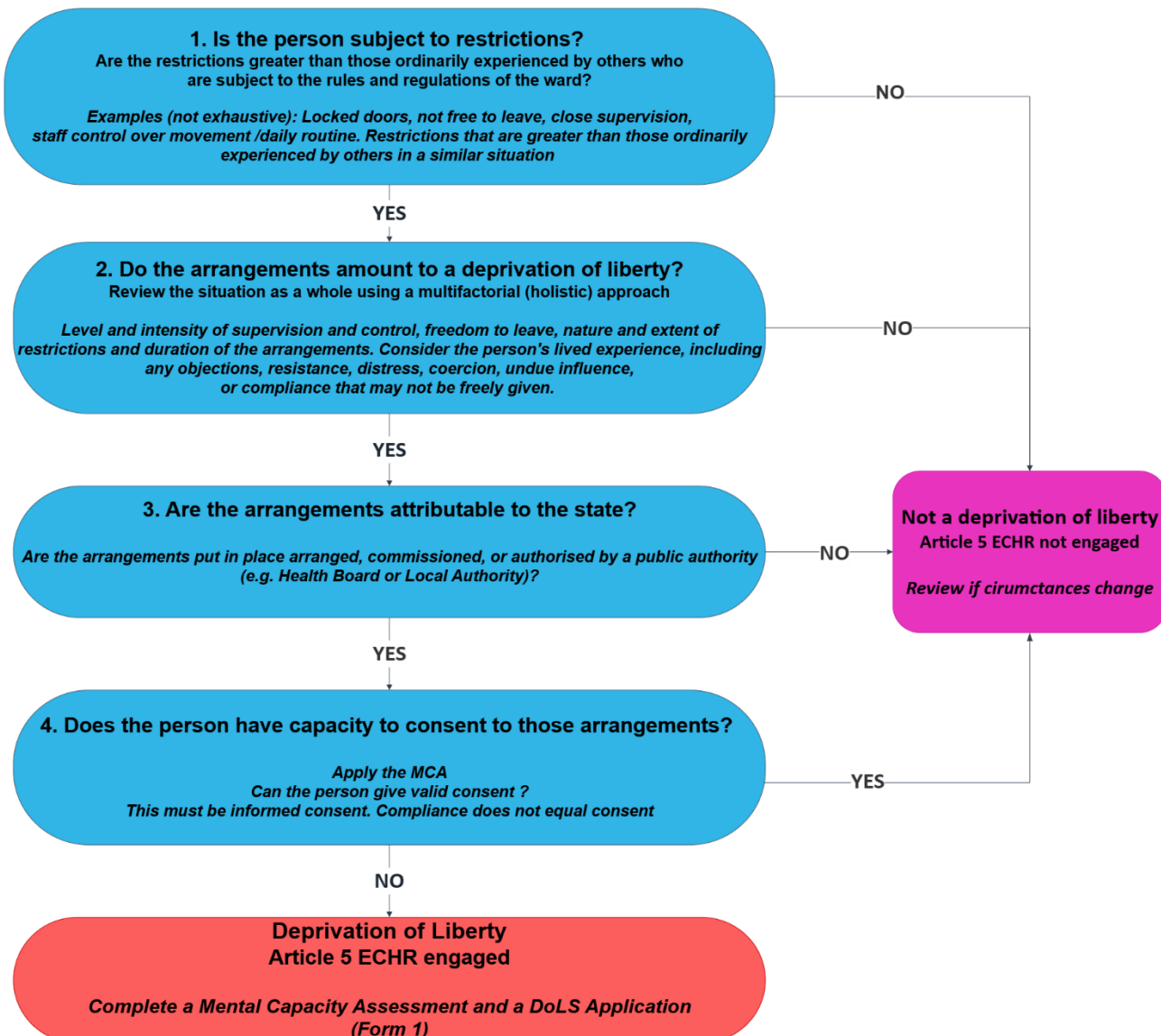
Signed	
Date	



Safeguarding and Public Protection / Deprivation of Liberty Safeguards Team

Deprivation of Liberty Safeguards (DoLS) Process Following the 2026 Supreme Court Judgment

A practical step by step decision flowchart



Key Takeaways

It's the overall picture, not a single test

Always act in persons best interests

Ensure MCA is followed

Seek legal advice if unsure

Mental Health Legislation Committee

HIW Assurance Report (MHA Actions): January - March 2026

Dyddiad y Cyfarfod Date of Meeting	06 August 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Matthew Joyes Deputy Director for Legal Services Erika Dennis Quality Lead Manager Clare Jones Quality Assurance Manager
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Teresa Owen, Executive Director of Allied Health Professionals and Health Science Pam Wenger, Director of Corporate Governance
Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol **Executive Summary**

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales who inspect NHS services and regulate independent healthcare providers against a range of standards, policies, guidance and regulations to highlight areas requiring improvement.

HIW also monitor the use of the Mental Health Act and review the mental health services to ensure that vulnerable people receive good quality of care in mental health services.

This report provides assurance that following inspections, recommendations/actions in relation to the Mental Health Act.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Power of Discharge Group	21/04/2026	Noted.

Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms

HIW	Healthcare Inspectorate Wales
MHA	Mental Health Act
AMaT	Audit Management and Tracking System

HIW Assurance Report (MHA Actions): January - March 2026

Y SEFYLLFA **SITUATION**

This report provides assurance that following inspections, recommendations/actions in relation to the Mental Health Act.

Y CEFNDIR **BACKGROUND**

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales who inspect NHS services and regulate independent healthcare providers against a range of standards, policies, guidance and regulations to highlight areas requiring improvement.

HIW also monitor the use of the Mental Health Act and review the mental health services to ensure that vulnerable people receive good quality of care in mental health services.

The Health Boards Quality Assurance and Regulation Team track and monitor HIW Improvement / Action Plans via the Health Boards Audit Management and Tracking System (AMaT), as with other quality regulatory activity.

Reporting on progress with service improvement actions is based on the most up to date position on the AMaT system. This may not always fully reflect the progress of the service.

MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION

RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION

HIW and CIW carried out an Assurance Check of Conwy Disabilities Learning Team on 9th February 2026. The recommendations and actions pertaining to the Mental Health Act are as follows:-

Recommendation MD9/1

The Health Board must strengthen and standardise all MHA documentation and checks, ensuring that statutory requirements are met, records are complete and accurate, and that robust audit processes are put in place to prevent recurrence of these issues.

Action

Maintain ≥90% staff compliance with MHA intermediate/refresher training.

Progress Status

This action is in progress, with a completion date of 31st July 2026

Recommendation MD9/2

The Health Board must strengthen and standardise all MHA documentation and checks, ensuring that statutory requirements are met, records are complete and accurate, and that robust audit processes are put in place to prevent recurrence of these issues.

Action

MHA Office to maintain a live list of all CTOs and issue monthly “outstanding rights” lists to the MHA Manager for follow-up.

Progress Status

This action is in progress, with a completion date of 31st July 2026

Recommendation MD9/3

The Health Board must strengthen and standardise all MHA documentation and checks, ensuring that statutory requirements are met, records are complete and accurate, and that robust audit processes are put in place to prevent recurrence of these issues.

Action

Develop and implement a SOP for MHA Administrators covering rights, notifications and outcome letters

Progress Status

This action is in progress, with a completion date of 30th October 2026

Recommendation MD9/4

The Health Board must strengthen and standardise all MHA documentation and checks, ensuring that statutory requirements are met, records are complete and accurate, and that robust audit processes are put in place to prevent recurrence of these issues.

