Deprivation of Liberty Safeguards (DoLS)

DoL’s was introduced in April 2009 as part of the implementation of the Mental Capacity Act 2005 (MCA). The aim of DoLS and the related legislation and guidance is to ensure that there is better legal and administrative protection for all those who may for whatever reason lack capacity to consent to the care they are receiving including where they live and how they are cared for on a day to day basis. Prior to the MCA there was a lack of clarity about how the liberty and human rights of those lacking capacity to consent to their care arrangements, including where these restricted their movement and choices, should be protected. The MCA only applies to people aged 16 years and over, however Article 5 of the European Convention on Human Rights gives all people including children the right to liberty and so consideration needs to be given to the deprivation of this liberty.

Article 5 of the European Convention on Human Rights protects the right to liberty and security of person. No person – of any age – shall be deprived of their liberty unless (a) it is justified on a ground specified in Article 5, such as being of “unsound mind”, and (b) it is done in accordance with an Article 5-compliant legal procedure.

This provides safeguards, including that a person is entitled to have the lawfulness of their detention decided speedily by a court. Children and young people may be deprived of their liberty if the deprivation is in their interests, but the circumstances that make these acts lawful vary according to the circumstances that prevail at the time. The starting point should always be why the restrictions on the child are necessary and whether they are proportionate to the risk the child or others might face if they were not there. Local authorities need to be clear about when and how deprivation of liberty needs to authorised and should undertake an assessment before applying for authorisation that provides detailed information regarding why the child’s liberty should be deprived and has arrangements for renewing and challenging the authorisation.

The ‘acid’ test is commonly applied to determine if a person’s circumstances constitute deprivation of liberty. This asks -

- Is the person subject to continuous supervision and control?
- Is the person free to leave?

If the person is subjected to the above then they are considered to be being deprived of their liberty. Deprivation of liberty is the same for everyone, whether or not they have physical or mental disabilities. If it would be a deprivation of a person’s 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 then this is a deprivation of the liberty of a disabled person also.

Recognising that a child can be deprived of liberty calls for increased scrutiny as to the basis of such detention, and additional safeguards are necessary to prevent the arbitrary use of power and ensure that the rights of the child are protected.
Three factors determine deprivation of liberty under Article 5 of the European Convention on Human Rights:

1. The objective element – The person is confined in a particular place for an extended period of time.
2. The subjective element – There is no consent either because the person has not consented to, or lacks capacity to consent to, the control placed on them.
3. The state element – The deprivation of liberty may be on the responsibility of the state, either directly or indirectly.

Identifying when child care deprives liberty is not easy. All children are, of course, subject to certain universal constraints as without them, those with parental responsibility would be prosecuted for neglect or ill-treatment. The law expects those constraints to lessen as the child matures to adulthood.

If a person is objectively confined, their circumstances will not fall within the scope of Article 5 of the European Convention on Human Rights if they have validly consented to the confinement. Someone is said to lack capacity if they can’t make their own decisions because of impairment in the functioning of their mind or brain. This could arise due to illness, disability or exposure to drugs/alcohol. It doesn’t have to be a permanent condition.

Summary: How deprivations of liberty must be authorised

1. Under 16s who are confined and unable to consent: parents can give valid consent if that is an appropriate exercise of parental responsibility unless child subject to Care or Interim care order,
2. Those of any age under an interim/final care order who are confined and unable to consent themselves: Article 5 safeguards are required.
3. 16 and 17 year olds who are confined and lack capacity to consent: Article 5 safeguards are required.
4. Those under 18 who are able to make the relevant decision and object to their confinement: Article 5 safeguards are required.

Parents can give consent for deprivation of liberty if it falls within the scope of parental responsibility. Deprivation of liberty can also be lawful if warranted under statute i.e. Section 25 of the Children Act 1989, secure accommodation provisions. However where a child is looked after then different considerations apply even where the parents’ consent to deprivation of liberty. If a child under 16 is not under a formal care or interim care order, his/her parents can authorise deprivation of liberty in the exercise of parental responsibility, for instance, in a hospital, or NHS facility or day care or with a private foster carer, regardless of the child’s personal mental capacity.

