



## The Zone of Parental Control, The 'Gilded Cage' And The Deprivation of a Child's Liberty: Getting Around Article 5.

Journal:	<i>Tizard Learning Disability Review</i>
Manuscript ID	TLDR-05-2016-0014.R1
Manuscript Type:	Legal Feature
Keywords:	Deprivation of liberty, Human rights, Mental Capacity Act, Learning disabilities, Challenging behaviour, Law Commission

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3 **The Zone of Parental Control, The ‘Gilded Cage’ And The Deprivation of a**  
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5 **Child’s Liberty: Getting Around Article 5.**  
6

7 **Introduction**  
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10 The Mental Health Act 1983 Code of Practice describes the law that covers  
11 admissions to hospital and treatment for mental disorders in children as ‘complex’  
12 (Department of Health (DH), 2015). This article will establish that, following *P v*  
13 *Cheshire West and Chester Council* [2014] (referred to as *Cheshire West*), the law’s  
14 consideration of the right to liberty under Article 5 of the European Convention on  
15 Human Rights (ECHR) for children under the age of sixteen is not only complex but  
16 confusing. The protection of children being deprived of liberty is most timely in light  
17 of the current review of Deprivation of Liberty Safeguards (DoLS) by the Law  
18 Commission and the likelihood of a replacement framework. The differing legal  
19 protection for deprivation of liberty in children under the age of sixteen with a mental  
20 health disorder or a learning disability was highlighted in the very recent case of *Re*  
21 *Daniel X* [2016], contrasted with *Birmingham City Council v D* [2016] and the earlier  
22 decision in the same case *Trust A v X* [2015]. Importantly, Keehan J held in  
23 *Birmingham City Council v D* that a parent could consent to what would amount to a  
24 deprivation of liberty, however this would not be the case for the same child when  
25 they attain the age of sixteen because of the protection afforded under the Mental  
26 Capacity Act (MCA) 2005.  
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49 The main argument presented in this paper is that, as a result of parental consent  
50 being recognised as holding legal authority, these children have their right to liberty  
51 under Article 5 breached. The lack of court support for this position will be explained  
52 in the context of the confusing concept of the ‘zone of parental control’ in relation to  
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3 deprivation of liberty. It will be argued that Keehan J's notion of a 'common sense  
4 approach' to the zone of parental control in *Trust A v X* is not satisfactory where the  
5 issue is deprivation of liberty. Furthermore, that the logical solution is to support  
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7 Mackenzie and Watts' (2014) call for procedural safeguarding through an extension  
8 of DoLS or any subsequent safeguarding system to apply equally to children.  
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12 Detention authorised under the Mental Health Act 1983 (MHA) or if applicable under  
13 section 25 of the Children Act 1989 (CA), in which there are legislated procedural  
14 requirements and reviews, will not be considered in this discussion.  
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### 20 21 22 **Deprivation of Liberty: The Gap between Children, Young People and Adults**

23 The law under *Gillick v West Norfolk and Wisbech Area Health Authority* [1986]  
24 provides that a competent child under the age of sixteen can consent to treatment,  
25 although where treatment is refused the courts almost always overrule any such  
26 decision (Cave, 2013). The child under the age of sixteen who lacks capacity to make  
27 decisions regarding their health has their welfare protected under the CA, whereby  
28 parents have a responsibility to act in their child's best interests.  
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40 In the case of children with a mental disorder, the emphasis is on those children and  
41 young people receiving treatment that is decided to be in their best interests and to  
42 avoid deprivation of liberty through use of the MHA (Cave, 2013). Cases concerning  
43 deprivation of liberty are most common outside of the MHA, where that child lacks  
44 capacity to consent to inpatient treatment through either a mental health disorder or a  
45 learning disability (Bowers and Dubicka, 2009). Outside of the MHA, deprivation of  
46 liberty for children under sixteen is either lawfully sanctioned by the courts under  
47 their inherent jurisdiction or considered not to be a deprivation of liberty, as it falls  
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3 under parental responsibility (Bowers and Dubicka, 2009). In sharp contrast, those  
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5 over the age of sixteen in the same position are protected under the MCA in  
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7 accordance with the Family Law Reform Act 1969 and furthermore, on attaining the  
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9 age of eighteen, are protected under the DoLS.  
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14 The DoLS were introduced following *HL v UK* [2005], known as *Bournemouth*, where  
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16 the European Court of Human Rights (ECtHR) held that the hospital admission of a  
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18 patient with learning disabilities and autism was a deprivation of liberty as he was not  
19  
20 permitted to leave, consequently engaging Article 5 of the ECHR. Article 5 requires  
21  
22 that such deprivation must be subject to judicial review and, as this was not provided  
23  
24 for in the MCA, a gap was identified in the compatibility of domestic law and the  
25  
26 ECHR, known as the '*Bournemouth* gap'. DoLS provides procedural safeguards to  
27  
28 protect vulnerable adults who are not being detained under the MHA but are deprived  
29  
30 of their liberty (Mackenzie and Watts, 2010). Importantly, these do not apply to those  
31  
32 under the age of eighteen, where common law and the CA are relied upon for those  
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34 under the age of sixteen and the MCA for those aged sixteen and seventeen.  
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38 Therefore, within the scope of children's decision-making, deprivation of liberty  
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40 outside of the MHA is differentiated from that of adults by the lack of legislative  
41  
42 safeguarding procedures. The issue identified is how a lack of universal safeguarding  
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44 can be compatible with Article 5, if the right to liberty is universal?  
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### 49 **The Influence of the European Court of Human Rights**

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51 The right to liberty is provided under Article 5 of the ECHR. Domestic courts and the  
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53 ECtHR in Strasbourg have both had to interpret the ECHR and apply it to the rights of  
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55 children as holders of those rights rather than objects of protection (European Union  
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3 Agency for Fundamental Rights, 2015). This was most significantly demonstrated in  
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5 the cases of *Elsholz v Germany* [2000] and *Yousef v Netherlands* [2003], where the  
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7 ECtHR held that a child's human rights should always be paramount.  
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11 Deprivation of liberty can be considered lawful under Article 5 for those of unsound  
12  
13 mind, providing that such deprivation is carried out within a legal framework.  
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16 Baroness Hale reiterated in *Cheshire West* the 'universal character' of the ECHR.  
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18 Specifically, Baroness Hale considered the universal application of Article 5  
19  
20 regardless of disability:  
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23 'In my view, it is axiomatic that people with disabilities, both mental and  
24  
25 physical, have the same human rights as the rest of the human race. It may  
26  
27 be that those rights have sometimes to be limited or restricted because of  
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29 their disabilities, but the starting point should be the same as that for  
30  
31 everyone else.' (Para 45)  
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35 However, the ECtHR has faced difficulties when interpreting Article 5 in the context  
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37 of whether a deprivation or merely a restriction of liberty has been imposed upon an  
38  
39 individual. In *Guzzardi v Italy* [1980] the ECtHR considered the distinction between  
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41 deprivation and restriction of liberty, holding that it was an objective test relating to  
42  
43 only the intensity or degree as opposed to subjective and therefore the nature or  
44  
45 substance that determines a deprivation of liberty. Later, in *Storck v Germany* [2005],  
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47 a subjective element was added, in that a deprivation could only occur if the person  
48  
49 had not validly consented to the deprivation.  
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52 Prior to *Storck*, the objective test was applied to children in *Nielson v Denmark*  
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54 [1988], where a twelve year old was detained in a psychiatric facility on the consent  
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56 of his mother. The court held that there was not a deprivation of liberty since a  
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3 responsible parent was exercising her custodial rights. However, the court did  
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5 recognise that the State is obligated to ensure that parental consent did not have  
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7 unlimited scope and, importantly, could not deprive a child of liberty. Harbour (2008)  
8  
9 explains that *Nielson* was heavily criticised on the basis that the child's views were  
10  
11 not considered, particularly in the depth they would be today. Furthermore, as the  
12  
13 duration of the admission was several months, there was concern that such a duration  
14  
15 of treatment did amount to a deprivation of liberty (Harbour, 2008). This point was  
16  
17 most accurately articulated by Judge Salcedo, dissenting in *Nielson*, who held that  
18  
19 'the fact that a parent may legally, and without being subject to any  
20  
21 judicial review, place a child in his custody in a psychiatric ward,  
22  
23 constitutes a violation of Article 5 (1)'. (Para 24)  
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28 It seems likely that, had the dissenting opinion been applied to the ruling in *Nielson*  
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30 and a deprivation of liberty found, the requirement for judicial review in accordance  
31  
32 with Article 5 (4) would have resulted in DoLS being applied to all persons deprived  
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34 of liberty regardless of age.  
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### 38 **The Impact of the 'Gilded Cage' for Children**