Action

Configure future Electronic Health Records (EHR) to flag missing MHA documents for follow-up (as part of the digital programme).

Progress Status

This action is fully complete and approved

*The Quality Assurance Manager attends local governance meetings in relation to the completion and monitoring of the HIW Improvement Plans, providing corporate support and any escalation requirements.

*All actions and progress are reported on a monthly basis to the Health Boards Regulatory Assurance Group (RAG), with chairs reporting to the executive team. Regular reports on progress are also provided to the Quality Safety and Experience (QSE) Committee and to Board.

ARGYMHELLION RECOMMENDATIONS

The Committee is asked to **NOTE** the contents of this report.

ASESIAD / ASSESSMENT		
Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Priorities	    	
	1. Building an effective organisation	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: 4. Improving quality outcomes and experience.	
Yr Egwyddorion Dylunio Design Principles	People First Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	Not applicable	
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable
Asesiad o'r Effaith Economaidd-gymdeithasol <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm:	Not applicable

Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	If no, please include rationale:	
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Galluogwyr Ansawdd Enablers of Quality All Apply	Meysydd Ansawdd Domains of Quality All Apply
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant</u> <u>Wellbeing of Future Generations Act – Wellbeing Goals</u>	Not Applicable	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: No - Not Applicable	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Do/Yes: ☐ Canlyniad/Outcome:	Naddo/No: ☒ Os naddo, dylech gynnwys y rheswm: If no, please include rationale:
Asesiad o Effaith ar Ddiogelu Data	Do/Yes: ☐ Canlyniad/Outcome:	Naddo/No: ☒

<i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol Legal	Yes (Include further detail below) Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales who inspect NHS services and regulate independent healthcare providers against a range of standards, policies, guidance and regulations to highlight areas requiring improvement. HIW also monitor the use of the Mental Health Act and review the mental health services to ensure that vulnerable people receive good quality of care in mental health services.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	



Mental Health Legislation Committee

Associate Hospital Managers (AHM) Update Report April - June 2026

Dyddiad y Cyfarfod Date of Meeting	06 August 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Wendy Lappin Mental Health Act Legislation Manager Matthew Joyes Deputy Director for Legal Services
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Teresa Owen, Executive Director of Allied Health Professionals and Health Science Pam Wenger, Director of Corporate Governance
Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol **Executive Summary**

The purpose of this paper is to provide an update on Associate Hospital Managers (AHM) activity for the period April to June 2026, including Mental Health Act hearings, statutory scrutiny of detention paperwork, training compliance, recruitment and governance arrangements. The report is intended to support assurance to the Committee regarding the effectiveness, compliance and capacity of the AHM function.

During the reporting period, 33 hearings were held, predominantly relating to section renewals, including Community Treatment Order renewals. Three appeal hearings were held within the quarter. The majority of hearings were held via Microsoft Teams, patient choice of venue is routinely offered where capacity allows. Two hearings that proceeded resulted in discharge by the panel, one Section 3 appeal and a CTO renewal hearing, both were held via Teams.

There has been an improvement in the receipt of the patients' proformas stating their choices being returned for CTO patients.



Performance against the locally agreed hearing quality standard of six weeks following renewal has shown a continued improvement this quarter with 81.8% of hearings held within standard.

Training compliance within the Associate Hospital Manager cohort remains strong and has seen a continued improvement with ten persons being 100% compliant. Compliance is actively monitored and supported through forums and training events. Information Governance and the Mental Health Act training amongst others report a compliance of 100%.

An additional two persons have been interviewed for the Associate Hospital Manager role and will be joining the cohort within the next quarterly period. There is the need to increase the numbers due to a number of hearings (four) needing to be rearranged this quarter due to a lack of panel members being available.

The Committee is asked to note the contents of this report and to acknowledge the continued commitment of Associate Hospital Managers.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Power of Discharge Group	21/07/2026	Noted.

**Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms**

AHM	Associate Hospital Manager
CTO	Community Treatment Order
RC	Responsible Clinician
MHA	Mental Health Act



Associate Hospital Managers (AHM) Update Report April – June 2026

Y SEFYLLFA

SITUATION

This paper provides an update on the operation of the Associate Hospital Managers (AHM) function for the period April to June 2026. It includes Mental Health Act hearings activity, statutory scrutiny of detention paperwork, training compliance, recruitment and governance arrangements. The paper supports assurance to the Mental Health Legislation Committee regarding the effectiveness, capacity and statutory compliance of the AHM role.

Y CEFNDIR

BACKGROUND

Associate Hospital Managers have a statutory role under the Mental Health Act, including conducting managers' hearings and scrutiny of statutory documentation. Hearings continue to be held using a blended approach of Microsoft Teams and face-to-face formats, with patient choice of venue routinely sought where the patient has capacity.

Scrutiny of the clinical notes by the Associate Hospital Managers began again in 2026, an audit report will be produced at the end of the year.

MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION

Hearings Activity

Between April and June 2026, 33 hearings were held, primarily in relation to section renewals, including Community Treatment Order renewals and three Section 3 Appeal Hearings were held within the quarter. Six hearings were held face to face and 27 via Teams. Two hearings that proceeded resulted in discharge by the panel, one Section 3 appeal and a CTO renewal hearing, both were held via Teams.

A number of hearings did not proceed reasons are detailed within the table below.

Month and total arranged	Number of hearings		Reasons not held
	Held	Not Held	
April 11	9	2	One patient was regraded to informal status. One hearing the chair was stuck in traffic due to an accident on the A55, the hearing went ahead within a week and the patient remained detained.

May 17	12	5	Two patients were regraded to informal status. One hearing was postponed – not enough panel members, the hearing was held in June and the patient remained detained. One hearing was postponed – the Care Coordinator had not been made aware of the date, the hearing was rescheduled for June, the patient was subsequently discharged prior. One hearing was postponed – the panel were missing an important report, the hearing was held in June and the patient remained detained.
June 14	12	2	One patient was discharged. One hearing was rescheduled the Care Coordinator had left, the hearing was held within the month of June and the patient remained detained.

Of the 33 hearings held 14 patients were supported by an advocate, three represented by a solicitor and five had their nearest relative or family member attend. One hearing also included a translator present. The record of decision forms noted 11 patients attended for their hearings.

There were 13 hearings held where no one attended, eight of the patients had returned their proforma forms which state their wishes this includes if they wish to attend, wishes for a solicitor, IMHA or family member to be invited. In addition, one confirmation was received via email from a solicitor rather than the use of the proforma. There were instances where family and solicitors were invited but did not attend, supporting emails confirmed that the patient still wished for the hearing to go ahead without the attendance of a solicitor.

There has been an improvement of CTO patients' proformas being returned out of the 12 CTO hearings eight proformas were received.

Performance against the locally agreed hearing quality standard of six weeks following renewal improved during this period, with 81.8% of hearings held within standard.

Scrutiny

Scrutiny sessions have been reinstated since February, this involves the Associate Hospital Managers viewing the clinical notes and using a specific audit tool to report on. A scrutiny audit report will be produced at the end of 2026.

Training and Workforce

Training compliance within the Associate Hospital Manager cohort remains strong overall, with compliance monitored through individual meetings. Recruitment and retention remain stable, supported by quarterly forums and training events.

Compliance figures are reported below, at the time of writing the report ten Associate Hospital Managers (63%) are 100% compliant with the training.

