

Restricting Movement or Depriving Liberty?

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“It is of course helpful to know that the question is one of degree and the matters which should be taken into account in answering it. But one also needs to be told what the question is. What is the criterion for deciding whether someone has been deprived of liberty or not?”²

This judicial appeal for clarity exposes a jurisprudential problem which threatens one of our most fundamental human values; the right to liberty. For no-one really knows what it means to be “deprived” of one’s “liberty”. The extremities are straightforward. Prisoners are deprived; picnickers are not. But liberty deprivations may “take numerous other forms [whose] variety is being increased by developments in legal standards and in attitudes”.³ Technology, too, has played its part in such developments by introducing novel ways of restricting movement beyond the paradigmatic lock and key. The more expansive those other forms, however, the greater the risk of legal uncertainty.

The challenge in this paper is one of interpretation. Article 5 of the European Convention on Human Rights 1950 protects the “liberty and security of person” which is said to have a “Council of Europe-wide meaning”.⁴ But how should this autonomous concept be transposed into English law? Adopting Berlin’s classic dichotomy,⁵ does liberty relate to the absence of external barriers or constraints, where we enjoy it to the extent that no-one is preventing us from doing whatever we might want to do (negative liberty)? Or does it concern the presence of internal factors, where we enjoy liberty to the extent that we are able to take control of our lives and self-determine in our own interests (positive liberty)?⁶ These complex philosophical perspectives cannot be ignored and are, to varying degrees, protected by other Convention articles.⁷ But article 5 is not concerned with such broad notions of liberty because it contemplates liberty in its *classic* sense. That is, the *physical* liberty of the person.⁸

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2 *Secretary of State for the Home Department v JJ* [2008] 1 AC 385 at para 39 per Lord Hoffmann.

3 *Guzzardi v Italy* (1980) 3 EHRR 333 at para 95.

4 *Ibid* n.2 at para 13 per Lord Bingham.

5 I. Berlin, ‘Two Concepts of Liberty’ in *Four Essays on Liberty* (Oxford: OUP, 1969).

6 The notion of autonomy can be derived from this concept of positive liberty; see I. Kant, *Fundamental Principles* (1785); G. Dworkin, *A Theory and Practice of Autonomy* (Cambridge: CUP, 1999); J. Raz, *The Morality of Freedom* (Oxford: Clarendon Press, 1986); J.

Rawls, *A Theory of Justice* (Oxford: OUP, 1971).

7 For example, see N. Allen, ‘A human right to smoke?’ (2008) 158 *New Law Journal* 886 for a discussion of the extent to which the Health Act 2006 interferes with our liberty to smoke in the context of article 8 of the Convention.

8 *Ibid* n.3 at para 92; see also *Engel v The Netherlands* (No 1) (1976) 1 EHRR 647 at para 58. The reference to “security of person” in article 5 does not provide any separate interpretation from the right to liberty; see *Altun v Turkey* (Application no. 24561/94, 1 June 2004) at para 57. Contrast this with the interpretation afforded to analogous provisions in the Universal Declaration of Human Rights (article 3), the International Covenant on Civil and Political Rights (article 9), and the American Declaration on the Rights and Duties of Man (article 1).

The circumstances in which this particular type of liberty might be deprived go to the heart of this paper. Although the issue will be considered principally in the context of the forthcoming statutory safeguards for the detention of hospital and care home residents,⁹ what follows may be equally applicable to other forms of confinement. After outlining the distinction between simple and arbitrary detention, I shall critically evaluate the jurisprudence to identify potential cracks which threaten its future development. Finally, a fresh approach will be suggested which focuses upon the core elements of confinement and coercion in distinguishing restricted movement from deprived liberty.

Detention and Arbitrariness

The perceived dangers associated with psychiatric illness have long justified a person's detention, whether under the prerogative powers,¹⁰ at common law,¹¹ or statute.¹² It is not uncommon for these individuals to be subjected to physical, mechanical or chemical restraints, and varying degrees of social isolation, be it from family or fellow patients. But the very nature of detention is transforming as science and technology develop innovative ways of restricting our freedoms. Sensors, pressure pads, and controlled locks enable others to remotely monitor our movements at home and to control our ability to venture outside. They are seen by many as a less restrictive alternative to hospital or care home detention which promote independent, supported living. To others, such measures simply substitute one form of detention for another.

Unsurprisingly, article 5 of the European Convention does not protect us from detention itself. Quite the contrary. For it expressly permits the lawful confinement of suspected and convicted criminals, illegal immigrants, truant children, alcoholics, drug addicts, vagrants, spreaders of infectious diseases and those of unsound mind. But article 5 may be violated even when the authorities have lawful grounds for detention. For the essence of the right to liberty is to safeguard individuals from *arbitrary* detention by requiring liberty deprivations to be made in accordance with a procedure prescribed by law.¹³

The distinction can clearly be seen in the *Bournewood* case.¹⁴ A compliant incapacitated man with autism was informally admitted to the intensive behavioural unit of Bournewood Hospital; a place from which he would have been prevented from leaving had he tried to do so. For the majority of the House of Lords, Mr L was not detained for the purposes of the tort of false imprisonment. Lord Goff drew a distinction between the actual restraint of a patient and restraint which was conditional upon them seeking to leave. Placed on an unlocked ward, the patient was free to leave and was not restrained by any physical barriers from choosing to do so. In those circumstances, he was not imprisoned unless he attempted to leave.