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40 Before addressing the UK interpretation of Article 5 and *Nielson* in relation to a  
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42 child's deprivation of liberty, it is paramount to analyse the scope of the application of  
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44 any breach to a child's rights under Article 5 following *Cheshire West*. The UK  
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46 Supreme Court established that a deprivation of liberty must subjectively lack the  
47  
48 consent of the person. In considering the decision in *Guzzardi*, Baroness Hale held  
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50 that the essence of a deprivation of liberty must be that it amounts to a restriction of  
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52 *physical* liberty. In considering the scope and universal application of the definition of  
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54 deprivation of liberty, Baroness Hale explained that  
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3 'If it would be a deprivation of my liberty to be obliged to live in a  
4 particular place, subject to constant monitoring and control, only allowed  
5 out with close supervision, and unable to move away without permission  
6 even if such an opportunity became available, then it must also be a  
7 deprivation of the liberty of a disabled person. The fact that my living  
8 arrangements are comfortable, and indeed make my life as enjoyable as it  
9 could possibly be, should make no difference. A gilded cage is still a  
10 cage.'

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23 Baroness Hale's broadened definition went beyond earlier interpretations of Article 5  
24 in *Bournemouth*, but effectively meant that the number of people deprived of their  
25 liberty was increased as a result of the widened definition (Penny and Exworthy,  
26 2015). In response, Stavert (2015) questioned whether the DoLS now satisfy the  
27 procedural requirement under Article 5. In particular, Stavert (2015) identified  
28 children and young people as being particularly vulnerable because of both the lack of  
29 safeguarding and the broad scope of health and social care settings that could  
30 potentially deprive liberty following *Cheshire West*. The Department of Health (2015)  
31 guidance following *Cheshire West* did not address the issues for those under the age  
32 of eighteen. It could be considered that the responsibilities expected of parents to the  
33 welfare of their children justify there being no additional safeguarding requirements.  
34 Wheeler and Crabb (2016) argued that parents are in a better position to make  
35 decisions because of the complex and differing needs of settings caring for children  
36 with a learning disability or mental health disorder with associated challenging  
37 behaviour. However, as highlighted by Penny and Exworthy (2015), this fails to  
38 consider the potentially unlawful position in which *Cheshire West* has now placed  
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3 local authorities, charities, hospital trusts, clinicians and other practitioners, where  
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5 deprivation of liberty is of concern.  
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### 10 **The Scope of Article 5 for Children within English Law**

11 The common law position of parental consent authorising treatment for mental health  
12 disorders, which could also amount to a deprivation of liberty, for children under the  
13 age of sixteen lacking capacity to consent, was established in a series of cases at the  
14 end of the twentieth century. In the cases of *Re R* [1991] and *Re K, W and H* [1993]  
15 the courts held that parental consent was valid for compulsory psychiatric treatment  
16 and did not require further court approval. While these cases related to refusal of  
17 treatment, they involved admission to secure, inpatient, psychiatric hospitals, the  
18 children were not free to leave and the treatment was not carried out under the MHA.  
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20 Hawkins *et al.* (2011) argued that, if these cases were considered today in light of the  
21 Human Rights Act 1998, deprivation of liberty would be a central issue.  
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36 Despite the MCA not being applicable to children under 16, section 25 of the CA  
37 does allow for the courts to authorise local authorities to restrict the liberty of  
38 children. This is only where secure accommodation is necessary to prevent the child  
39 from absconding or to protect the child from self-harm or harming others, outside of a  
40 clinical setting. In authorising such a restriction, the courts must specify duration and  
41 that the child must be legally represented in any hearings.  
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49 In *Re K* [2001] the England and Wales Court of Appeal considered whether restricting  
50 liberty under section 25 of the CA was compatible with Article 5. Butler-Sloss P held  
51 that it was compatible because of the judicial review involved in such decisions and  
52 that it was within the jurisdiction of the courts to protect the child or others from  
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3 harm. She further held that if such restrictions were authorised by a parent alone it  
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5 would not be compatible with Article 5. In *RK v BCC, YB and AK* [2011] the Court of  
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7 Appeal was asked this question again in relation to deprivation of liberty and Mostyn  
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9 J's decision in the lower court, that section 25 would never result in deprivation of  
10  
11 liberty in respect of Article 5. Although agreeing that on the facts of the case, only a  
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13 restriction of liberty had amounted, the court was not in agreement that a deprivation  
14  
15 of liberty could never occur under section 25. Thorpe LJ held that a parent cannot  
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17 lawfully detain or deprive a child of their liberty without this engaging Article 5.  
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19 However, both Lord Neuberger and Lord Kerr in *Cheshire West* disagreed with this,  
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21 noting that deprivation of liberty does occur during childhood within the family home  
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23 and is well within the responsibilities of parents expected by society. This is where  
24  
25 the decision by Keehan J in *Birmingham City Council v D* was so crucial, as to  
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27 whether parents consenting to what could otherwise be considered a deprivation of  
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29 liberty outside of section 25 in long-term inpatient care fell within the zone of  
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31 parental control.  
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39 As already highlighted the decision was that parents did have the authority to provide  
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41 such consent. Before continuing the argument that the decision was incorrect, it is  
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43 worth noting the valid argument against common law establishing such a legal  
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45 position. The scope of the common law could certainly be viewed as too broad and  
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47 that the authority should be legislative in the case of mental health law to provide  
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49 greater clarity and align with existing mental health legislation. Indeed, it is  
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51 imperative that the Law Commission, in its current review of DoLS, explores the  
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53 issue of deprivation of liberty in children in collaboration with parents, clinicians and  
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55 practitioners. The recent case of *Re Daniel X* [2016] has rather added to the confusing  
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3 position of the courts outside of section 25 of the CA. Daniel was severely autistic  
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5 and had a learning disability. He was placed into a care home because of difficulties  
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7 in his home circumstances, which deprived him of his liberty as he was not free to  
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9 come and go as he pleased. Although these were care proceedings and the issue was  
10  
11 not parental consent, it is important to note that Roberts HHJ agreed that a section 25  
12  
13 order would not be appropriate since this would require Daniel to move to more  
14  
15 secure accommodation. Therefore, the court ordered that Daniel stay where he was  
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17 but (crucially in recognition of Article 5) that the order be reviewed in twelve months  
18  
19 and that this time limit was for the courts to set to ensure that Daniel's rights were  
20  
21 protected. Should the same level of procedural safeguarding not be required in the  
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23 context of parental consent alone? The unsatisfactory answer, as argued by Keehan J,  
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25 is that parental authority falls within the 'zone of parental control'.  
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### 32 **The Zone of Parental Control**