Parental consent may be adequate where the child is accommodated under Section 20 but where there is a level of ongoing dispute or doubts about the ability of parents to act in the child’s best interests then it is likely that their consent will not be accepted. Given that the local authority provide the placement for the child the consideration to whether the parents can consent becomes more subjective and it is recommended that the local authority seek authority through the court.
Where the child is the subject of an interim care order or care order neither the parent or the local authority can consent, this means that where there is a deprivation of liberty the local authority must either use a statutory route or seek leave of the high court to invoke its inherent jurisdiction to make an order for deprivation of the child’s liberty. Even where the child is considered Gillick competent, it would be advisable to seek authority. Applications in respect of over 16’s would go to the Court of Protection where there are concerns about capacity under the MCA and in respect of those over 16, having capacity but not consenting and under 16’s applications would be made for an order under the inherent jurisdiction Section 100 of Children Act 1989 and go to the High Court (Wardship).

Local authorities must consider whether looked-after children are being deprived of their liberty, but the authority cannot consent to the deprivation. A deprivation of liberty will be lawful if warranted under statute; for example, under Section 25 of the Children Act 1989 or the Mental Health Act 1983 or under the remand provisions of LASPO 2012 or if a child has received a custodial sentence under the PCCSA 2000.

A Court may not implicitly approve a deprivation of liberty by making an ICO or care order with a plan for a placement which amounts to a deprivation of liberty. It is therefore essential for the LA to apply for further orders and not rely on the ICO or Care order; if they do not, the placement may be a breach of the child’s Article 5 rights, be unlawful and thereby put the LA at risk of a damages claim.

It is no criticism of health and social care bodies if the living arrangements constitute a deprivation of liberty; it is merely a recognition that human rights are for everyone and those rights include the right to liberty.

We are likely to see two cohorts of children who require authority for deprivation of liberty - those who have social restriction due to risk and those with complex medical needs.

For cohort 1 (risk) it will be the social worker who will do the assessment and give evidence before the court.

For cohort 2 (medical) social worker will do the mental capacity assessment but will need information and guidance from mental health services.

Social workers must evidence that they have assessed children and they have taken into account the possibility of deprivation of liberty.

**Cohort 1:**

The child was aged 15. He had been removed from his mother's care when aged six and had exhibited overly sexualised behaviour towards other children. After two long-term foster placements broke down because of his difficult behaviour, he was placed in a residential unit when aged 14. At the unit he was supervised at all times and was not allowed to interact with other residents alone. He was not allowed to leave the unit unaccompanied without permission, the unit was locked at night, and bedroom doors were alarmed. He was accompanied on all social events and was not
permitted internet access. The use of his mobile phone was limited to calling only four telephone numbers. The child had occasionally refused to comply with restrictions. He had left the unit without permission for short periods, but had not absconded.

The child was of sufficient intelligence to fully understand what was involved in him living at the unit and the restrictions which were imposed on him. He also understood why those restrictions were necessary and how they benefited him, although he sometimes found the pressures of close supervision difficult to bear. He was Fraser/Gillick competent and capable of consenting to his confinement at the unit.

While he had breached the rules from time to time, and had left the unit without permission, he had always returned of his own volition, he had never had to be returned by the police or under coercion, and he had never left the unit for a period of time that amounted to absconding. There was no evidence that the child had regularly changed his mind about living at the unit or being the subject of the restrictions. The fact that he might withdraw consent at some point in the future did not negate the valid consent he had given, or its legal consequences. It was not necessary to exercise the court’s powers in relation to deprivation of liberty but if he withdrew his consent then it would be necessary to seek authorisation from the court.

**Cohort 2:**

For children or young people who have or lack capacity, the detention arrangements under the Mental Health Act (MHA) 1983 are similar to those in adults. They must have a mental disorder that falls under the Act’s definition, and the assessment or treatment that they require must be for this disorder. Section 63 of the Mental Health Act 1983 operates to allow children and young people treatments for physical health problems only to the extent that such treatment is part of or ancillary to the treatment for mental disorder. In a case of a 17 year old in the emergency department after a paracetamol overdose, who was not detained under the Mental Health Act 1983, the court found it lawful to restrain her for 21 hours, sufficient only to ensure that an antidote could be administered. When considering informal (consensual) admission, the statute prohibits the use of parental consent to override the refusal of a competent young person to agree to these voluntary arrangements. In the terminology of mental health legislation, an ‘informal’ patient denotes someone who is being treated for a mental disorder and who is not detained (sectioned) under the Mental Health Act 1983.