Training		Training	
Environmental Waste and Energy	94% ↑	Violence and Aggression	88% ↑
Equality Diversity and Human Rights	75% ↓	Welsh Language Awareness	100% →
Fire Safety	94% ↑	Dementia Awareness	94% →
Health, Safety and Welfare	100% →	Fraud Awareness	100% →
Infection Prevention and Control	100% ↑	Violence against women, domestic abuse	94% →
Information Governance	100% ↑	Mental Capacity Act	88% ↓
Safeguarding Adults	88% ↓	Paul Ridd LD training	100% ↑
Safeguarding Children	100% ↑	Mental Health Act	100% →
Anti Racism	100% →		

Two additional persons have been interviewed and offered the role of Associate Hospital Manager within the quarter; both are progressing through checks with a hope to start training and shadowing panels within the next quarterly period. There is a need to increase the cohort due to four hearings this month needing to be rearranged due to a lack of volunteers for the panels, it has been discussed within the forum meeting that members will identify if they can assist if the Health Board is struggling if they feel they are able to rearrange any personal commitments.

RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION

There are no current key risks or matters for escalation.

ARGYMHELLION RECOMMENDATIONS

The Committee is asked to **NOTE** the contents of this report.

ASESIAD / ASSESSMENT		
Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Priorities	    	
	1. Building an effective organisation	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: 4. Improving quality outcomes and experience.	
Yr Egwyddorion Dylunio Design Principles	People First Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	The MHA department continues to experience significant capacity pressures within the team, with Royal Assent being gained for the Mental Health Act 2025 this will increase workloads and demands on the team and the Associate Hospital Managers going forward.	
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant</u> <u>Wellbeing of Future Generations Act – Wellbeing Goals</u>	Not Applicable Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	The use of the Mental Health Act sections apply to all persons and all policies in relation to the use of the Mental Health Act and Hospital Managers Hearings have been equality impact assessed. There are two specific policies related to Associate Hospital Managers.
Asesiad o'r Effaith Economaidd-gymdeithasol <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm:	Not applicable

<i>Have you undertaken a Socio-Economic Impact Assessment</i>	If no, please include rationale:	
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i>	Galluogwyr Ansawdd Enablers of Quality All Apply	Meysydd Ansawdd Domains of Quality All Apply
<u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant</u> <u>Wellbeing of Future Generations Act – Wellbeing Goals</u>	Not Applicable	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog <i>A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog:</i> Armed Forces Covenant Due Regard Duty <i>Have you considered the Armed Forces Covenant Due Regard Duty?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	



Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol Legal	Yes (Include further detail below)	
	There is a legal requirement that patients are required to have a renewal hearing undertaken by the Associate Hospital Managers on renewal of a detention. Whilst there is no specified timeframe for this to happen within the renewal period one must occur otherwise the renewal detention will become invalid.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

Mental Health Legislation Committee

Power of Discharge Group Chair's Report – July 2026

Dyddiad y Cyfarfod Date of Meeting	06 August 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Matthew Joyes Deputy Director for Legal Services
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Teresa Owen Executive Director of Allied Health Professionals and Health Science Pam Wenger Director of Corporate Governance

Pwrpas yr Adroddiad Report Purpose	For Noting / Approval
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Crynodeb Gweithredol **Executive Summary**

The Power of Discharge Group is held on a quarterly basis to provide a forum for Associate Hospital Managers to discuss matters related to their role, chaired by the Deputy Director for Legal Services.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Power of Discharge Group	21/07/2026	Items for report discussed.

Acronymau / Rhestr Termau
Acronyms / Glossary of Terms

AHM	Associate Hospital Manager
CTO	Community Treatment Order
RC	Responsible Clinician
MHA	Mental Health Act

Power of Discharge Group Chair's Assurance Report**Y SEFYLLFA**
SITUATION

The Power of Discharge Group is held on a quarterly basis to provide a forum for Associate Hospital Managers to discuss matters related to their role. The July meeting was chaired by the Deputy Director for Legal Services and considered operational updates, assurance reports, open actions and matters requiring escalation or ongoing oversight.

Y CEFNDIR
BACKGROUND

Section 23 of the Mental Health Act gives certain powers and responsibilities to Hospital Managers. In Wales, NHS hospitals are managed by Local Health Boards and the Local Health Board is therefore defined as the Hospital Managers for the purposes of the Act.

Hospital Managers have responsibility for ensuring that the requirements of the Act are followed, including ensuring that patients are detained and treated only as the Act allows, and that patients are fully informed of, and supported in, exercising their statutory rights. These responsibilities also apply in relation to Community Treatment Order patients.

In practice, decisions about discharge from detention and Community Treatment Orders are taken by Hospital Manager Discharge Panels, made up of Associate Hospital Managers who are not employees of the Health Board. They are directly accountable to the Board in the execution of their delegated functions via the Mental Health Legislation Committee.

MATERION PENODOL I'W HYSTYRIED
SPECIFIC MATTERS FOR CONSIDERATION

The minutes of the previous meeting were reviewed and accepted as accurate. The Group noted that the Director of Mental Health post remains vacant following the retirement of the previous postholder. This continues to have a practical impact on the appointment of a Vice Chair and on future representation from Mental Health and Learning Disabilities.

The Group reviewed its open actions. Training for Associate Hospital Managers on scrutiny of paperwork and detention documentation remains outstanding and is to be arranged once the vacant Mental Health Act administrator post is filled. The work to review patient information, to support informed choice about hearing format, also remains open and is being progressed through the Associate Hospital Manager forum.

The Associate Hospital Manager Update Report was received. Thirty-three hearings were held during the reporting period: twenty-seven by Microsoft Teams and six face-to-face. Hearings primarily related to section renewals and Community Treatment Order renewals. Two discharges were authorised during the quarter.

Hearing postponements were reported as arising from a range of issues, including panel availability, missing reports, staffing issues and wider operational factors. The Group also discussed ongoing parking difficulties at the Hergest Unit, with a further action agreed to follow up progress on parking access arrangements and consider whether this has contributed to recent hearings being rearranged because of lack of panel members.

The report noted that fourteen patients were supported by advocates, three by solicitors and five by relatives or nearest relatives. One Welsh-language translator was used, and eleven patients attended hearings directly. The Group agreed that future reporting should include the number of Welsh-speaking Associate Hospital Managers, in order to strengthen assurance around Welsh language provision.

Members discussed the potential value of benchmarking against other Welsh Health Boards, and an action was agreed for information to be sought from other Health Boards. The Group also requested a review of recent discharge decisions, including those made by the Mental Health Review Tribunal, to identify any emerging themes and share learning with Associate Hospital Managers.

The Mental Health Act Assurance Report was received. The Group noted that the Mental Health Review Tribunal has reviewed its process for listing hearings, but that this has not been well received by the Health Board and there are no plans for Hospital Managers' hearings to follow the same process. Three exceptions were reported during the period and were described as having been dealt with appropriately.

The Group discussed detention paperwork errors, including a recent issue involving incorrect patient details on Community Treatment Order documentation. Members highlighted the importance of scrutiny and of understanding the distinction between rectifiable and fundamental defects. This will be addressed through future training.

RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO

KEY RISKS / MATTERS FOR ESCALATION

The main matters for escalation are as follows:

- The ongoing vacancy in the Director of Mental Health post, which continues to affect the appointment of a Vice Chair and appropriate senior Mental Health and Learning Disabilities representation at the Group.
- The need to maintain sufficient Associate Hospital Manager panel availability, particularly where hearings are at risk of postponement because of panel availability, missing reports, staffing issues or other operational pressures.