9 Pursuant to Schedules A1 and 1A of the Mental Capacity Act 2005 as inserted by the Mental Health Act 2007.

10 *The duty of the monarch as parent of the people, or parens patriae, to protect persons unable to care for themselves or their property dates back to the De Prerogativa Regis of 1324. See Eyre v Countess of Shaftesbury (1725) Gilb Ch 172; Smith v Smith (1745) 3 Atk. 204; Wellesley v Beaufort (1829) 2 Russ 1.*

11 *See Brookshaw v Hopkins (1772) Lofft 240 at 243; R v Coate and others (1772) Lofft 73 at 75; Anderdon v Burrows (1830) 4 C & P 210 at 213; Re Shuttleworth (1846) 9 QB 651; Nottidge v Ripley (1850) 14 LTOS 445; R v Pinder, Re Greenwood (1855) 24 LJQB 148; Fletcher v Fletcher (1859) 1 El & El 420 at 423–4; Scott v Wakem (1862) 3 F and F 328 at 333; Symm v Fraser*

(1863) 3 F and F 859 at 883; and R v Whitfield, ex parte Hillman (1885) 15 QBD 122 at 132.

12 *See, for example, the Vagrancy Acts of 1714 and 1744; Madhouses Act 1774; Criminal Lunatics Act 1800; County Asylums Acts of 1808, 1811, 1815, 1828, 1845, and 1846; Care and Treatment of Lunatics Acts of 1828, 1842, and 1845; Lunatic Asylums Inspection Act 1842; Lunatic Asylums Acts of 1853 and 1863; Lunacy Acts Amendment Acts of 1862, 1885 and 1889; Lunacy Act 1890; Medical Treatment Act 1930; Mental Health Acts of 1959, 1983 and 2007.*

13 *Kurt v Turkey (1998) 27 EHRR 373 at para 122.*

14 *R v Bournewood Community and Mental Health NHS Trust, ex p L [1999] 1 AC 458.*

The approach of the European Court of Human Rights (ECtHR) was quite different.¹⁵ Article 5 was considered engaged mainly because the clinicians exercised complete and effective control over his care and movements and he was not free to leave. The common law doctrine of necessity could justify such detention. But the key, quite distinct, issue was whether that detention was *arbitrary*. It was unclear who could propose his informal admission and for what reasons. There was no procedure requiring medical or other assessments to justify the admission or detention thereafter. No one knew its exact purpose or for how long it could last. No one had to be nominated who might object or make applications on Mr L's behalf. Furthermore, and because he lacked capacity, any treatment could be given in his best interests which, in 1997, was still being inappropriately determined according to the *Bolam* test for negligence.¹⁶ Cumulatively, this total lack of procedural safeguards amounted to arbitrary detention.¹⁷

The process of informal hospital admission was never originally intended to enable a deprivation of liberty to take place.¹⁸ Indeed, its common law basis was previously recognised¹⁹ as being unsystematic, full of glaring gaps and not resting upon clear or modern foundations of principle. In order to conform with its international obligations, the government now had to plug this legal hiatus left in the wake of the ECtHR's ruling. Using the Mental Health Act 2007, a complex set of deprivation of liberty safeguards (DoLS) have been added to the Mental Capacity Act 2005 so as to avoid such arbitrariness. They require managers of publicly and privately funded²⁰ hospitals and care homes to identify incapacitated and mentally disordered adults who are at risk of having their liberty deprived. A detailed assessment process is then undertaken by the respective primary care trust or local authority to determine whether the person's best interests warrant their deprivation of liberty for up to twelve months.²¹

At the heart of these safeguards is the deprivation of liberty concept.²² The Joint Committee on Human Rights proposed a statutory definition, whereby "if it is known that a person will be taken from their home to a place where they will be prevented from leaving, and complete and effective control will be exercised over their movements, that person is deprived of their liberty from the point of removal from their home."²³ However, this was rejected by the government which preferred to rely upon the jurisprudence of article 5 to determine the issue. Regrettably perhaps, the DoLS thus provide a complex answer to what remains a largely hitherto unknown question.

15 *HL v United Kingdom* (2004) 40 EHRR 761 at para 91. For an excellent summary of the proceedings, see K. Keywood, 'Detaining mentally disordered patients lacking capacity: The arbitrariness of informal detention and the common law doctrine of necessity' (2005) 13 *Medical Law Review* 108.

16 See *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, 587.

17 *Ibid* n.15 at para 120. Article 5(4) was also violated because neither habeas corpus nor judicial review proceedings prior to the Human Rights Act 1998 were sufficient to adequately examine the Winterwerp criteria for detention (see *Winterwerp v Netherlands* (1979–1980) 2 EHRR 387 at para 39).

18 *Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, 1954–1957* (Report Cmnd 169,

HMSO, 1957) at paras 290–291. See N. Morris, (1958) 21(1) *Modern Law Review* 63.

19 *Law Commission, Mental Incapacity* (Law Com. No. 231, London, HMSO, 1995) at para 1.1. See also the judicial observations in *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 at 51 and 71.

20 *Mental Capacity Act 2005* s.64(6) as inserted by the *Mental Health Act 2007* Schedule 9, para 10(4).

21 *Mental Capacity Act 2005* Schedules A1 and 1A.

22 *Ibid* Schedule A1 para 1(1) refers to being "detained ... in circumstances which amount to deprivation of the person's liberty" which has "the same meaning as in Article 5(1)" according to s.64(5).

23 *Legislative Scrutiny: Mental Health Bill* (HL 40/HC 288), 4th February 2007 at para 89.