The Mental Capacity Act (MCA) 2005 applies only to patients of 16 years and over who lack capacity. In an emergency, if it is necessary to deprive an incapacitated young person of their liberty so as to sustain life or prevent a serious deterioration (whilst a decision is being sought from a court), then do so. The Mental Health Act 2005 makes this intervention lawful. Incapacitated young people may lawfully be deprived of their liberty for treatment outside of the Mental Health Act 1983 under the terms of the Mental Health Act 2005 following a relevant decision by a court. Significantly, however, the 16-year-old watershed does not apply where the child is
under an interim or final care order. Here, the local authority cannot consent to the confinement of a child of any age because there is a lack of proper safeguards.

Competent young people cannot be deprived of their liberty under the Mental Capacity Act 2005, since it only applies to those lacking capacity. Those competent with mental illness may be dealt with under Mental Health Act 1983. The inherent jurisdiction of the High Court may be used to achieve the detention of a young person if it’s deemed necessary. English courts have consistently overridden the refusal of consent by 16 and 17 year olds when considering compulsory feeding or blood transfusion. In the recent case of a 16 year old boy the court did not challenge his competence, but nevertheless his refusal of transfusion was overridden, and was declared compulsory in the last resort.

The restrictions put in place to protect children (being under continuous supervision, and control, and not being free to leave) should not be seen as inherently negative - in most cases they will be necessary and appropriate. Many children with complex disabilities will fall into this camp - but as long as parents are actively and appropriately involved in their child’s care, and able to provide effective challenge on behalf of their child, they can authorise the deprivation, provided the child is under 16 and not Gillick competent. However, if the child is in the care of the local authority (subject to a Care or Interim Care Order) then authorisation from the court is required.

Much will depend upon the extent to which the degree of care and support for the child with a disability departs from the ‘norm’ for a child of that age without disability. So the greater the deviation from the typical freedoms expected by someone of that age and relative maturity who is free from disability, the more likely the disabled child or young person is to be deprived of their liberty.

The case of a 14 year old boy (AB) who was residing in a children’s home under an interim care order should be considered. He had previously been accommodated under Section 20 of the Children Act 1989. He had moderate to severe learning disability, Attention Deficit Hyperactivity Disorder, a statement of special educational needs and was under the care of child and adolescent mental health services. He was happy, settled and wished to remain in the children’s home but lacked capacity to make the decision. He was deprived of his liberty and authorisation from the court was necessary to continue the arrangement.

His care regime provided for the following:
- There were three staff members on duty during the day, and two at night, for the three child residents;
- AB was not on one-to-one supervision within the unit and could be left unsupervised for short periods. But his behaviour plan stated: “Staff must be aware of where AB is at all times. AB should be checked regularly. Staff must be authorised to work alone with AB. AB must never be left alone with another resident.” He was under 15-minute observations.
- Took medication for ADHD under supervision;
- He was not allowed to leave the unit (e.g. to go to school) unaccompanied and was closely supervised when out of the unit;
He was only taken on public transport if calm and settled, with a staff member sat beside or behind him;
If he behaved negatively when out and, despite warnings, he continued, he would be immediately returned to the placement;
If he were to leave the placement unaccompanied, staff would call social services and the police to assist with his return;
The front door was locked at night and if he left his room, staff must redirect him back unless he wanted a drink or the toilet.

Top Tips:
Ensure you have completed an assessment that addresses the capacity of the child with regards to making decisions and being able to give consent about their care and support needs.
If you feel the child has capacity to consent make sure you have a clear agreement with them about what they are providing consent for.
Consent should be reviewed, children can withdraw consent but if you still feel that there needs to be a restriction regarding their liberty then you must seek authority from the court if they are subject to an Interim or Full Care Order and it is advised to if they are Section 20.
If a child does not have capacity and they are accommodated either under Section 20 or an Interim Care Order or Care Order, you must seek authority from the court regarding deprivation of liberty.
The issues of deprivation of liberty should be regularly considered, assessed and reviewed.
Take a look at the helpful Law Society documents

deprivation-of-liberty-under-18s-quick-guide.pdf
DOLs Flowchart.pptx