ARGYMHELLION

RECOMMENDATIONS

The Committee is asked to:

- **NOTE** this report.

ASESIAD / ASSESSMENT		
Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Priorities	    	
	1. building an effective organisation	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: 4. Improving quality outcomes and experience.	
Yr Egwyddorion Dylunio Design Principles	People First Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	The MHA department continues to experience significant capacity pressures within the team, with Royal Assent being gained for the Mental Health Act 2025 this will increase workloads and demands on the team and the Associate Hospital Managers going forward.	
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	The use of the Mental Health Act sections apply to all persons and all policies in relation to the use of the Mental Health Act and Hospital Managers Hearings have been equality impact assessed. There are two specific policies related to Associate Hospital Managers. MHLD 0042 Associate Hospital Managers Procedure and

		MHLD 0032 Policy/Procedure for review of a patient's detention or CTO conducted by the Managers Discharge Panel.
Asesiad o'r Effaith Economaidd-gymdeithasol <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Galluogwyr Ansawdd Enablers of Quality All Apply	Meysydd Ansawdd Domains of Quality All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</u>	Not Applicable	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol Legal	Yes (Include further detail below)	
	This report is generated quarterly. The Mental Health Act (MHA) and MHA Code of Practice for Wales (CoPW) requires that the Health Board must ensure that there are Associate Hospital Managers available to conduct panels for the patients on their request or at the time of a renewal. These Managers cannot be employees of the Health Board to ensure that an independent view is taken when reviewing the detention.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

Mental Health Legislation Committee

ANNUAL 2025/26 STATUTORY ADVOCACY (IMHA) REPORT

Dyddiad y Cyfarfod Date of Meeting	06 August 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Joanne Janes Commissioning Manager - Mental Health and Learning Disability Division Zoe Prince Director of Nursing – Mental Health and Learning Disability Division Carole Evanson Director of Operations – Mental Health and Learning Disability Division
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Teresa Owen- Executive Director of Allied Health Professionals and Health Science
Pwrpas yr Adroddiad Report Purpose	For Noting and assurance

Crynodeb Gweithredol **Executive Summary**

This report has been prepared in response to a request from the Mental Health Act Legislation Committee for assurance regarding BCUHB's provision of Independent Mental Health Advocacy (IMHA) services across North Wales. The information presented is consistent with a report previously provided to the Quality, Safety and Experience Committee following a separate request for assurance and reflects the Health Board's annual position for 2025/26

The IMHA service is delivered by Conwy and Denbighshire Mental Health Advocacy Service (CADMHAS), which operates across a range of healthcare settings to ensure consistent access for eligible individuals.

The purpose of the IMHA service is to support qualifying patients in understanding their rights and the legal frameworks that apply to their care, particularly under the Mental Capacity Act 1983, as amended by the Mental Health (Wales) Measure 2010.

Part 4 of the Mental Health Measure establishes a statutory entitlement for all eligible inpatients in Wales who are receiving assessment or treatment for a mental disorder to request support from an Independent Mental Health Advocate (IMHA). This provision extends the Independent Mental Health Advocacy arrangements set out under the Mental Health Act 1983 and applies to a wider group of patients.

The entitlement covers both:

- individuals subject to compulsory measures under the Mental Health Act 1983; and
- individuals receiving assessment or treatment in hospital on a voluntary basis.

Eligibility applies across a range of inpatient settings, including specialist mental health hospitals, independent hospitals, and general hospitals where treatment for a mental disorder is being provided.

Regulations may specify the circumstances under which an individual may act as an IMHA, the conditions attached to the role, and the approval process required. This ensures consistency, quality, and safeguarding within the advocacy service.

A fundamental principle of Part 4 is that Independent Mental Health Advocacy must, as far as practicable, be provided by someone who is independent of those professionally involved in the patient's medical treatment. This independence is central to the purpose of IMHA and ensures that patients can receive impartial support to understand their rights, express their views, and engage in decisions about their care without conflict of interest. The legislation is clear that advocacy undertaken under specific statutory arrangements, such as the Mental Capacity Act 2005, does not compromise this independence.

Key assurance findings (appendix 1)

Appendix 1 is a quarterly assurance proforma and the following key assurance findings summarise the performance, quality, and statutory compliance of the IMHA service across BCUHB during 2025/26:

- There was high demand for advocacy services, with 1,300 patients supported during the year 25/26 (compared to 1258 24/25), predominantly compulsory patients (78%).
- Full statutory compliance achieved, with 100% of patients seen within 5 working days and no breaches recorded.
- Comprehensive service coverage, with IMHA provision available across 100% of BCUHB hospital settings.
- Strong service throughput, with 1,289 discharges closely aligned to new referrals, indicating effective case flow and capacity management.
- There was a sustained caseload, with 191 patients actively supported at year end, reflecting ongoing demand.
- Activity appropriately concentrated in mental health inpatient settings (87%), while maintaining access across independent and community-based settings.
- Workforce capacity and capability in place, with 11 WTE IMHAs, all meeting required standards.
- Quality assurance in place, with the provider holding a recognised advocacy quality performance mark. The provider reports that Welsh language needs are assessed as part of initial contact, with arrangements in place to provide advocacy support in Welsh where required.

Conclusion

Overall, the current IMHA contract is performing effectively and is compliant with statutory requirements. There are no immediate risks identified in relation to service delivery, access, or workforce capacity.

Committee Members should note that IMHA provision may be subject to future change following legislative reform to the Mental Health Act, which received Royal Assent in December 2025. The Health Board will continue to monitor these developments and assess any implications for service delivery and commissioning arrangements.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Not applicable for this report		

Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms

CADMHAS	Conwy and Denbighshire Mental Health Advocacy Service
IMHA	Independent Mental Health Advocacy
MCA	Mental Capacity Act – legislation that provides a framework for decision-making on behalf of individuals who lack capacity.
MH	Mental Health
MHLD	Mental Health and Learning Disabilities
Mental Health (Wales) Measure 2010 – Part 4	Welsh legislation that establishes a statutory right to Independent Mental Health Advocacy for eligible individuals in Wales.
SORD	Scheme of Reservation and Delegation
BCUHB	Betsi Cadwaladr University Health Board

ANNUAL 2025/26 STATUTORY ADVOCACY (IMHA) REPORT

1. **Y SEFYLLFA** **SITUATION / BACKGROUND**

- 1.1 All Health Boards have a statutory duty to instruct and make available an Independent Mental Health Advocacy (IMHA) service. The Mental Health Act 1983, as amended by the Mental Health (Wales) Measure 2010, requires all Health Boards to ensure the provision of independent Mental Health advocacy for qualifying compulsory and informal patients in Wales.
- 1.2 Under the Act the following people over the age of 16 are legally entitled to have an IMHA advocate.
- i) People who are detained under the Mental Health Act 1983, except where:
 - They have been detained in an emergency under Section 4
 - They have been detained under Section 5 holding powers
 - They have been taken to a place of safety under Section 135 and 136 of the Mental Health Act
 - ii) People who are "liable to be detained" including:
 - Where people are on leave of absence from hospital
 - Where people are absent without leave from hospital
 - Where a court order or application for admission has been made
 - Where people are subject to a community treatment order (CTO)
 - Where people are subject to guardianship
 - Where people are a conditionally discharged restricted patient
 - where people are a voluntary/informal patient and certain treatments, including neurosurgery, are being considered for them
- 1.3 The purpose of the IMHA service is to provide assistance to qualifying patients to ensure that they understand the legal procedures of the Act and the rights and safeguards to which they are entitled.
- 1.4 This may include assistance in obtaining information about any of the following:
- The patient's rights under the Act
 - The provision of the Act under which the patient qualifies for an IMHA
 - Any conditions or restrictions to which the patient is subject

- The medical treatment the patient is receiving, or which is being proposed or discussed, and the reasons for this
- The legal authority for providing such treatment
- The requirements of the Act which apply in relation to treatment

1.5 The responsibility for commissioning and managing the service sits with the Mental Health and Learning Disabilities Division (MHLD), and Conwy and Denbighshire Mental Health Advocacy Service (CADMHAS), who are commissioned to deliver the regional Independent Mental Health Advocacy service. The contract has been in place since February 2022 and runs until 31st March 2027.