Guiding Principles from Strasbourg to London

Although it is “perilous to transpose the outcome of one case to another where the facts are different”,²⁴ the domestic courts must “take into account” the jurisprudence of the Strasbourg court.²⁵ In particular, the principles laid down in *Guzzardi*²⁶ and *Engel*.²⁷ The government is yet to ratify article 2 of protocol 4 which provides a right to liberty of movement and the freedom to choose one’s residence.²⁸ Yet its very existence assists in our interpretation of article 5. The distinction between them is said to be merely one of degree or intensity, not nature or substance. However, determining whether there has been a liberty deprivation “sometimes proves to be no easy task in that some borderline cases are a matter of pure opinion”.²⁹

It is significant to note that the ECtHR has so far applied these principles consistently to each of the six detention grounds listed in article 5(1). In *Guzzardi*, for example, a residence order confined a mafia member to a makeshift camp on a small part of the Asinara island, off the Sardinian coast. He lived with his family but was subject to a 9 hour curfew. He was able to move about the 2½ squared kilometre settlement during the rest of the day, could get permission to journey beyond its boundaries from time to time – although only under strict police supervision – and he had to report to the police station twice a day. Moreover, he was not free to make social contact with the outside world. In deciding that these measures constituted a deprivation of liberty, the majority of the Court adopted the same approach in their consideration of grounds (a), (b), (c) and (e).

Transferring a person under house arrest (article 5(1)(c)) to a psychiatric clinic for assessment (article 5(1)(e)) requires separate consideration to be given to the separate grounds for detention that have been relied upon.³⁰ Whether that person is deprived of liberty in the first place, however, is resolved using the same guiding principles.³¹ Those of unsound mind may thus be deprived of liberty in a hospital.³² Or in a Polish sobering-up centre if alcoholic.³³ Or within a French airport transit zone so as to prevent an unauthorised immigration entry.³⁴ The *Guzzardi/Engel* guidelines are equally applicable in cases where none of the exhaustive list of grounds is applicable. A ten day period of confinement in a Spanish hotel for “deprogramming” members of a sect is but one example.³⁵ Imposing non-derogatory control orders upon suspected terrorists would be another.³⁶

A useful summary of these guiding principles was given in *JE v DE and Surrey County Council*.³⁷ An elderly blind man with dementia and impaired memory was confined to a residential care home. He had a

24 *R (Gillan) v Commissioner of Police of the Metropolis* [2006] 2 AC 307 at para 23 per Lord Bingham.

25 Human Rights Act 1998 s.2.

26 *Ibid* n.3.

27 *Ibid* n.8.

28 Being a qualified right, it can be lawfully restricted, provided the state’s interference is in accordance with the law, pursues a legitimate aim, and is necessary in a democratic society; see *Raimondo v Italy* (1994) 18 EHRR 237 at para 39 and *Hajibeyli v Azerbaijan* (Application no. 16528/05, 10 July 2008) at para 58.

29 *Ibid* n.3 at para 93.

30 See *Atanasov v Bulgaria* (Application no. 73281/01, 6 November 2008) at paras 71–72.

31 For example, see *Mancini v Italy* (Application no.

44955/98, 12 December 2001) where the *Guzzardi* principles were applied to article 5(1)(c).

32 *HL v United Kingdom* *ibid* n.15 (lockable ward); see also *Storck v Germany* (2005) 43 EHRR 96 (clinic); *Ashingdane v United Kingdom* (1985) 7 EHRR 528 (open ward); *Shtukaturov v Russia* (Application no. 44009/05, 27 March 2008) (locked ward).

33 *Litwa v Poland* (2001) 33 EHRR 53.

34 *Amuur v France* (1996) 22 EHRR 533.

35 *Blume and others v Spain* (2000) 30 EHRR 632.

36 *Ibid* n.2.

37 [2006] EWHC 3459 at para 77. See also *LLBC v TG and others* [2007] EWHC 2640 (Fam); *A Primary Care Trust and P v AH and a Local Authority* [2008] EWHC 1403 (Fam); and *Salford City Council v GJ and others* [2008] EWHC 1097 (Fam).

significant degree of freedom within it, was also taken out for walks, and had regular telephone contact with his family and visits. However, staff would not accede to his repeated requests to return home and his wife was told that the police would be called if she attempted to remove him. Determining that his liberty was deprived, Munby J. outlined the following expansive approach taken by the ECtHR:

- 1) There are three elements relevant to the question of whether in the case of an adult there has been a 'deprivation' of liberty engaging the state's obligation under Article 5(1) (different considerations may apply in the case of a child where a parent or other person with parental authority has, in the proper exercise of that authority, authorised the child's placement and thereby given a substituted consent):
 - (a) An objective element of a person's confinement in a particular restricted space for a not negligible length of time;
 - (b) Subjective element, namely that the person has not validly consented to the confinement in question;
 - (c) The deprivation of liberty must be imputable to the state.
- 2) As regards the objective element:
 - (a) The starting point must be the concrete situation of the individual concerned and account must be taken of a whole range of criteria such as the type, duration, effects and manner of implementation of the measure in question. The distinction between a deprivation of and a restriction upon liberty is merely one of degree or intensity and not one of nature or substance.
 - (b) In [this] type of case, the key factor is whether the person is, or is not, free to leave. This may be tested by determining whether those treating and managing the person exercise complete and effective control over the person's care and movements.
 - (c) Whether the person is in a ward which is 'locked' or 'lockable' is relevant but not determinative.
- 3) As regards the subjective element:
 - (a) A person may give a valid consent to their confinement only if they have capacity to do so.
 - (b) Where a person has capacity, consent to their confinement may be inferred from the fact that the person does not object.
 - (c) No such conclusion may be drawn in the case of a patient lacking capacity to consent.
 - (d) Express refusal of consent by a person who has capacity will be determinative of this aspect of 'deprivation of liberty'.
 - (e) The fact that the person may have given himself up to be taken into detention does not mean that he has consented to his detention, whether he has capacity or not. The right to liberty is too important in a democratic society for a person to lose the benefit of the Convention protection for the single reason that he may have given himself up to be taken into detention.