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34 The concept of the zone of parental control was established in the MHA Code of  
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36 Practice 2008 update. The concept was introduced to provide greater clarity for  
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38 clinicians involved in decision-making with children and young people within mental  
39  
40 health care, as the expectation to consider both legislation and evolving common law  
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42 was far too great (Hawkins *et al.*, 2011). The zone of parental control allows parents  
43  
44 to consent for treatment and inpatient admission through recognition of *Nielson*,  
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46 although no definition was provided because the cases were dependent on the  
47  
48 individual facts (Hawkins *et al.*, 2011). The concept of the zone of parental control  
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50 was widely criticised. Watts and Mackenzie (2013) argued that its interpretation by  
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52 clinicians was likely to be too subjective. In the case of psychiatric treatment of long  
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54 duration, where a deprivation of liberty can occur without parental consent, Gillam  
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3 (2010) raises concern over the ethical boundaries between this and short-term  
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5 treatment admission. Gillam (2010) further describes the original concept as being so  
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7 wide that a definition of the scope of parental control was needed.  
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11 Following *Cheshire West*, the MHA Code of Practice was updated in 2015 and  
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13 attempted to expand on the concept. Specifically, the update included a section on the  
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15 deprivation of liberty of children, recognising the complexities of such cases. The  
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17 Code of Practice requires that clinicians have regard to the degree of parental control  
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19 and supervision that would be expected for a child of that age with the characteristics  
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21 of the child in question. However, this approach fails to acknowledge that, if a child  
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23 lacks capacity to consent, and this is not going to change in adulthood, why should  
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25 parents not continue to provide such control after the age of sixteen? What is  
26  
27 highlighted is the arbitrary consideration of age under domestic law, where the issue  
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29 must be a broad subjective assessment, as is the case for adults under the MCA.  
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31 Parental authority through legislated responsibility exists to protect a natural element  
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33 of parenting and it is without question that this is a feature of the upbringing of all  
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35 children. However, as Akerele (2014) argues, it is not the case that this ordinarily  
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37 involves inpatient secure care for a prolonged period of time.  
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45 The Code of Practice asks that, in establishing the limits of parental responsibility,  
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47 account be taken of the child's rights under Article 5 and the rights of the parents  
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49 under Article 8 in respect of family life. This relationship between the child's and  
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51 parents' rights under the ECHR draws attention to the importance of Gillam's (2010)  
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53 point about defining the scope of parental consent. Watts and Mackenzie (2013)  
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55 suggested that all cases on whether a decision falls in the zone of parental control are  
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3 published to provide a body of knowledge to clinicians. However, the cases are so  
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5 fact specific and dependent on individual diagnosis and circumstance that this could  
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7 create further confusion. Furthermore, it is recognised that clinicians and  
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9 practitioners, faced with the expectation to interpret a complex body of case law, are  
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11 already reluctant to accept parental consent without court approval (Paul, 2004). The  
12  
13 challenge for clinicians is, as summarised by Cave (2014), to involve the parents  
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15 whilst still ensuring that the child's rights under the ECHR are not breached. Keehan J  
16  
17 appeared to dismiss this position in the first case of *Trust A v X*, favouring greater  
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19 reliance on the parent's rights under Article 8 (the Right to Privacy and Family Life).  
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21 Reliance on this decision would allow that the breach of Article 5 can be avoided  
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23 through parental consent and, therefore, that a child is deprived of liberty without  
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25 safeguarding and judicial review.  
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### 32 **Is it Common Sense?**

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34 Keehan J held that it would be disproportionate and without common sense to not  
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36 allow parental consent to authorise the deprivation of liberty in *D's* case. Indeed,  
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38 under English law, parents have the ability to consent for treatment or care providing  
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40 it is in the best interests of the child, satisfying the welfare principle under the CA. In  
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42 *Nielson* the ECtHR acknowledged that parents could consent to medical treatment  
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44 necessary for the immediate health of their children under Article 5, this not  
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46 breaching the child's rights under the same, even if the child disagreed. In the case of  
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48 deprivation of liberty, this may be a flawed argument outside of immediate treatment  
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50 necessity for two reasons. Firstly, in a broader context there are obvious limits to the  
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52 zone of parental control, for example a parent could not provide sexual consent for a  
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54 sixteen year old. Secondly, in recognition of the importance that the ECtHR has  
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3 placed on protecting the human rights of children and that if a ‘gilded cage is still a  
4 cage’, then the right to procedural and judicial review under Article 5 remains. To put  
5 it simply, a ‘common sense’ approach is contradictory to the complex nature of these  
6 cases for all those involved, particularly the child, and this is where safeguarding  
7 would support children in long-term care where there is a deprivation of liberty.  
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11 The alternative advocated here is an amended version of Mackenzie and Watts’  
12 (2014) DoLS (Minors’ Safeguards) with the support of the Family Courts, to provide  
13 the right for review to those aged under sixteen. The DoLS (Minors’ Safeguards)  
14 would allow for a  
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16  
17 ‘series of assessments including a mental health assessment, a mental  
18 capacity assessment, a children’s rights assessment and a best interests  
19 assessment by a number of trained professionals’ (Mackenzie and Watts,  
20 2014, p.101).  
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25 This proposal might be usefully amended to consider learning disability assessment as  
26 separate to mental health assessment. This separation is recognised by Herlihy and  
27 Holloway (2009) as being in line with the separation of learning disability from  
28 mental health disorder within current law. The assessments would allow for greater  
29 safeguards in considering deprivations of liberty for children but would also support  
30 the avoidance of a breach of Article 5, as they are intended to do in adults (Mackenzie  
31 and Watts, 2014). Additionally they could also incorporate Cave’s (2014) suggestion  
32 that the best interests test under the MCA be universally applied. Gratton (2013)  
33 further argues in favour of a holistic capacity assessment where it may have been  
34 assumed that a child lacks capacity based on a learning disability. Bartlett (2014)  
35 argues that there has to be recognition that safeguarding can be harmful to the  
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3 wellbeing of those who do not need such intervention. However, it should be noted  
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5 that such safeguards would remove the requirement of a subjective assessment by a  
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7 clinician and recognise the importance of parental consent through a more holistic  
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9 approach, involving the child as much as possible. Furthermore, safeguarding would  
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11 allow a more consistent framework and provide an alternative to the current arbitrary  
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13 age law.  
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18 There are further, potentially valid objections to this suggestion: whether these  
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20 safeguards are needed when cases are already brought before the courts; and whether  
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22 the increased guidance for deprivation of liberty in the 2015 MHA Code of Practice is  
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24 sufficient enough for both clinicians and the courts. Regarding the former, the ECtHR  
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26 recognised that UK law had insufficient safeguards for deprivation of liberty prior to  
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28 the DoLS. The DoLS might be considered to be correcting a legal technicality but, as  
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30 Kelly (2011) argues, in practice they also provide that a deprivation of liberty is  
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32 justified and considered under a broad scope of assessment, allowing the Court of  
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34 Protection to provide judicial review when required. Hawkins *et al.* (2011) suggest  
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36 that the relationship between parents and clinicians would be better supported through  
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38 the demonstration of a robust process to ensure that the child's best interests are being  
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40 considered. Such would certainly be the case using the DoLS (Minors' Safeguards)  
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42 and they would also be expected to reduce the use of the court by clinicians,  
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44 healthcare trusts and local authorities to determine the zone of parental control. In  
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46 response to the objection, it is true that the MHA Code of Practice has expanded in  
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48 light of *Cheshire West*. However, it still requires clinicians and practitioners to make  
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50 subjective judgements. Furthermore, if the law in *Birmingham City Council v D and*  
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52 *Trust A v X* is to be applied, then this could result in an expectation by parents that  
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3 they have complete authority following Keehan J's decision not to provide guidance  
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5 for all cases of deprivation of liberty for those under 16. It is argued here, therefore,  
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7 that the MHA Code of Practice is insufficient and, because of the complex nature of  
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9 the assessment in relation to rights, a safeguarding system that considers the issues in  
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11 a broad context and through the skills of a number of professionals and the parents is  
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13 preferable.  
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### 16 17 18 **Conclusion** 19