2 **MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION**

2.1 The dataset represents the BCUHB statutory return and includes all qualifying patients for whom the Health Board is responsible, across NHS, independent and other settings.

In response to the Committee's request for assurance, the Health Board can confirm that the statutory duties under Part 4 of the Mental Health (Wales) Measure 2010 are being met. Assurance is provided through the performance, quality and compliance information summarised below

IMHA Quantitative Performance Summary – BCUHB (2025/26)

Measure	Compulsory Patients	Informal / Voluntary Patients	Total
New patients accepted into IMHA services	1,018	282	1,300
Patients in receipt of IMHA at year end (caseload)	168	23	191
Patients discharged from IMHA services	1,012	277	1,289

Patients seen within 5 working days	1,018	282	1,300 (100%)
Patients waiting over 5 working days	0	0	0 (0%)

Service Capacity and Coverage – BCUHB

Metric	Number
Total number of hospital settings	27
Hospitals with IMHA provision	27 (100%)
Total WTE IMHAs	11
Fully qualified IMHAs	8
IMHAs in training	3
IMHAs with additional qualifications	3
Quality performance mark	Yes

Activity by Setting – BCUHB Patients

Setting	New Patients	% Of Total Activity
NHS Mental Health Hospitals	1,137	87%
Independent Hospitals	104	8%
Other NHS Settings	28	2%
Other Settings (e.g. CTO/guardianship)	31	2%
Total	1,300	100%

IMHA Qualitative Summary – BCUHB (2025/26)

- 2.4 Qualitative feedback from the provider and patient experience data indicates that the IMHA service is delivering meaningful benefits for patients i.e. ensuring patients are fully heard, explaining, fully, issues to both parties in an understandable way and removing perceived barriers to enable effective therapeutic relationships. For example, an autistic patient detained under Section 3 presented challenging behaviour and limited communication. Through adapted communication, the IMHA increased engagement, improved family contact, and reduced challenging behaviour. Advocacy support is

consistently reported to improve patients' understanding of their rights and treatment, enabling greater involvement in care planning and decision-making.

- 2.5 Patients particularly value the independence of the advocacy role, which supports them to express their views and raise concerns, especially during periods of detention or vulnerability. IMHAs also play an important role in facilitating engagement with services and supporting resolution of concerns where they arise.
- 2.6 These qualitative insights complement the quantitative performance data, providing assurance that the service is not only meeting statutory requirements, but is also impactful, patient-centred, and supporting improved experience and outcomes
- 2.7 Annual and quarterly advocacy reports will be routinely presented to the Mental Health and Learning Disabilities (MHLDD) Divisional Senior Leadership Team, where they are subject to review, scrutiny, and provide assurance on service performance and compliance
- 2.8 The advocacy reports will also be incorporated into the governance framework of the Health Board, specifically feeding into the Mental Health Act Legislation Group. This will ensure that advocacy provision is subject to ongoing oversight, aligns with statutory requirements, and contributes to broader assurance in relation to compliance with mental health legislation, quality of practice, and patient rights

3 RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION

The continued high demand and challenging time requirements puts pressure on the provider and its staff. The value of the contract has remained static for the last 3 years with a small 1% increase. This puts the service at risk due to staff retention. Conversations are ongoing at a national level to address this.

As above the rising costs of delivering the service may impact on the ability of the service to continue to train staff, raised during National negotiations about the service.

4. ARGYMHELLION RECOMMENDATIONS

- 1.1 Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp:

The Mental Health Legislation Committee is asked to:

- Note the contents of the Annual 2025/26 Independent Mental Health Advocacy (IMHA) Report;
- Take assurance that statutory advocacy requirements under Part 4 of the Mental Health (Wales) Measure 2010 are being met across BCUHB
- Note the identified workforce and funding risks which will continue to be monitored through the Health Board's commissioning and governance arrangements

Appendix 1 – Mental Health Measure (Part 4) Annual Submission Proforma

Mental Health Measure (Part 4) - quarter 4 Submission Proforma

Local Health Board BCUIB		Select HB:	Summary
Indicator			Data relating to:
			2025/26
1	Total number of all hospitals within the Local Health Board [end of March census snapshot]		27
2	Total number of all hospitals which have arrangements in place to ensure advocacy is available to qualifying patients? [end of March census snapshot]		27
3	Total number of WTE Independent Mental Health Advocates (IMHAs) in the Local Health Board at the end of March [end of March census snapshot]		11
4	What is the qualification status of the IMHAs in the Local Health Board (see indicator 3) [end of March census snapshot]	Number of WTE IMHAs who satisfy appointment requirements	11
		Number of WTE IMHAs who are working towards the IMHA diploma	3
		Number of WTE IMHAs who have successfully completed the IMHA diploma	8
		Number of WTE IMHAs who have any additional qualifications	3
5	Does your advocacy provider have or is working towards a recognised advocacy quality performance mark (select from drop down list)?		Yes
6	Number of new qualifying patients accepted into IMHA services during the year: [annual count]	Compulsory patients	1018
		Informal/voluntary patients	282
		Total number of new qualifying patients accepted into IMHA services during the year	1300
7	Number of qualifying patients currently in receipt of IMHA services at the end of the year - i.e. the caseload: [end of March snapshot]	Compulsory patients	168
		Informal/voluntary patients	23
		Total number of qualifying patients currently in receipt of IMHA services at the end of the year	191
8	Number of qualifying patients discharged from IMHA services during the year: [annual count]	Compulsory patients	1012
		Informal/voluntary patients	277
		Total number of qualifying patients discharged from IMHA services during the year	1289
9	Of the qualifying compulsory patients who had their first contact with an IMHA during the year, how many had waited: [annual count]	Up to and including 5 working days following their request for an IMHA	1018
		6 working days or more following their request for an IMHA	0
		Total number of qualifying compulsory patients who had their first contact with an IMHA during the year	1018
10	Of the qualifying informal/voluntary patients who had their first contact with an IMHA during the year, how many had waited: [annual count]	Up to and including 5 working days following their request for an IMHA	282
		6 working days or more following their request for an IMHA	0
		Total number of qualifying informal/voluntary patients who had their first contact with an IMHA during the year	19



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Betsi Cadwaladr
University Health Board

Mental Health Measure Part 4

Local Health Board		Select HB:
Indicator		Data relating to:
		2025/26
1	Total number of all hospitals within the Local Health Board [end of March census snapshot]	27
2	Total number of all hospitals which have arrangements in place to ensure advocacy is available to qualifying patients? [end of March census snapshot]	27
3	Total number of WTE Independent Mental Health Advocates (IMHAs) in the Local Health Board at the end of March each year [end of March census snapshot]	11
4	What is the qualification status of the IMHAs in the Local Health Board (see indicator 3) [end of March census snapshot]	Number of WTE IMHAs who satisfy appointment requirements
		Number of WTE IMHAs who are working towards the IMHA diploma
		Number of WTE IMHAs who have successfully completed the IMHA diploma
		Number of WTE IMHAs who have any additional qualifications
5	Does your advocacy provider have or is working towards a recognised advocacy quality performance mark (select from drop down list)?	Yes