This summary was not cited to the House of Lords when it was considering a number of related cases.³⁸ Control orders were imposed on those for whom there were reasonable grounds to suspect involvement in terrorism-related activity.³⁹ Individuals were electronically tagged and required to remain at home for 18 hours a day. The remaining 6 hours could be spent outside, but only within a designated urban area. Visitors were not generally allowed and unauthorised people could not be met outside. The police could conduct random searches and remove any items they wished. Their use of communications equipment was also restricted. The majority of the House of Lords adopted an expansive approach which foresaw numerous forms of liberty deprivation other than classic detention in prison. Deciding that these measures constituted a deprivation of liberty, their Lordships transposed the following principles into domestic law:⁴⁰

- 1) There is no “bright line” separating deprivation of liberty from restriction on liberty with borderline cases falling within an area of “pure opinion”.
- 2) The test is objective: the task of the Court is to assess the impact of the measures “on a person in the situation of the person subject to them”.
- 3) Many relevant factors must be taken into account (e.g. the type, duration, effects and manner of implementation of the measures), but the starting point or “core element” is the length of the curfew.
- 4) Social isolation is a significant factor, especially if it approaches solitary confinement during curfew periods.

Those dissenting guarded against an over-expansive interpretation of the deprivation of liberty concept so as to maintain the necessary distinction between article 5 and article 2 of protocol 4. Preferring a narrower construction, which departs from the Strasbourg jurisprudence, Lord Hoffmann noted how imprisonment was the paradigm case for article 5 engagement, although “one may have some degree of deviation ... without it ceasing to be ... a deprivation”.⁴¹ The essential question was “whether his situation approximates sufficiently closely to being in prison”.⁴² Similarly, for Lord Carswell the criterion for a liberty deprivation was “illegitimate imprisonment, or confinement so close as to amount to the same thing”.⁴³ Such divergence of judicial opinion does not bode well for the implementation of DoLS. Indeed, the following are amongst a number of issues which are likely to be exposed in forthcoming litigation.

38 *Ibid* n.2; see also *Secretary of State for the Home Department v GG* [2009] EWHC 142 (Admin); *Secretary of State for the Home Department v AU* [2009] EWHC 49 (Admin); *AH v Secretary of State for the Home Department* [2008] EWHC 1018 (Admin); *Secretary of State for the Home Department v AP* [2008] EWHC 2001 (Admin); *Secretary of State for the Home Department v E* [2008] EWHC 585 (Admin); *Secretary of State for the Home Department v MB* [2008] 1 AC 440. For a useful commentary, see D. Feldman, ‘Deprivation of liberty in anti-terrorism law’ (2008) 67(1) *Cambridge Law Journal* 4.

39 The Prevention of Terrorism Act 2005 has replaced the Anti-terrorism, Crime and Security Act 2001 whose

provisions enabling the detention of foreign nationals without trial was held to be unlawful in *A v Secretary of State for the Home Department* [2005] AC 68.

40 As summarised in *Secretary of State for the Home Department v AH* [2008] EWHC 1018 (Admin) at para 21.

41 *Ibid* n.2 at para 38.

42 *Ibid* at para 43 relying on the dissenting judgments in *Guzzardi* as adopted by the Court of Appeal in *R (Gillan) v Commissioner of Police of the Metropolis* [2005] QB 388, 406 and approved by the House of Lords [2006] 2 AC 307, 343.

43 *Ibid* at para 79.

Jurisprudential Cracks

(a) A question of degree, not substance?

The ECtHR has never explained or justified why the difference between restricted movement and deprived liberty should be one of intensity or degree, rather than nature or substance, or indeed a combination of the two. Neither has this approach been doubted in English law. But the dichotomy is not easily drawn. A disciplinary measure for example, which would usually deprive a civilian of their liberty, may not necessarily deprive a serviceman if it does not sufficiently deviate from the ‘normal conditions’ of military life.⁴⁴ Is this because the measure is more *intense* for the civilian? Or is it because of the *nature* of military life? Or both?

Such dichotomous ambivalence can clearly be seen in *Ashingdane v United Kingdom*.⁴⁵ A patient subject to an indefinite restricted hospital order was transferred from Broadmoor to Oakwood hospital. The intensity of the security regimes differed dramatically. The former had barred windows, a high perimeter wall, and locked hospital blocks and outer gates. With such conditions of high security, Mr Ashingdane was permitted only two escorted periods of leave during his nine year stay. Oakwood hospital had no surrounding wall. Neither its main entrance nor reception area was locked and he was given unescorted leave to go home every weekend from Thursday till Sunday. Moreover, he could come and go as he pleased from Monday to Wednesday, provided only that he returned to the ward at night. And yet, according to the ECtHR, the differences between these regimes “were not such as to change the character of his deprivation of liberty as a mental patient”.⁴⁶ Such a conclusion is difficult to draw if we focus solely upon the intensity of the measures without considering their nature.

The European jurisprudence considers both the nature of the detention and the degree of the liberty restrictions in other article 5 contexts. Where an individual is transferred from lawful house arrest into hospital detention, for example, nature and degree is relevant in determining whether separate justification under article 5(1)(e) is required for the latter.⁴⁷ Why, then, should the test for determining whether liberty is deprived be any different?

(b) Motives behind the measures

Our physical liberty may be restricted for a variety of reasons. The confinement could be therapeutic, preventative, rehabilitative, or punitive in nature, or a combination thereof. Should the confiner’s motives be relevant? Might therapeutic detention be less likely to deprive liberty than its retributive equivalent? In *HM v Switzerland*,⁴⁸ an 84 year-old widow with a disputed diagnosis of senile dementia was placed in a foster home on account of serious neglect at home. Reference was made to the fact that this was in her own interests so that she would be provided with the necessary medical care and satisfactory living and hygiene conditions.