20 From the outset this paper has argued that decisions regarding deprivation of liberty in  
21  
22 children under the age of sixteen should reflect, in part, parental choice. The cause for  
23  
24 concern is the sovereignty of parental consent over all else. The law is confusing. In  
25  
26 one respect rights under the ECHR are universal. However, in the context of these  
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28 children's right under Article 5, courts have demonstrated an acceptance of the  
29  
30 premise that it is entirely within the zone of parental control to effectively deprive a  
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32 child of liberty without procedural or judicial review. However, where parental  
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34 consent is not involved, the courts have supported the provision of such safeguards in  
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36 the form of reviews. This juxtaposition seems ridiculous in the case of long-term  
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38 inpatient care and clinicians have demonstrated their discomfort with this extension of  
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40 the zone of parental control. It seems illogical for the law to allow a child to be  
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42 provided with no legislated safeguarding, yet that same child be subject to legislative  
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44 protection upon attaining the age of sixteen, or be provided with such protection if the  
45  
46 court itself authorises a deprivation of liberty. This is particularly of concern when the  
47  
48 child's capacity to make their own decisions about such matters is always likely to be  
49  
50 limited. Such a state of affairs highlights the failed application of Article 5 to  
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52 children, stemming from *Nielson*.  
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5 This paper has only discussed long-term inpatient care but consideration should be  
6  
7 given to applying the suggested safeguarding to a broader context. While such  
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9 extension might be controversial, it is paramount that sufficiently structured and  
10  
11 multidimensional assessment (as currently provided in adulthood) is carried out to  
12  
13 establish the best interests of those who are unable to make their own decisions.  
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16 Indeed, the proposed amended DoLS (Minors' Safeguarding) should be considered by  
17  
18 the Law Commission in their current review and implemented into any changes. Most  
19  
20 profoundly, adopting such safeguarding for children would correct the deficit that  
21  
22 both the ECtHR and the domestic court's interpretations of Article 5 have created,  
23  
24 leading to the confusing cases that are now setting worrying precedents for the scope  
25  
26 of parental consent.  
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3 **The Zone of Parental Control, The ‘Gilded Cage’ And The Deprivation of a**  
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5 **Child’s Liberty: Getting Around Article 5.**  
6

7 **Abstract**  
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10 Despite the significance of *Cheshire West* and the impact it has had on the scope of  
11 being deprived of liberty, children under the age of sixteen remain vulnerable through  
12 a lack of protection under Article 5. This paper will specifically analyse the legal  
13 position of children under sixteen who lack capacity to make the decision to consent  
14 to long-term inpatient care. My main argument is that as a result of parental consent  
15 being recognised as holding legal authority, these children have their right to liberty  
16 under Article 5 engaged. In recognition of the courts not currently supporting my  
17 position, I will argue that the reason this is the case, stems from the confusing concept  
18 of the zone of parental control in relation to deprivation of liberty. A doctrinal  
19 methodology is used, examining domestic law and the European Convention on  
20 Human Rights, with analysis of relevant literature. Deprivation of liberty in  
21 incompetent children under the age of sixteen should undoubtedly in part include  
22 parental consent, but it is parental consent having sovereignty over whether a child is  
23 being deprived of liberty that causes concern. The law is confusing, in one respect  
24 rights under the ECHR are universal, however in the context of these children’s right  
25 under Article 5 the courts demonstrate an acceptance of the premise that it is entirely  
26 within the zone of parental control to effectively deprive a child of liberty without  
27 procedural or judicial review. Furthermore, there are wider potential issues for  
28 children being considered to be deprived of liberty following *Cheshire West*.  
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51 **Introduction**  
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3 The Mental Health Act 1983 Code of Practice describes the law that covers  
4 admissions to hospital and treatment for mental disorders in children as ‘complex’.<sup>1</sup>  
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7 Whereas this paper will establish that following *P v Cheshire West and Chester*  
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10 *Council*<sup>2</sup> (referred to as *Cheshire West*), the law’s consideration of the right to liberty  
11 under Article 5 of the European Convention on Human Rights (ECHR)<sup>3</sup> for  
12 incompetent children under the age of sixteen is not only complex but indeed  
13 confusing. This confusion exists because despite Baroness Hale’s universal  
14 recognition of Article 5 in *Cheshire West*, both European and domestic case law,  
15 previously and subsequently, has allowed children to be deprived of liberty without  
16 judicial review, using parental consent as sufficient justification. The differing legal  
17 protection for deprivation of liberty in children under the age of sixteen, with a mental  
18 health disorder or a learning disability, was highlighted in the very recent case of  
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21 *Birmingham City Council v D*<sup>4</sup> and the earlier decision in the same case *Trust A v X*<sup>5</sup>.  
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This paper will specifically analyse the legal position of children under sixteen who lack capacity to make the decision to consent to long-term inpatient care. My main argument is that as a result of parental consent being recognised as holding legal

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<sup>1</sup> Department of Health, *Code of Practice Mental Health Act 1983* (HMSO 2015) <[www.gov.uk](http://www.gov.uk)> accessed 18/03/2016

<sup>2</sup> [2014] UKSC 19

<sup>3</sup> <[http://www.echr.coe.int/Documents/Convention\\_ENG.pdf](http://www.echr.coe.int/Documents/Convention_ENG.pdf)> accessed 09/03/2016

<sup>4</sup> [2016] EWCOP 8

<sup>5</sup> [2015] EWHC 922 (Fam)

<sup>6</sup> *Birmingham City Council v D* [2016] EWCOP [142]

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3 authority, these children have their right to liberty under Article 5 engaged. In  
4  
5 recognition of the courts not currently supporting my position, I will argue that the  
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7 reason this is the case stems from the confusing concept of the zone of parental  
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9 control in relation to deprivation of liberty. My argument is not that parents have no  
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11 rights to make decisions regarding their children, it is simply that if an incompetent  
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13 child is deprived of liberty in long-term in-patient care, the same level of safeguarding  
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15 that is provided to adults should be provided to children. I suggest that not only does  
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17 this provide equality and promote the universal application of the right to liberty,  
18  
19 regardless of age, but also that such safeguarding would support both parents and  
20  
21 clinicians in decision-making. I argue that the notion of a ‘common sense’<sup>7</sup> approach  
22  
23 to the zone of parental responsibility is not satisfactory where the issue is deprivation  
24  
25 of liberty. Furthermore, that the logical solution is to support Mackenzie and Watts’<sup>8</sup>  
26  
27 notion of legislation to provide procedural safeguarding through ‘Deprivation of  
28  
29 Liberty Safeguards for Minors’. I will only focus on the legal position of depriving a  
30  
31 child of their liberty in healthcare settings, where that detention is not made under the  
32  
33 Mental Health Act 1983 (MHA) or if applicable under section 25 of the Children Act  
34  
35 1989 (CA), in which there are legislated procedural requirements and reviews<sup>9</sup>.  
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### 43 **Deprivation of Liberty: The Gap between Children, Young People and Adults**