Mental Health Measure (Part 4) - quarterly Submission Proforma

Local Health Board		Select HB:	NHS Mental Health Hospitals
Indicator			Data relating to:
			2025/26
6	Number of new qualifying patients accepted into IMHA services during the year: [annual count]	Compulsory patients	874
		Informal/voluntary patients	263
		Total number of new qualifying patients accepted into IMHA services during the year	1137
7	Number of qualifying patients currently in receipt of IMHA services at the end of the year - i.e. the caseload: [end of March snapshot]	Compulsory patients	136
		Informal/voluntary patients	19
		Total number of qualifying patients currently in receipt of IMHA services at the end of the year	155
8	Number of qualifying patients discharged from IMHA services during the year: [annual count]	Compulsory patients	863
		Informal/voluntary patients	261
		Total number of qualifying patients discharged from IMHA services during the year	1124
9	Of the qualifying compulsory patients who had their first contact with an IMHA during the year, how many had waited: [annual count]	Up to and including 5 working days following their request for an IMHA	874
		6 working days or more following their request for an IMHA	0
		Total number of qualifying compulsory patients who had their first contact with an IMHA during the year	874
10	Of the qualifying informal/voluntary patients who had their first contact with an IMHA during the year, how many had waited: [annual count]	Up to and including 5 working days following their request for an IMHA	263
		6 working days or more following their request for an IMHA	0
		Total number of qualifying informal/voluntary patients who had their first contact with an IMHA during the year	0



Mental Health Measure (Part 4) - quarterly Submission Proforma

Local Health Board		Select HB:	Independent Mental Health Hospitals
Indicator			Data relating to:
			2025/26
6	Number of new qualifying patients accepted into IMHA services during the year: [annual count]	Compulsory patients	93
		Informal/voluntary patients	11
		Total number of new qualifying patients accepted into IMHA services during the year	104
7	Number of qualifying patients currently in receipt of IMHA services at the end of the year - i.e. the caseload: [end of March snapshot]	Compulsory patients	21
		Informal/voluntary patients	2
		Total number of qualifying patients currently in receipt of IMHA services at the end of the year	23
8	Number of qualifying patients discharged from IMHA services during the year: [annual count]	Compulsory patients	97
		Informal/voluntary patients	11
		Total number of qualifying patients discharged from IMHA services during the year	108
9	Of the qualifying compulsory patients who had their first contact with an IMHA during the year, how many had waited: [annual count]	Up to and including 5 working days following their request for an IMHA	93
		6 working days or more following their request for an IMHA	0
		Total number of qualifying compulsory patients who had their first contact with an IMHA during the year	93
10	Of the qualifying informal/voluntary patients who had their first contact with an IMHA during the year, how many had waited: [annual count]	Up to and including 5 working days following their request for an IMHA	11
		6 working days or more following their request for an IMHA	0
		Total number of qualifying informal/voluntary patients who had their first contact with an IMHA during the year	11

Mental Health Measure (Part 4) - quarterly Submission Proforma

Local Health Board		Select HB:	Other NHS
Indicator			Data relating to:
			2025/26
6	Number of new qualifying patients accepted into IMHA services during the year: [annual count]	Compulsory patients	26
		Informal/voluntary patients	2
		Total number of new qualifying patients accepted into IMHA services during the year	28
7	Number of qualifying patients currently in receipt of IMHA services at the end of the year - i.e. the caseload: [end of March snapshot]	Compulsory patients	7
		Informal/voluntary patients	1
		Total number of qualifying patients currently in receipt of IMHA services at the end of the year	8
8	Number of qualifying patients discharged from IMHA services during the year: [annual count]	Compulsory patients	28
		Informal/voluntary patients	3
		Total number of qualifying patients discharged from IMHA services during the year	31
9	Of the qualifying compulsory patients who had their first contact with an IMHA during the year, how many had waited: [annual count]	Up to and including 5 working days following their request for an IMHA	26
		6 working days or more following their request for an IMHA	0
		Total number of qualifying compulsory patients who had their first contact with an IMHA during the year	26
10	Of the qualifying informal/voluntary patients who had their first contact with an IMHA during the year, how many had waited: [annual count]	Up to and including 5 working days following their request for an IMHA	2
		6 working days or more following their request for an IMHA	0
		Total number of qualifying informal/voluntary patients who had their first contact with an IMHA during the year	2



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Mental Health Measure (Part 4) - quarterly Submission Proforma

Local Health Board		Select HB:	Any other setting
Indicator			Data relating to:
			2025/26
6	Number of new qualifying patients accepted into IMHA services during the year: [annual count]	Compulsory patients	25
		Informal/voluntary patients	6
		Total number of new qualifying patients accepted into IMHA services during the year	31
7	Number of qualifying patients currently in receipt of IMHA services at the end of the year - i.e. the caseload: [end of March snapshot]	Compulsory patients	4
		Informal/voluntary patients	1
		Total number of qualifying patients currently in receipt of IMHA services at the end of the year	5
8	Number of qualifying patients discharged from IMHA services during the year: [annual count]	Compulsory patients	24
		Informal/voluntary patients	2
		Total number of qualifying patients discharged from IMHA services during the year	26
9	Of the qualifying compulsory patients who had their first contact with an IMHA during the year, how many had waited: [annual count]	Up to and including 5 working days following their request for an IMHA	25
		6 working days or more following their request for an IMHA	0
		Total number of qualifying compulsory patients who had their first contact with an IMHA during the year	25
10	Of the qualifying informal/voluntary patients who had their first contact with an IMHA during the year, how many had waited: [annual count]	Up to and including 5 working days following their request for an IMHA	6
		6 working days or more following their request for an IMHA	0
		Total number of qualifying informal/voluntary patients who had their first contact with an IMHA during the year	6

N.B. For clarity, whilst the title references a quarterly report, the content presented relates to the annual 2025/26 statutory advocacy report.

Mental Health Legislation Committee

CORPORATE GOVERNANCE REPORT

Dyddiad y Cyfarfod Date of Meeting	06 August 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Philippa Peake-Jones – Head of Corporate Governance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance.

Pwrpas yr Adroddiad Report Purpose	For Noting
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Crynodeb Gweithredol Executive Summary
Members are asked to: • NOTE the Summary of Business considered in Private from the previous meeting. • NOTE the Committee Terms of Reference • NOTE the Committee Cycle of Business

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Not applicable for this report		

Acronymau / Rhestr Termiau Acronyms / Glossary of Terms

CORPORATE GOVERNANCE REPORT

1. **Y SEFYLLFA SITUATION**

- 1 The Health Board is required to act according to its Standing Orders. This report contains information to allow the Health Board to conform to this.
- 2 It is essential that the Board has robust arrangements in place for Corporate Governance and failure to do so could have legal implications for the Health Board.

3 **Y CEFNDIR BACKGROUND**

- 3.1 The purpose of this report is to provide the Committee with an update on key corporate governance matters.

4 **MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION**

4.1 **Summary of Business Considered in Private**

- 4.1.1 Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.
- 4.1.2 There were no private items for consideration at the last Committee meeting on 14 May 2026.