In *JJ*, there was judicial disagreement over this issue, even amongst the majority. According to Lord Brown, “[t]he borderline between deprivation of liberty and restriction of liberty of movement cannot vary according to the particular interests sought to be served by the restraints imposed.”⁴⁹ Such a stance resonates with Berlin’s concept of negative liberty by taking an *objective* look at the measures and their

44 Engel n.8. Deviation from the norm explained why the ‘strict arrest’ of soldiers in locked cells engaged article 5 but their ‘aggravated arrest’ in unlocked designated places did not, despite not being free to leave.

45 (1985) 7 EHRR 528.

46 *Ibid* at para 47.

47 See *Atanasov v Bulgaria* *ibid* n.30 at para 71–2.

48 (2004) 38 EHRR 17 at para 48.

49 *Ibid* n.2 at para 107.

impact upon a person who finds themselves in the situation of the person subject to them. Whereas for Baroness Hale, “restrictions designed, at least in part, for the benefit of the person concerned are less likely to be considered a deprivation of liberty than are restrictions designed for the protection of society”.⁵⁰ This perspective conforms more to the philosophy of positive liberty with its more paternalistic undertones towards those lacking capacity. It takes account of the *subjective* characteristics of the person and the motives behind the measures, coupled with their effects upon that individual.

This jurisprudential crack has been fully exposed in *Austin v Commissioner of Police of the Metropolis*.⁵¹ The House of Lords cautiously held that measures of crowd control taken in the interests of public safety would not infringe article 5 rights, provided they were proportionate, taken in good faith and enforced for no longer than was reasonably necessary. The purpose behind the restrictions was an additional factor to take into account, at least where article 5(1) did not permit the deprivation of liberty to be justified.

(c) Freedom to leave

Whether Mr L and Mr DE were free to leave their respective hospital and care home was considered to be the “key factor”. But it has not featured elsewhere. Asylum seekers kept in an airport transit zone, for example, were held to be deprived of their liberty despite being (at least theoretically) free to leave the country at any time.⁵² Moreover, in *JJ* the suspected terrorists were free to leave their homes daily between 10am and 4pm, provided they remained within a designated area. Similarly, in *Ashingdane* the patient was free to leave the unsecured hospital for most of the week and yet remained deprived of his liberty.

Whilst one’s freedom to leave a particular location is a useful indicator of the restrictive regime’s intensity, it may suffer from definitional problems. For example, if care home staff position an otherwise wandering resident in a deep bean bag, is he “free to leave” through the open door before him if he cannot get up? Munby J. defined being free to leave “in the sense of removing [oneself] permanently in order to live where and with whom [one] chooses.”⁵³ Can a resident ever be free to permanently leave their accommodation when they lack the capacity to make that decision? Applying such reasoning to *JJ*, it would follow that anyone subject to a control order, *regardless of the length of curfew*, would not be “free to leave”.

One’s freedom to leave “may be tested by determining whether those treating and managing the person exercise complete and effective control over [their] care and movements”.⁵⁴ Is this the *only* way? Might the individual’s disabling condition, for example, satisfy this “key factor”? In relation to the right to life as protected by article 2 of the Convention, Baroness Hale recently commented, *obiter*, that whilst some patients are deprived of their liberty by the law, others like Mr L “are deprived of their liberty by their own condition.”⁵⁵ If the physical liberty of a person can be deprived by their own immobility, this would radically broaden the scope of article 5. Not only would the law take account of the *external* restrictions being implemented by the managing authority. Consideration would also be given to otherwise liberating measures that the authority failed to implement to help the person overcome their *internal* restrictions.

50 *Ibid* at para 58. See also *R (Secretary of State for the Home Department) v Mental Health Review Tribunal (PH)* [2003] MHLR 202.

51 [2009] 2 WLR 372. For commentary see D. Hewitt, ‘Whose Liberty?’ (2009) 153(6) *Solicitors Journal* 17. The Appellate Committee followed Lord Hoffmann’s dissenting judgment in *JJ*. Much reliance was also placed on *Saadi v United Kingdom* (Application No 13229/03, 29 January 2008) at paras 68 and 74 which concerned

arbitrariness rather than deprivation of liberty.

52 *Amuur v France* *ibid* n.34.

53 *Ibid* n.37 at para 115.

54 *HL v United Kingdom* *ibid* n.15 at para 91 (*emphasis added*).

55 *Savage v South Essex Partnership NHS Foundation Trust* [2009] 2 WLR 115 at para 101.

(d) Consensual confinement

We consent to restrictions on our liberty on a daily basis. Airplane passengers, for example, cannot insist on being allowed to get off in mid-flight. Football crowds are often contained for periods before being permitted to leave the ground. Members of religious orders choose to live eremitic lives. The extent to which consent should influence the engagement of article 5 has witnessed a somewhat seismic jurisprudential shift. The ECtHR's former view was that "[d]etention might violate Article 5 even although [sic] the person concerned might have agreed to it".⁵⁶ In *HL v United Kingdom*⁵⁷ it recalled that "the right to liberty is too important in a democratic society 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". It was held in *Storck v Germany*, however, that "[i]ndividuals 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".⁵⁸ Furthermore, where a person is legally capable of expressing an opinion, their consent can be inferred if they are undecided as to whether or not they wish to stay.⁵⁹

In relation to hospital and care home detention, if an otherwise detained person's capacitous consent is to preclude the engagement of article 5, no authorisation would have to be sought from the supervisory body. As a result, a substantial number would not be safeguarded against arbitrary detention. Indeed, the underlying aims of the Mental Capacity Act 2005, to promote autonomy and empower individuals, make this more likely, for every patient and resident must be assumed to have capacity according to the statutory principles. Moreover, the capacity assessment under DoLS need not be performed by a doctor or approved mental health professional.⁶⁰ In those circumstances, should the presence or absence of consent play such a decisive role in determining their right to liberty?