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45 The law under *Gillick*<sup>10</sup> enables the competent child under the age of sixteen to  
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47 consent to treatment, although in the case of refusal of treatment the courts almost  
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52 <sup>7</sup> *Trust A v X* [2015] EWHC 922 (Fam) [64]

53 <sup>8</sup> Mackenzie R, Watts J, ‘Is childhood a disability? Using Mental Capacity Tribunals and the  
54 Deprivation of Liberty Safeguards to shield children’s capacity to consent to and refuse medical  
55 treatment’ (2014) *Law and Disability Review* 9 (2) 96-106

56 <sup>9</sup> Kelly B, ‘Mental Health Legislation and Human Rights in England, Wales and the Republic of  
57 Ireland’ (2011) *International Journal of Law and Psychiatry* 34 439-454

58 <sup>10</sup> *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112  
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3 entirely overrule any such decision.<sup>11</sup> The child under the age of sixteen who is  
4 incompetent to make decisions regarding their health has their welfare protected  
5 under the CA, whereby parents have a responsibility to act in their child's best  
6 interests.<sup>12</sup> In the case of children with a mental disorder, the emphasis is on those  
7 children and young people receiving treatment that is decided to be in their best  
8 interests and to avoid deprivation of liberty through use of the MHA.<sup>13</sup> However,  
9 cases concerning deprivation of liberty are most common outside of the MHA, where  
10 that child is not competent to make a decision to consent to inpatient treatment  
11 through either having a mental health disorder or having a learning disability that  
12 renders them incompetent.<sup>14</sup> Outside of the MHA, deprivation of liberty for children  
13 under sixteen is either lawfully sanctioned by the courts under their inherent  
14 jurisdiction or considered not to be a deprivation of liberty, as it lies within the zone  
15 of parental responsibility.<sup>15</sup> In sharp contrast, those over the age of sixteen in the same  
16 position are protected under the MCA in accordance with the Family Law Reform Act  
17 1969 and furthermore, on attaining the age of eighteen are protected under the  
18 Deprivation of Liberty Safeguards (DoLS)<sup>16</sup>.

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48 <sup>11</sup> Cave E, 'Competence and authority: adolescent treatment refusals for physical and mental  
49 health conditions' (2013) *Contemporary Social Science* 8 (2) 92-103

50 <sup>12</sup> 'Meaning of "parental responsibility".

51 <sup>3</sup> (1) In this Act "parental responsibility" means all the rights, duties, powers, responsibilities and  
52 authority which by law a parent of a child has in relation to the child and his property.'

53 <sup>13</sup> *Supra*: Cave E (2013)

54 <sup>14</sup> Bowers M, Dubicka B, 'Legal dilemmas for clinicians involved in the care and treatment of  
55 children and young people with a mental disorder' (2009) *Child: Care, Health and Development*  
56 36 (4) 592-596

57 <sup>15</sup> *Ibid*

58 <sup>16</sup> The National Archives (2007) *The Mental Capacity Act Deprivation of Liberty Safeguards*  
59 <http://webarchive.nationalarchives.gov.uk> (accessed 21/03/2016)

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3 The DoLS were introduced in response to *HL v UK*<sup>17</sup>, originally known as  
4  
5 *Bournewood*, where the European Court of Human Rights (ECtHR) held that the  
6  
7 admission of a patient with learning disabilities and autism was a deprivation of  
8  
9 liberty as he was not permitted to leave, consequently engaging Article 5 of the  
10  
11 ECHR. Furthermore, that in accordance with Article 5, such deprivation must be  
12  
13 subject to judicial review and as this was not provided for in the MCA, a gap was  
14  
15 identified in the compatibility of domestic law and the ECHR, known as the  
16  
17 ‘*Bournewood* gap’. The DoLS provide procedural safeguards to protect vulnerable  
18  
19 adults who are not being detained under the MHA but are deprived of their liberty.<sup>18</sup>  
20  
21 Importantly these do not apply to those under the age of eighteen, instead this is  
22  
23 where common law and the CA are relied upon for those under the age of sixteen and  
24  
25 the MCA for those aged sixteen and seventeen.<sup>19</sup> Therefore, within the scope of  
26  
27 children’s decision-making, deprivation of liberty outside of the MHA is  
28  
29 differentiated from that of adults by the lack of legislative safeguarding procedures.  
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31 The issue identified is how a lack of universal safeguarding can be compatible with  
32  
33 Article 5, if the right to liberty is universal?<sup>20</sup>  
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### 41 **The Influence of the European Court of Human Rights**

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43 The right to liberty is provided under Article 5 of the ECHR. Deprivation of liberty  
44  
45 can be considered lawful for those ‘of unsound mind’, providing that such deprivation  
46  
47 is carried out within a legal framework<sup>21</sup>. Baroness Hale reiterated in *Cheshire West*  
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53 <sup>17</sup> (2005) 40 E.H.R.R 32

54 <sup>18</sup> Mackenzie R, Watts J, ‘Mind the gap: the Deprivation of Liberty Safeguards in the amended  
55 Mental Capacity Act 2005’ (2010) *Learning Disability Review* 5 (1) 51-55

56 <sup>19</sup> *Ibid*

57 <sup>20</sup> Samanta J, Samanta A, *Medical Law* (2<sup>nd</sup> Ed, Palgrave 2015) pp372

58 <sup>21</sup> Section 1 (e)  
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3 the 'universal character' of the ECHR being for everyone.<sup>22</sup> Specifically, Baroness  
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5 Hale considered the universal application of Article 5 regardless of disability; 'In my  
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7 view, it is axiomatic that people with disabilities, both mental and physical, have the  
8  
9 same human rights as the rest of the human race. It may be that those rights have  
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11 sometimes to be limited or restricted because of their disabilities, but the starting  
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13 point should be the same as that for everyone else.'<sup>23</sup> The issue though for the ECtHR  
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15 has been interpreting Article 5 in the context of whether a deprivation or merely a  
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17 restriction of liberty has been imposed upon an individual.  
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23 In *Guzzardi v Italy*<sup>24</sup> the ECtHR considered the distinction between deprivation and  
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25 restriction of liberty, holding that it was an objective test relating to only the intensity  
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27 or degree as opposed to subjective and therefore the nature or substance that  
28  
29 determines a deprivation of liberty.<sup>25</sup> Later though in *Storck v Germany*<sup>26</sup>, a  
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31 subjective element was added, in that a deprivation could only occur if the person had  
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33 not validly consented to the deprivation.  
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39 Prior to *Storck*, the objective test was applied to children in *Nielson v Denmark*<sup>27</sup>,  
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41 where a twelve year old was detained in a psychiatric facility on the consent of his  
42  
43 mother. The court held that there was not a deprivation of liberty; rather it was the  
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45 exercise of a responsible parent with custodial rights.<sup>28</sup> However, the court did  
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47 recognise that the State is obligated to ensure that parental consent did not have  
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51 <sup>22</sup> *P v Cheshire West and Chester Council* [2014] UKSC 19 [36]