4.2 **Committee Forward Work Plan**

- 4.2.1 The Forward Work Plan sets out the Committee's priorities and scheduled business outside of the normal Cycle of Business, helping ensure a structured, timely, and transparent approach to decision-making and oversight. It collates suggested referral items from other Committees and the Board.

5 **RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION**

- 5.1 There are no matters for escalation.

6 **ARGYMHELLION**

RECOMMENDATIONS

6.1 Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp:
The Committee/Meeting/Group is asked to:

- **NOTE** the Summary of Business considered in Private from the previous meeting.
- **NOTE** The Committee Terms of Reference
- **NOTE** The Committee Cycle of Business

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Priorities	     1. building an effective organisation Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	BAF24-01 Building an Effective and Accountable Organisation CRR-16 – Leadership/Special Measures
<u>Deddf Llesiant</u> <u>Cenedlaethau'r Dyfodol -</u> <u>Nodau Llesiant</u> <u>Wellbeing of Future</u> <u>Generations Act – Wellbeing</u> <u>Goals</u>	Not Applicable Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report.
Asesiad o'r Effaith Economaidd-gymdeithasol <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report

<i>Have you undertaken a Socio-Economic Impact Assessment</i>		
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Galluogwyr Ansawdd Enablers of Quality All Apply	Meysydd Ansawdd Domains of Quality All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant</u> <u>Wellbeing of Future Generations Act – Wellbeing Goals</u>	Not Applicable	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog <i>A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog:</i> Armed Forces Covenant Due Regard Duty <i>Have you considered the Armed Forces Covenant Due Regard Duty?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Asesiad o Effaith ar Ddiogelu Data	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

<i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	



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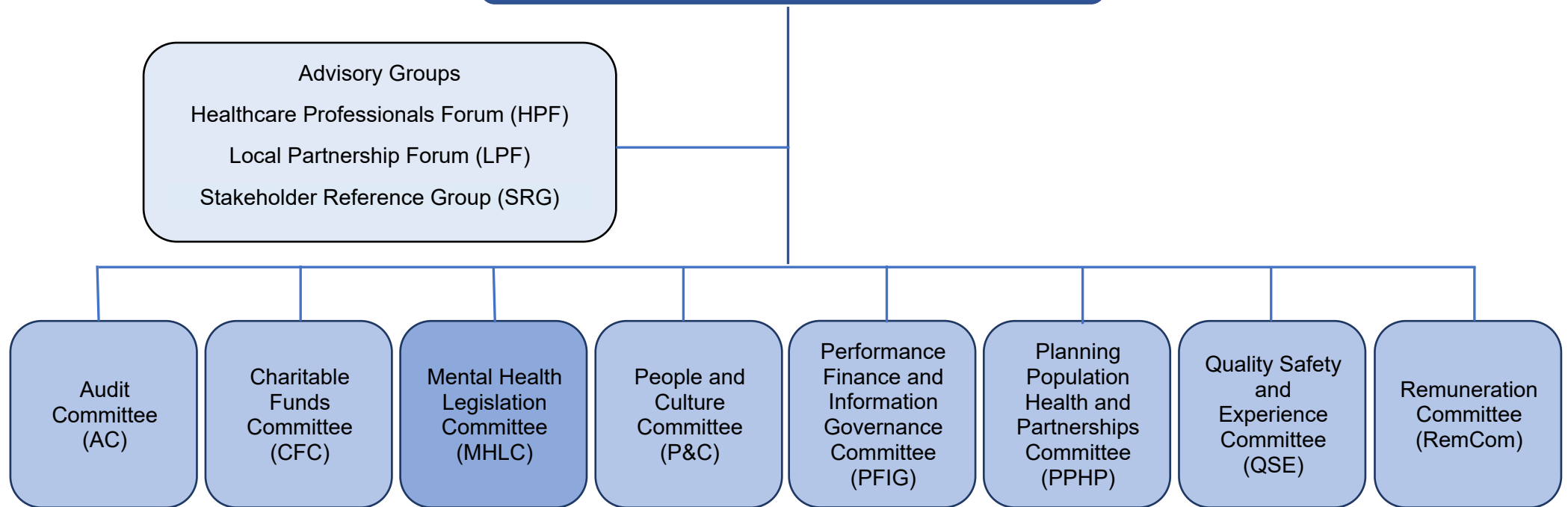
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

MENTAL HEALTH LEGISLATION COMMITTEE

Terms of Reference & Operating Arrangements
(Schedule 3.5 of the Standing Orders)

Date approved by Health Board: 29 May 2025

Betsi Cadwaladr University Health Board



Version Control

Version	Issued to	Date	Comments
V0.01	MHLC		

TERMS OF REFERENCE

1 INTRODUCTION

- 1.1 The Betsi Cadwaladr University Health Board (BCUHB) Standing Orders provide that “The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board’s behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board’s commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees
- 1.2 In accordance with Standing Orders (and the BCUHB scheme of delegation), the Board shall nominate annually a committee to be known as the Mental Health Legislation Committee. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set in this document.
- 1.3 Due to the nature of the business being considered at the RC these meetings will be held in private and papers/minutes will not be made publically available. A summary highlight report will be received at the Public Board meeting that follows.

2 PURPOSE

The purpose of the Committee is to act on behalf of the Board to:

- 2.1.1 Provide assurance that those functions of the Mental Health Act 1983, as amended and Mental Capacity Act, 2005, as amended which have been delegated to officers and staff are being carried out correctly:
 - The wider operation of the two Acts in relation to the Health Board’s area is appropriate and effective;
 - The Health Board’s responsibilities as Hospital Managers are being discharged effectively and lawfully; and.
 - The Health Board is compliant with Codes of Practice for the two Acts.
- 2.1.2 Identify any areas of concern in relation to compliance with mental health legislation and agree issues to be escalated to the Board with recommendations for action.
- 2.1.3 Seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern.

3 DELEGATED POWERS

With regard to its role in acting on behalf of the Board, and in providing advice and assurance to the Board, the Mental Health Legislation Committee will comment specifically upon:

- 3.1 The Committee shall provide advice, assurance and support to the Board in ensuring the provision of high quality, safe healthcare for its citizens of all ages, as follows:
- 3.2 Review reports in relation to the two Acts from Healthcare Inspectorate Wales visits, NHS Wales

Executive and other external scrutiny bodies and approve the action plans for monitoring.

3.3 Consider issues arising from related Committees or Health Board Groups.

3.4 Receive Mental Health Legislation Assurance Reports to ensure compliance with the Codes of Practice. In respect of its provision of assurance to the Board, the Mental Health Legislation Committee will seek assurances that:

3.5 The operation of mental health legislation is exercised fairly and lawfully and that specific issues related to compliance are managed through its Committee and Group structures.

3.6 The powers provided by the Mental Health Act 1983 (notably the Board's delegated functions as Hospital Managers) are being exercised reasonably, fairly and lawfully and that specific issues related to compliance are managed through the Board's Committee and Group structure.

3.7 The powers provided by the Mental Capacity Act 2005 (notably in regard to the Deprivation of Liberty) are being exercised reasonably, fairly and lawfully and that decisions by the Court of Protection are implemented appropriately.

3.8 Identified matters of risk relating to compliance with mental health legislation are being appropriately mitigated.

3.9 Ensure that Associate Hospital Managers are being appointed, trained and appraised effectively to ensure the proper discharge of their duties and that there is appropriate access to mental health advocates; and draw on the experience of both Associate Hospital Managers and mental health advocates to receive assurance on the quality of care provided to patients.