(e) Assessing capacity

The matter is compounded by uncertainty surrounding the issue of capacity. If the absence of consent is to be a necessary additional element to a liberty deprivation, the individual must have capacity to give that consent. According to the Act,⁶¹ they must lack capacity "in relation to the question whether or not he should be accommodated in the relevant hospital or care home for the purpose of being given the relevant care or treatment". However, making that assessment may be far from straightforward.⁶² The DoLS Code of Practice is silent on this issue. For no guidance is given as to what relevant information a resident must be able to understand, retain and use when deciding whether to consent to going into such accommodation.

Across the Atlantic, in response to the US Supreme Court's decision in *Zinerman v Burch*,⁶³ which touched upon issues similar to those in *Bournewood*, the American Psychiatric Association favoured what they considered to be a lenient but meaningful test.⁶⁴ This would require a person to understand that (a)

56 *De Wilde, Ooms and Versyp v Belgium (No. 1) (1971) 1 EHRR 373 at para 65.*

57 *Ibid* n.15 at para 90.

58 *Ibid* n.32 at para 74.

59 *Ibid* at para 77.

60 It can be undertaken by a best interests assessor; see *Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations (SI 2008/1858) regulation 6.*

61 *Mental Capacity Act 2005 Schedule A1 para 15.*

62 For an interesting discussion of the legal issues, see P. Bartlett, 'The test of compulsion in mental health law: Capacity, therapeutic benefit and dangerousness as possible criteria' (2003) 11 *Medical Law Review* 326 at 336–344. See also Owen et al, 'Mental capacity to make decisions on treatment in people admitted to psychiatric hospitals: cross sectional study' (2008) *British Medical Journal* 337.

63 (1990) 494 US 113.

64 'Consent to Voluntary Hospitalisation', Task Force Report 34 (APA, 1992).

they were being admitted to a psychiatric hospital for treatment; (b) their release may not be automatic; and (c) they could get help from staff to initiate procedures for release. However, such a low capacity threshold, reinforced by the statutory presumption of capacity in the 2005 Act, would result in more compliant patients being *de facto* detained without the protection of article 5.

(f) The inherent jurisdiction

Since Mr L's proceedings concluded in Strasbourg, the domestic legal landscape has changed dramatically in the sphere of substitute decision-making as the courts have striven to plug the Bournemouth gap.⁶⁵ The High Court is transforming its inherent jurisdiction by developing a "protective jurisdiction" over both mentally incapacitated and "vulnerable"⁶⁶ adults that enables the regulation of "everything that conduces to [their] welfare and happiness".⁶⁷ This includes the power to authorise both their detention and the use of reasonable force should they attempt to leave.⁶⁸

At this early stage it is unclear how the inherent and statutory jurisdictions will interface. Could the former be invoked to detain those who do not qualify for the latter? Or would this undermine Parliament's intentions? Early judicial signs indicate that the Mental Capacity Act 2005 exists alongside, and has not impliedly negated, the common law.⁶⁹ It therefore appears likely that the statutory authority to deprive liberty will operate in tandem with the common law power to detain which may not develop into the most harmonious of relationships.

A Fresh Approach? The Theory of Coerced Confinement

We know that article 5 is concerned with a particular type of liberty; the physical liberty of a person to move from one place to another. Opinions may differ as to whether a given set of measures are sufficient to cross the line that distinguishes restricted movement from a deprivation of liberty. On two points, however, a degree of consensus may exist. The reported judgments reveal two common themes, or core elements, when article 5 has been engaged. Firstly, the individual is always confined in a particular place, where they do not choose to be, for more than a negligible period of time. And, secondly, there is something extra, some additional factor present, which distinguishes simple detention from a liberty deprivation.

(a) A requirement for confinement

The diverse range of circumstances in which article 5 might be triggered does not lend itself to legal certainty. What does seem certain is that judicial references to the "concrete situation", "objective element" or "starting point" are indicative of a requirement for some form of confinement. Applying the *Guzzardi* criteria, different types of measures may restrict liberty, whose duration may vary as much as the

65 As Sedley LJ noted in *Re F (Adult: Court's Jurisdiction)* [2000] 2 FLR 512 at 532, "the court itself can do much to close the so-called Bournemouth gap in the protection of those without capacity."

66 The latter group extends beyond the remit of the Mental Capacity Act 2005 to include those who are incapacitated 'by reason of such things as constraint, coercion, undue influence or other vitiating factors' (*Re SA (vulnerable adult with capacity: marriage)* [2006] 1 FLR 867 at para 79 per Munby J). See M. C. Dunn et al, 'To empower or to protect? Constructing the 'vulnerable adult' in English law and public policy' (2008) 28(2) *Legal Studies* 234.

67 *Re SA* *ibid* at para 45. See also *Ealing LBC v KS* [2008] EWHC 636 (Fam); *Westminster City Council v C* [2008] EWCA Civ 198; *X City Council v MB, NB and MAB* [2006] EWHC 168 (Fam); *Local Authority X v MM (By the Official Solicitor) and KM* [2007] EWHC 2003 (Fam).

68 *City of Sunderland v PS* [2007] EWHC 623 (Fam) at para 16.

69 *KC, NNC v City of Westminster Social & Community Services Department, IC (a protected party, by his litigation friend the Official Solicitor)* [2008] EWCA Civ 198 para 54.

manner in which they are implemented. But cumulatively they must amount to confinement. Being surrounded by four walls is certainly not a prerequisite; after all, the suspected mafiosa was bounded on one side by the sea.