52 <sup>23</sup> *Ibid*: [45]

53 <sup>24</sup> (1980) 3 EHRR 333

54 <sup>25</sup> *Ibid*: [93]

55 <sup>26</sup> (2005) 43 EHRR 96 [74]

56 <sup>27</sup> (1988) 11 EHRR 175

57 <sup>28</sup> *Ibid*: [73]

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3 unlimited scope, importantly that it could not deprive a child of liberty.<sup>29</sup> *Nielson* was  
4  
5 heavily criticised on the basis that the child's views were not considered in the depth  
6  
7 they would be today.<sup>30</sup> Furthermore, that as the duration of the admission was several  
8  
9 months, parental authority was questioned as to whether long term admission to  
10  
11 inpatient treatment for a mental health disorder only required parental consent and  
12  
13 whether such duration of treatment did amount to a deprivation of liberty.<sup>31</sup> This point  
14  
15 was most accurately articulated by Judge Salcedo dissenting, who held that ' the fact  
16  
17 that a parent may legally, and without being subject to any judicial review, place a  
18  
19 child who in his custody in a psychiatric ward, constitutes a violation of Article 5  
20  
21 (1)'.<sup>32</sup> I suggest that had the dissenting opinion been applied to the ruling in *Nielson*  
22  
23 and a deprivation of liberty found, the requirement for judicial review in accordance  
24  
25 with Article 5 (4) would have resulted in the DoLS being applied to all persons  
26  
27 deprived of liberty regardless of age.  
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### 31 **The Impact of The 'Gilded Cage' For Children**

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33 Before addressing the domestic interpretation of Article 5 and *Nielson* in relation to a  
34  
35 child's deprivation of liberty, it is paramount to analyse the scope of the application of  
36  
37 any breach to a child's right under Article 5, following *Cheshire West*. The Supreme  
38  
39 Court established that a deprivation of liberty must subjectively lack the consent of  
40  
41 the person. Objectively, Baroness Hale considered the decision in *Guzzardi* and held  
42  
43 that a deprivation of liberty must amount to a restriction of physical liberty.<sup>33</sup> In  
44  
45 considering the scope and universal application of the definition of deprivation of  
46  
47 liberty, Baroness Hale further held that; 'If it would be a deprivation of my liberty to  
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53 <sup>29</sup> *Ibid*: [72]

54 <sup>30</sup> Harbour A, *Children with Mental Disorder and the Law* (Jessica Kingsley Publishers 2008) pp  
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56 <sup>31</sup> *Ibid*

57 <sup>32</sup> *Nielson v Denmark* (1988) 11 EHRR 175 [24].

58 <sup>33</sup> [46]

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3 be obliged to live in a particular place, subject to constant monitoring and control,  
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5 only allowed out with close supervision, and unable to move away without permission  
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7 even if such an opportunity became available, then it must also be a deprivation of the  
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9 liberty of a disabled person. The fact that my living arrangements are comfortable,  
10  
11 and indeed make my life as enjoyable as it could possibly be, should make no  
12  
13 difference. A gilded cage is still a cage.<sup>34</sup>  
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18 This broadened definition went beyond earlier interpretations of Article 5 in  
19  
20 *Bournewood*, but effectively meant that the number of people deprived of their liberty  
21  
22 was increased as a result of the widened definition.<sup>35</sup> In response Stavert questions  
23  
24 whether the DoLS even now satisfy the procedural requirement under Article 5.<sup>36</sup> In  
25  
26 particular, Stavert identifies incompetent children and young people as being  
27  
28 particularly vulnerable because of both the lack of safeguarding and the broad scope  
29  
30 of health and social care settings that could potentially deprive liberty following  
31  
32 *Cheshire West*.<sup>37</sup> The Department of Health (DH) did issue guidance following  
33  
34 *Cheshire West*, however the issues for those under the age of eighteen were not  
35  
36 addressed.<sup>38</sup> It could be considered that the responsibilities expected of parents to the  
37  
38 welfare of their children justify there being no safeguarding requirements, particularly  
39  
40 because of the complex and differing needs and settings within caring for incompetent  
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49  
50 <sup>34</sup> *Ibid*

51 <sup>35</sup> Penny C, Exworthy T, 'A gilded cage is still a cage: *Cheshire West* widens 'deprivation of  
52 liberty' (2015) *British journal of Psychiatry* 206 (2) 91-92

53 <sup>36</sup> Stavert J, 'Deprivation of Liberty and Persons with Incapacity: The *Cheshire West* Ruling'  
54 (2015) *Edinburgh Law Review* 19 (1) 129-134

55 <sup>37</sup> *Ibid*

56 <sup>38</sup> Department of Health, *Department of Health Guidance: Response to the Supreme Court*  
57 *Judgment/ Deprivation of Liberty Safeguards* (HMSO 2015) < [www.gov.uk](http://www.gov.uk) > (accessed  
58 21/03/2016)  
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3 children, being better decided by their parents.<sup>39</sup> However, this position fails to  
4  
5 consider the potentially unlawful position that *Cheshire West* has now placed local  
6  
7 authorities, charities, hospital trusts, clinicians and other practitioners in, where  
8  
9 deprivation of liberty is of concern.<sup>40</sup> This is where I argue the law has become  
10  
11 confused in interpreting Article 5 and the unsatisfactory position Keehan J has  
12  
13 established.  
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### 16 17 18 **The Scope of Article 5 for Children within English Law** 19

20  
21 The common law position of parental consent authorising treatment for mental health  
22  
23 disorders, which could also amount to a deprivation of liberty for incompetent  
24  
25 children under the age of sixteen, was established in a series of cases at the end of the  
26  
27 twentieth century. In the cases of *Re R*<sup>41</sup> and *Re K, W and H*<sup>42</sup> the courts held that  
28  
29 parental consent was valid for compulsory psychiatric treatment and did not require  
30  
31 further court approval. Arguably these cases relate to refusal of treatment, however  
32  
33 the treatment involved admission to secure inpatient psychiatric hospitals, the children  
34  
35 were not free to leave and the treatment was not carried out under the MHA. Hawkins  
36  
37 et al suggest that if these cases were considered today in light of the Human Rights  
38  
39 Act 1998, deprivation of liberty would be a central issue.<sup>43</sup>  
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46 Despite the Mental Capacity Act 2005 not being applicable to children under 16,  
47  
48 section 25 of Children Act 1989 does allow for the courts to authorise local  
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52 <sup>39</sup> Wheeler R, Crabb A, 'The legal basis for compulsorily detaining children and young people for  
53 treatment' (2016) *Archives of Disease in Childhood* 101 (3) 210-211

54 <sup>40</sup> *Supra*: Penny C, Exworthy T,  
55 <sup>41</sup> [1991] 3 WLR 592