3.10 Ensure policies and procedures are in place to facilitate compliance with the Mental Health Act 1983 and the Mental Capacity Act 2005.

3.11 Ensure that those staff who exercise the functions of mental health legislation have access to, and undertake, appropriate training to provide them with the requisite skills and competencies to discharge the Board's responsibilities.

3.12 Ensure adherence to the relevant legislation, in particular, the Human Rights Act 1998, the Equality Act 2010, and the Data Protection Act 1998.

3.13 Assure the Board in relation to its compliance with relevant national practice, mandatory guidance, healthcare standards and duties, including Duty of Quality, Duty of Candour, Quality Standards and Quality Management ensuring the Board is supported to make strategic decisions from a quality perspective.

4 AUTHORITY

4.1 The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and
- Other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2 It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

5 SUB-COMMITTEES

- 5.1 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to perform specific aspects of Committee business.

6 MEMBERSHIP

- 6.1 Formal membership of the Committee shall comprise of the following:

MEMBERS
Independent Member (Chair)
2 x Independent Members (one of whom will be designated as Vice Chair)

- 6.2 The following should attend Committee meetings:

IN ATTENDANCE
Executive Director with responsibility for Mental Health and Learning Disabilities (Executive Lead)
Executive Director of Nursing and Midwifery
Executive Medical Director
Medical Director for Mental Health and Learning Disabilities
At least one of the Medical Directors of the Integrated Health Communities
Chief Operating Officer
Deputy Director for Legal Services
Senior Manager for Mental Health Act
Senior Manager for Mental Capacity Act
At least one Director of Operations from the Integrated Health Communities
Director of Safeguarding/Head of Safeguarding
Associate Hospital Managers
CAMHS Representative
Other Attendees
The Chair can if required, invite representatives of partner agencies to attend Committees.

- 6.3 The attendance of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by the Welsh Government.
- 6.4 Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation whom the Committee considers should attend, taking into account the matters under consideration at each meeting.

5. COMMITTEE MEETINGS

5.1 Quorum

- A quorum shall consist of no less than two of the membership, and must include as a minimum the Chair or Vice Chair of the Committee.

5.2 Frequency of meetings

- The Committee will meet quarterly and an annual schedule of meetings will be determined by the corporate calendar.
- Any additional meetings will be arranged under exceptional circumstance and shall be determined by the Chair of the Committee in discussion with the Executive Lead.

5.2 Withdrawal of individuals in attendance

- The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

5.3 Meeting arrangements

- The agenda and papers will be distributed/published seven days in advance of the meeting.
- The Director of Corporate Governance is to hold an agenda setting meeting with the Chair and/or Vice Chair and the Executive Director of Allied Health Professionals and health Science at least six weeks before the meeting date.
- The agenda will be based on the Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year, and requests from Committee members.

6. REPORTING AND ASSURANCE ARRANGEMENTS

The Committee, through its Chair and members, shall work closely with the other Committees to provide advice and assurance to the Board through joint planning and co-ordination of Board and Committee business including sharing information.

6.1 The Committee Chair, supported by the Committee Secretary, shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities;
- Bring to the Board's specific attention any significant matter under consideration by the Committee; and
- Ensure appropriate escalation arrangements are in place to alert the Health Board's Chair, Chief Executive and/or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

6.2 The Committee will undertake an annual review on the effectiveness of its arrangements and responsibilities. The Director of Corporate Governance will oversee this review.

7. RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for these matters.

7.1 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

7.2 The Committee, through its Chair and members, shall work closely with the Board's other

committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:

- ~ Joint planning and co-ordination of Board and Committee business and
- ~ Sharing of information

In doing so, it will contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

- 7.3 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Health Board's overall system of assurance.
- 7.4 The Committee shall embed the Health Board's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

- 8.1 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:
- Quorum

9. REVIEW

These Terms of Reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

- 10.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board – after first consulting with all Members of the Committee. The Secretariat must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.
- 10.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.



Betsi Cadwaladr University Health Board

Mental Health Legislation Committee

Cycle of Business
(1 April 2026 – 31 March 2027)

Betsi Cadwaladr University Health Board should, on an annual basis, receive a cycle of business that identifies the items which will be regularly presented for consideration. The annual cycle is one of the key components in ensuring that the Health Board is effectively carrying out its role.

The Committee Cycle of Business cover the period 1 April 2025 to 31 March 2026.

The Committee Cycle of Business has been developed to help plan the management of Health Board matters and facilitate the management of agendas and Health Board business. The Annual Cycle of Business will be complemented by a “Non-Routine Board Business (Forward Work Plan)” for ‘one-off’ Ad-hoc items raised during the course of meetings.

The role of the Mental Health Legislation Committee is set out in the Terms of Reference which is available here: [\[Insert here\]](#)

Committee Chair Gareth Williams	Independent Members Dyfed Jones Rhian Watcyn Jones	Executive Members Teresa Owen (Executive Director of Allied Health Professionals and Health Science) – Exec Lead Angela Wood (Executive Director of Nursing and Midwifery) Dr Clara Day (Executive Medical Director) Tehmeena Ajmal (Chief Operating Officer)	In Attendance Pam Wenger (Director for Corporate Governance) Alberto Salmoiraghi (Medical Director of Learning Disabilities) Matt Joyces (Deputy Director of Quality Governance) Wendy Lapin (Senior Manager for Mental Health Act) Chris Walker (Senior Manager for Mental Capacity Act) At least one Director of Operations from the Integrated Health Communities Michelle Denwood (Head of Safeguarding) Jenny Gilmour (Hospital Manager) Phil Williams (Hospital Manager)
Committee Vice Chair			

MENTAL HEALTH LEGISLATION COMMITTEE CYCLE OF BUSINESS 2026-27

Item of Business	Executive Lead	Reporting period	Q1			Q2			Q3			Q4			2027-28	
			April 2026	May 2026	June 2026	July 2026	Aug 2026	Sep 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	Mar 2027	April 2027	May 2027
Preliminary Matters																
Minutes of the Previous Meeting	Chair	All Regular Meetings		℞			℞			℞			℞			
Action Log	Chair	All Regular Meetings		℞			℞			℞			℞			
Routine Reporting for Assurance																
Mental Health Act Assurance Report	Deputy Director of Legal Services	All Regular Meetings		℞			℞			℞			℞			
Mental Capacity Assurance Report	Director Of Safeguarding And Public Protection	All Regular Meetings		℞			℞			℞			℞			
Healthcare Inspector Wales (HIW) Assurance Report	Deputy Director of Legal Services	All Regular Meetings		℞			℞			℞			℞			
Associate Hospital Managers Update Report	Deputy Director of Legal Services	All Regular Meetings		℞			℞			℞			℞			
Report from the Power of Discharge Group	Deputy Director of Legal Services	All Regular Meetings		℞			℞			℞			℞			
For Information																
Corporate Governance Report (to include forward workplan & COB)	Director of Corporate Governance	All Regular Meetings		℞			℞			℞			℞			
Summary of Business to be reported from Private	Director of Corporate Governance	All Regular Meetings		℞			℞			℞			℞			
Closing Business																
Agree Items for Referral to Board / Other Committees	Chair	All Regular Meetings		℞			℞			℞			℞			
Review of meeting effectiveness	Chair	All Regular Meetings		℞			℞			℞			℞			
Date of the next meeting	Chair	All Regular Meetings		℞			℞			℞			℞			
Resolution to exclude the Press and Public	Chair	All Regular Meetings		℞			℞			℞			℞			