In relation to hospital and care home detention, possible indicators of a liberty deprivation include the use of physical and chemical restraint, staff control over assessments, treatments, social contacts and residence and the loss of autonomy resulting from continuous supervision.⁷⁰ Other relevant factors may include a high staff to resident ratio, locked or lockable doors, a remote geographical location, and the use of subterfuge and electronic surveillance.

There are a number of ways in which the relativist requirement for confinement might be more clearly defined. Firstly, a better approach may be to consider it as a question of *both* intensity or degree *and* nature or substance. Solitary confinement, for example, is by its very nature a particularly intensive measure, even for short periods of time. Whereas being kept in hospital is less so, even for long periods. But the necessary degree of intensity may derive from the accumulation of other, more restrictive, measures such as being prevented from having contact with one's carers. Similarly, having to remain in a hotel for ten days with one's family is perhaps less intensive than a locked hospital ward; but being subjected to a psychological process of "deprogramming" changes the nature of that confinement.⁷¹

Secondly, it may be helpful to consider the circumstances enjoyed by the individual *prior to* the restrictions being implemented. It could be argued, for example, that the more familiar the nature of the surroundings, the more intensive must be the other measures before the circumstances can amount to confinement. This might go some way towards explaining why a 24 hour house arrest would engage article 5,⁷² whereas a 12 hour home curfew each weekday and throughout the weekend would not;⁷³ nor a 10 hour curfew with a requirement not to leave home without informing the police.⁷⁴

Thirdly, the person's freedom to leave should be but one factor in what is a complex equation. In general, the freer they are to leave, the less likely they can be said to be confined. But not being free to leave does not necessarily equate to a deprivation of liberty; for a person may not be free whilst their movement is being merely restricted. Thus, to overly rely upon this factor could potentially threaten the basic distinction between restricted movement and depriving liberty. Moreover, their ability to leave must be more than a theoretical possibility. A care home resident may face an open door through which he is free to walk. But he is not free to leave if staff are ready to bring him back in. Similarly, an asylum seeker's ability to leave a country "becomes theoretical if no other country offering protection comparable to the protection they expect to find in the country where they are seeking asylum is inclined or prepared to take them in."⁷⁵ This may explain why, according to the DoLS Code of Practice, to prevent a person from leaving, so as to guard against immediate harm, is unlikely without more to amount to a deprivation.⁷⁶

70 See *Deprivation of liberty safeguards: Code of Practice to supplement the main Mental Capacity Act 2005* (2008) at para 2.5.

71 *Blume and others v Spain* *ibid* n.35.

72 *NC v Italy* (Application no. 24952/94, 11 January 2001), para 33; *Mancini v Italy* (Application no. 44955/98, 12 December 2001), para 17; *Vacher v Bulgaria* (Application no. 42987/98, 8 October 2004), para 64; *Nikolova v Bulgaria* (No 2) (Application no. 40896/98, 30 December 2004), para 60; *Trijonis v*

Lithuania (Application no. 2333/02, 17 March 2005); *Pekov v Bulgaria* (Application no. 50358/99, 30 June 2006), para 73.

73 *Trijonis v Lithuania* (Application no. 2333/02, 17 March 2005).

74 *Raimondo v Italy* (1994) 18 EHRR 237.

75 *Amuur v France* *ibid* n.34 at para 48. Syria was not a signatory to the 1951 Refugee Convention.

76 *Ibid* n.70 at para 2.10.

As for the role of consent, fourthly, imagine an altruistic man with tuberculosis who consents to his therapeutic detention in order to protect the public.⁷⁷ Can he be said to be “deprived” of something which he is happy to give away? Presumably not. But what is the position if those responsible for his detention go beyond the restrictive measures to which he has agreed? Would his consent still mean that he was not then deprived? Or is this subjective element dependent upon the terms to which he initially consented? Rather than imposing an absolute embargo upon there being a deprivation of liberty, perhaps consent should be relevant to the intensity and nature of the objective element. It would also be relevant to the second feature of a deprivation.

(b) The missing ingredient

Confinement alone will not trigger the procedural due process required by article 5.⁷⁸ Something more is required. If the concrete situation is merely the “starting point”, what considerations should follow? Baroness Hale captured the dilemma:

*“My Lords, what does it mean to be deprived of one’s liberty? Not, we are all agreed, to be deprived of the freedom to live one’s life as one pleases. It means to be deprived of one’s physical liberty ... And what does this mean? It must mean being forced or obliged to be at a particular place where one does not choose to be ... But even that is not always enough, because merely being required to live at a particular address or to keep within a particular geographical area does not, without more, amount to a deprivation of liberty. There must be a greater degree of control over one’s physical liberty than that. But how much?”*⁷⁹

In *HL v United Kingdom*, it was the clinicians’ “complete and effective control” over Mr L’s care and movements which ultimately tipped the balance. Would this threshold satisfy the horns of the dilemma? It would appear to sit uncomfortably with the *Ashingdane* decision. There, the detaining authorities certainly exercised a degree of control in permitting weekend leave and in requiring him to return to the ward during the remainder of the week. But would it not stretch ordinary language to describe that as “complete and effective” control? Moreover, what do the terms mean and how do they differ? In what circumstances might complete control be ineffective and effective control incomplete? There is also uncertainty regarding the proper approach to be taken. Is it a single or dualist approach? That is to say, should the presence and degree of control be part and parcel of the confinement issue; or should it be tackled after the concrete situation has already been established?

Confinement distinguishes restricted movement from detention. Perhaps a concept of coercion might be used to distinguish detention from a deprivation of liberty. After all, “[i]n many respects human rights law is all about the protection of the individual from undue coercion.”⁸⁰ It could be argued that neither confinement without coercion, nor coercion without confinement, can deprive liberty. The former may justify an action for habeas corpus and false imprisonment; the latter may interfere with other articles of the European Convention. But both features could be required to be contemporaneously present in order to engage article 5.