56 <sup>42</sup> [1993] 1 FLR 854

57 <sup>43</sup> Hawkins T, Player B, Curtice M, 'The zone of parental control and decision-making in young  
58 people, legal derivation and influences' (2011) *Advances in Psychiatric Treatment* 17 220-226  
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3 authorities to restrict the liberty of children. This is within the limits of where that  
4  
5 secure accommodation is necessary to prevent them from absconding or to protect the  
6  
7 child from self-harm or harming others, outside of a clinical setting.<sup>44</sup> In authorising  
8  
9 such a restriction, the courts must specify duration and that the child must be legally  
10  
11 represented in any hearings.<sup>45</sup>  
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15  
16 In *Re K*<sup>46</sup> the Court of appeal considered whether restricting liberty under section 25  
17  
18 of the CA was compatible with Article 5. Butler-Sloss P held that it was compatible  
19  
20 because of the judicial review involved in such decisions and that it was within the  
21  
22 jurisdiction of the courts to prevent the child or others from harm, however that if  
23  
24 such restrictions were authorised by a parent alone it would not be compatible with  
25  
26 Article 5.<sup>47</sup> In *RK v BCC, YB and AK*<sup>48</sup> the Court of Appeal was asked this question  
27  
28 again in relation to deprivation of liberty and Mostyn J's decision in the lower court,  
29  
30 that section 25 would never result in deprivation of liberty in respect of Article 5.  
31  
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33  
34 Although agreeing that on the facts of the case, only a restriction of liberty had  
35  
36 amounted, the court was not in agreement that a deprivation of liberty could never  
37  
38 occur under section 25. Thorpe LJ held that a parent cannot lawfully detain or deprive  
39  
40 a child of their liberty without it engaging Article 5.<sup>49</sup> However, both Lord Neuberger  
41  
42 and Lord Kerr in *Cheshire West* disagreed with this, as they recognised that  
43  
44 deprivation of liberty does occur during childhood within the family home and is well  
45  
46 within the expected responsibilities of parents within society.<sup>50</sup> This is where the  
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51 <sup>44</sup> Section 25 (1)

52 <sup>45</sup> Section 25 (4) and (6)

53 <sup>46</sup> [2001] Fam 377

54 <sup>47</sup> *Ibid*: [29]

55 <sup>48</sup> [2011] EWCA Civ 1305

56 <sup>49</sup> [14]

57 <sup>50</sup> [72] and [75]

1  
2  
3 decision by Keehan J in *Trust A v X* was so crucial, as to whether parent's consenting  
4  
5 to what could otherwise be considered a deprivation of liberty outside of section 25 in  
6  
7 long-term inpatient care fell within the zone of parental control.  
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11 As already highlighted the decision was that parents did have the authority to provide  
12  
13 such consent and before continuing my argument that the decision was incorrect, it is  
14  
15 worth noting the valid argument against common law establishing such a legal  
16  
17 position. The scope of the common law could certainly be viewed as too broad and  
18  
19 that the authority should be legislative in the case of mental health law to provide  
20  
21 greater clarity and align with existing mental health legislation.<sup>51</sup> Indeed perhaps it is  
22  
23 the role of Parliament to explore the issue of deprivation of liberty in children and  
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25 through collaboration with parents, clinicians and practitioners.  
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### 32 **The Zone of Parental Control**

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34 The concept of the zone of parental control was established in the MHA Code of  
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36 Practice 2008 update.<sup>52</sup> The concept was introduced to provide greater clarity for  
37  
38 clinicians involved in decision-making with children and young people, as the  
39  
40 expectation to consider both legislation and evolving common law was far too  
41  
42 subjective.<sup>53</sup> The zone of parental control allowed parents to consent for treatment and  
43  
44 inpatient admission through recognition of *Nielson*, although no definition was  
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46 provided because the cases were dependent on the individual facts.<sup>54</sup> The concept of  
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54 <sup>51</sup> *Supra*: Kelly B,

55 <sup>52</sup> Department of Health, *Code of Practice Mental Health Act 1983* (HMSO 2008) para 36.9  
56 <[www.gov.uk](http://www.gov.uk)> (accessed 18/03/2016)

57 <sup>53</sup> *Supra*: Hawkins T, Player B, Curtice M,

58 <sup>54</sup> *Ibid*  
59  
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2  
3 the zone of parental control was widely criticised.<sup>55</sup> Watts and Mackenzie<sup>56</sup> argue that  
4  
5 it left far too greater subjectivity for clinicians when interpreting the guidance. In the  
6  
7 case of psychiatric treatment for a long duration, where a deprivation of liberty would  
8  
9 otherwise occur without the parental consent, Gillam<sup>57</sup> raised concern over the ethical  
10  
11 boundaries that differ from short-term treatment admission. Gillam further described  
12  
13 the original concept as being so wide that a definition of the scope of parental consent  
14  
15 was needed.<sup>58</sup>  
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21 Following *Cheshire West*, the MHA Code of Practice was updated in 2015 and  
22  
23 attempted to expand on the concept. Specifically, the update provided a section on the  
24  
25 deprivation of liberty of children, recognising the complexities of such cases.<sup>59</sup> The  
26  
27 Code of Practice requires that clinicians have regard to the degree of parental control  
28  
29 and supervision that would be expected for a child of that age with the characteristics  
30  
31 of the child in question.<sup>60</sup> However, this approach fails to acknowledge that if a child  
32  
33 is deemed incompetent and this is not going to change in adulthood, why should  
34  
35 parents not continue to provide such control after the age of sixteen? What is  
36  
37 highlighted is the arbitrary consideration of age under domestic law, where the issue  
38  
39 must be a broad subjective assessment, as is the case for adults under the MCA.  
40  
41 Parental authority through legislated responsibility exists to protect a natural element  
42  
43 of parenting and it is without question that this is a feature of the upbringing of all  
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51 <sup>55</sup> *Ibid*

52 <sup>56</sup> Watts J, Mackenzie R, 'The zone of parental control: a reasonable idea or an unusable concept?'  
53 (2013) *Learning Disability Review* 18 (1) 38-44

54 <sup>57</sup> Gillam L, 'Children's Bioethics and the Zone of Parental Discretion' (2010) *Bioethics Review* 29  
55 (2) 1-3

56 <sup>58</sup> *Ibid*

57 <sup>59</sup> Para's 19.44-19.88

58 <sup>60</sup> Para's 19.47-19.48  
59  
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3 children, however it is not the case that this ordinarily involves inpatient secure  
4  
5 treatment for a prolonged period of time.<sup>61</sup>  
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9  
10 Within the zone of parental control, the Code of Practice asks that in establishing the  
11 limits of parental responsibility, account be taken of the child's rights under Article 5  
12 and the rights of the parents under Article 8 in respect to the right to family life. This  
13 relationship between both the child and parents' rights under the ECHR is where the  
14 rationale for a definitive scope suggested by Gillam could be beneficial.<sup>62</sup> Watts and  
15 Mackenzie suggested that all cases deciding on whether a decision falls in the zone of  
16 parental control are published to provide a body of knowledge to clinicians.<sup>63</sup> I  
17 disagree and argue that this would provide further confusion, as cases are so fact  
18 specific and dependent on individual diagnosis and circumstance. Furthermore, it is  
19 recognised that clinicians and practitioners being expected to interpret a complex  
20 body of case law still results in a reluctance to accept parental consent without court  
21 approval now.<sup>64</sup> The challenge for clinicians is involving the parents whilst still  
22 ensuring that the child's rights under the ECHR are not engaged.<sup>65</sup> Keehan J appears  
23 to dismiss this position in the first case of *D*, favouring greater reliance on the  
24 parent's rights under Article 8.<sup>66</sup> Relying on this decision allows that the engagement  
25 of Article 5 can be avoided through parental consent and therefore that a child is  
26 deprived of liberty without safeguarding and judicial review.  
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50 <sup>61</sup> Akerele F, 'Adolescent decision-making and the zone of parental control: a missed opportunity  
51 for legislative change' (2014) *Advances in Psychiatric Treatment* 20 144-150

52 <sup>62</sup> *Supra*: Gillam L,

53 <sup>63</sup> *Supra*: Watts J, Mackenzie R, (2013)

54 <sup>64</sup> Paul M, 'Decision-making about children's mental health care: ethical challenges' (2004)  
55 *Advances in Psychiatric Treatment* 10 301-311

56 <sup>65</sup> Cave E, 'Goodbye Gillick? Identifying and resolving problems with the concept of child  
57 competence' (2014) *Legal Studies* 34 (1) 103-122

58 <sup>66</sup> *Trust A v X* [2015] EWHC 922 (Fam) [57]  
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### Is it Common Sense?