77 See ss.37–38 of the Public Health (Control of Disease) Act 1984 and the Public Health (Infectious Disease) Regulations 1988.

78 *Austin v Commissioner of Police of the Metropolis* [2008] QB 660 at paras 12 and 105. This was not doubted on appeal [2009] 2 WLR 372. For a discussion of the difference between being ‘detained’ and ‘deprived of liberty’, see D. Hewitt, ‘Boumewouldn’t’ (2007) 157 *New*

Law Journal 1600.

79 *Ibid* n.2 at para 57.

80 G. Richardson, ‘Coercion and human rights: A European perspective’ (2008) 17(3) *Journal of Mental Health* 245 at 246. See also BJ Winick, ‘A therapeutic jurisprudence approach to dealing with coercion in the mental health system’ (2008) 15 *Psychiatry, Psychology and Law* 25.

Such an approach may explain the decision in *HM v Switzerland* where there was coercion without confinement, followed by confinement without coercion. A court order, implemented by the police, was used to convey the elderly widow to the nursing home. Although the ward was open, she was not free to leave and was arguably held in confinement.⁸¹ But there was little in the way of coercion on the part of the detaining authorities *after* her admission. She had freedom of movement, was encouraged to have contact with the outside world and hardly felt the effects of her stay. Furthermore, she was undecided as to whether or not she wanted to stay but, within weeks of being there, agreed to stay.

A lack of coercion may also explain why, in *Nielsen v Denmark*,⁸² the locked confinement of a 12 year-old boy in a psychiatric hospital for five and a half months was held not to amount to a deprivation of liberty. The ward was “as similar as possible to a real home”; he was permitted to attend libraries, playgrounds, museums, was able to visit his family regularly; and, towards the end of his stay, went back to school. Similarly in *Storck v Germany*⁸³ in relation to the patient’s *second* stay on the locked ward of the psychiatric clinic. She presented of her own motion, remained there for four months and did not attempt to flee. Thus, although there was confinement, there was little evidence of coercion. She was assumed to be capable of validly consenting and accepted that she had “to a certain extent voluntarily” consented to her stay due to her need for treatment. After all, coercion can hardly be said to exist if the person capacitously consents to all of the terms of their confinement.

If coercion were to feature as one of the two core components of a liberty deprivation, further consideration would have to be given to its meaning. Prior to the 1970s, mainstream philosophical thought suggested that A coerced B when he used, or threatened to use, force or violence. Coercion thereby resembled A’s ability to implement and enforce decisions over B’s activities.⁸⁴ Although there remains no single definition, recent attempts have been made to particularise the concept.⁸⁵ Sz mukler and Appelbaum helpfully describe a “spectrum of pressures” in the context of treatment which could be applied to confinement.⁸⁶ It ranges from persuasion, interpersonal leverage, and inducements or offers, through to threats and the use of compulsion. At some point along that continuum, coercion will be exercised either on the will or body of the coercee.

Conclusions

Interpreting the scope of article 5 demonstrates that, even in an area of such supreme importance as personal liberty, the law is not an exact science. Transposing the European concept into English law has proved troublesome, even before DoLS have come into force. The expansive approach, embraced by Munby J. in *JE* and by the majority in *JJ*, certainly provides significant judicial elbow-room to flexibly protect the right to liberty. But this is at the cost of legal certainty, with borderline cases becoming a matter of pure opinion. The literal approach, preferred by Lords Hoffmann and Carswell, promotes legal certainty but narrows the scope of article 5 protection and contradicts European jurisprudence.

81 See *para O-16*.

82 (1988) 11 EHRR 175.

83 *Ibid* n.32.

84 J. R. Lucas, *The Principles of Politics* (1966) (Oxford: Clarendon Press) at p57. Coercion has more recently been defined as when “one person intentionally uses a credible and severe threat of harm or force to control another” in T. Beauchamp and J. Childress, *Principles of Biomedical Ethics* (2001) 5th ed. (Oxford University Press, New York).

85 See S. Anderson, *Coercion* (2006) in *Stanford encyclopedia of philosophy*. Available at <http://plato.stanford.edu/entries/coercion>.

86 G. Sz mukler and P.S. Appelbaum, ‘Treatment pressures, leverage, coercion, and compulsion in mental health care’ (2008) 17(3) *Journal of Mental Health* 233. See also R. Wynn, ‘Coercion in psychiatric care: clinical, legal, and ethical controversies’ (2006) 10(4) *International Journal of Psychiatry in Clinical Practice* 247.

The unenviable task of resolving these issues may madden those seeking some legal litmus test to distinguish the “deprived” from the “restricted”. However, given the diverse range of circumstances to which article 5 might apply, it is not surprising that the ECtHR has opted for a relativist approach. Detention, in conventional terms, is transforming as technology develops. Liberty deprivations may become more commonplace, particularly if an individual’s condition is included in the complex equation. Given the jurisprudential cracks that arise from applying the same guiding principles to the six detention grounds, perhaps a fresh approach is required to tackle developments in legal standards and in attitudes. One option might be to equate the deprivation of liberty concept with a theory of coerced confinement. Whilst it may not provide all the answers, it certainly helps to clarify the issues but requires further deliberation. Perhaps, in the end, the answer lies in our philosophical stance on liberty. After all, the truth is that “out of the crooked timber of humanity no straight thing was ever made.”⁸⁷

87 I. Berlin, *The Crooked Timber of Humanity: Chapters in the History of Ideas* (London: John Murray, 1990), p19 quoting I. Kant.