Keehan J held that it would be disproportionate and without common sense to not allow parental consent to authorise the deprivation of liberty in *D's* case.<sup>67</sup> I suggest this is a flawed argument, in that if a 'gilded cage is still a cage' then the right to procedural and judicial review under Article 5 remains. To put it simply a 'common sense' approach is contradictory to the complex nature of these cases for all those involved, particularly the child, and this is where safeguarding would support children in long term care where there is a deprivation of liberty.

The alternative I support is an amended version of Mackenzie and Watts' DoLS (Minors' Safeguards)<sup>68</sup> with the support of the Family Courts, to provide the right for review to those aged under sixteen. The DoLS (Minors' Safeguards) would allow for a 'series of assessments to including a mental health assessment, a mental capacity assessment, a children's rights assessment and a best interests assessment by a number of trained professionals'<sup>69</sup>. I would suggest that these safeguards are amended to consider learning disability assessment as separate to mental health assessment, in line with the separation of learning disability from mental health disorder within current law.<sup>70</sup> The assessments would allow for greater safeguards in considering deprivations of liberty for children but would also support the avoidance of engagement of Article 5, as they are intended to do in adults.<sup>71</sup> Additionally they

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<sup>67</sup> *Ibid*: [64]

<sup>68</sup> *Supra*: Mackenzie R, Watts J, (2014)

<sup>69</sup> *Ibid*: pp 101.

<sup>70</sup> Herlihy D, Holloway F, 'The Mental health Act and the Mental Capacity Act: untangling the relationship' (2009) *Psychiatry* 8 (12) 478-481

<sup>71</sup> *Supra*: Mackenzie R, Watts J, (2014)

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3 could also incorporate Cave's<sup>72</sup> suggestion that the best interests test under the MCA  
4 be universally applied. Gratton further argues in favour of a holistic capacity  
5 assessment where it may have been assumed that a child lacks capacity based on a  
6 learning disability.<sup>73</sup> There does though have to be recognition that safeguarding can  
7 be harmful to the wellbeing of those who do not need such intervention.<sup>74</sup> In response,  
8 such safeguards would I suggest remove the requirement of a subjective assessment  
9 by a clinician and recognise the importance of parental consent through a more  
10 holistic approach, involving the children in as much as possible. Furthermore, would  
11 allow a more consistent framework and provide an alternative to the current arbitrary  
12 age law.  
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27 There are further valid objections to this suggestion; whether these safeguards are  
28 needed when the cases are brought before the courts as it is and whether the increased  
29 guidance for deprivation of liberty in the 2015 MHA Code of Practice is sufficient  
30 enough for both clinicians and the courts. In response to whether these safeguards are  
31 needed, the ECtHR recognised that UK law had insufficient safeguards for  
32 deprivation of liberty prior to the DoLS. The DoLS can be considered to just be  
33 correcting a legal technicality but in practice they also provide that a deprivation of  
34 liberty is justified and considered under a broad scope of assessment, allowing the  
35 Court of Protection to provide judicial review when required.<sup>75</sup> Hawkins et al suggest  
36 that the relationship between parents and clinicians would be better supported through  
37 the demonstration of a robust process to ensure that the child's best interests are being  
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52 <sup>72</sup> *Supra*: Cave E, (2014)

53 <sup>73</sup> Gratton S, 'Use of the Mental capacity Act with children and young people with intellectual  
54 disability' (2013) *Advances in Mental Health and Intellectual Disabilities* 7 (2) 88-92

55 <sup>74</sup> Bartlett P, 'Reforming the Deprivation of Liberty Safeguards (DOLS): What Is It Exactly that We  
56 Want?' (2014) *European Journal of Current Legal Issues* 20 (3) 1-24

57 <sup>75</sup> *Supra*: Kelly B, (2011)  
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3 considered.<sup>76</sup> This would certainly be supported using the DoLS (Minors' Safeguards)  
4  
5 but it is also suggested that they would reduce the role of the court being required by  
6  
7 clinicians, healthcare trusts and local authorities to determine the zone of parental  
8  
9 control. In response to the second objection that the MHA Code of Practice is  
10  
11 sufficient for clinicians, it has to be recognised that the explanation has expanded in  
12  
13 light of *Cheshire West*. However, it still remains subjective to those treating clinicians  
14  
15 or practitioners. Furthermore, if the law in *Trust A v X* is to be applied, then this could  
16  
17 result in an expectation by parents that they have authority following Keehan J's  
18  
19 decision not to provide guidance for all cases of deprivation of liberty for those under  
20  
21 16.<sup>77</sup> I therefore suggest that the MHA Code of Practice is insufficient and because of  
22  
23 the complex nature of the assessment, in relation to rights, a safeguarding system of  
24  
25 assessments that considers the issues in a broad context and through the skills of a  
26  
27 number of professionals and the parents, is far more preferable.  
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### 34 **Conclusion**

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36 From the outset I made clear that deprivation of liberty in incompetent children under  
37  
38 the age of sixteen should undoubtedly in part include parental consent, but it is  
39  
40 parental consent having sovereignty over whether a child is being deprived of liberty  
41  
42 that causes concern. The law is confusing, in one respect rights under the ECHR are  
43  
44 universal, however in the context of these children's right under Article 5 the courts  
45  
46 demonstrate an acceptance of the premise that it is entirely within the zone of parental  
47  
48 control to effectively deprive a child of liberty without procedural or judicial review.  
49  
50 This is ridiculous in the case of long-term inpatient care and clinicians have  
51  
52 demonstrated that they are uncomfortable with the extension of this zone of parental  
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57 <sup>76</sup> *Supra*: Hawkins T, Player B, Curtice M,

58 <sup>77</sup> [68]  
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3 control. It seems illogical for the law to allow a child to be provided with no legislated  
4  
5 safeguarding, yet that same child be subject to legislative protection upon attaining  
6  
7 the age of sixteen. This is particularly of concern when that child will never become  
8  
9 competent to make their own decisions and highlights the failed application of Article  
10  
11 5 to children, stemming from *Nielson*.  
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16 I have only discussed long-term inpatient care but there has to be consideration of  
17  
18 applying the suggested safeguarding to a broader context. This does indeed warrant  
19  
20 further discussion beyond this paper and will likely be controversial. However, what  
21  
22 should be paramount is that safeguarding would allow a more structured and  
23  
24 multidimensional assessment, as is provided in adults, to establish the best interests of  
25  
26 those who are unable to do so. Indeed the proposed amended DoLS (Minors'  
27  
28 Safeguarding) should be viewed as a supportive scaffolding to promote a holistic and  
29  
30 thorough assessment of the child's best interests, with recognition that parental views  
31  
32 are paramount. If such treatment involves a deprivation of liberty, then the right to  
33  
34 judicial review would be available. Most profoundly, adopting such safeguarding for  
35  
36 children would correct the deficit that the ECtHR and the domestic judiciaries'  
37  
38 interpretation of Article 5 has created, leading to the confusing cases that are now  
39  
40 setting worrying precedents.  
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47 No conflicts of interest.  
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