



The Law Society

Identifying a deprivation of liberty: a practical guide

The hospital setting

This guidance does not constitute legal advice, which must be sought - if necessary - on the facts of any specific individual case. While care has been taken to ensure the guidance is accurate, up to date and useful, no legal liability will be accepted in relation to it.

A: Introduction

- 4.1 This chapter focuses on deprivation of liberty of those lacking the capacity to consent to care, treatment and confinement in a hospital setting for purposes of treatment of physical disorders. This includes NHS hospitals and treatment by the independent sector / private hospitals, but also transfer to hospital in the first instance by ambulance, and care in the hospice setting. Questions relating to deprivation of liberty in the psychiatric setting are dealt with in Chapter 6. In line with the other chapters, it does not provide detailed answers to the questions of what should happen where a deprivation of liberty has been identified.
- 4.2 The majority of patients who lack capacity to make decisions about their care and treatment and admission to or discharge from hospital can be treated in their best interests under s.5 MCA 2005. Restraint may be used provided that the person using restraint reasonably believes that it is necessary to restrain the patient in order to prevent harm to the patient, and that the act is a proportionate response to the likelihood of the patient suffering harm, and the seriousness of the harm.¹ The difficult issue to identify is the point at which the level and intensity of the restraint used amounts to a deprivation of liberty.
- 4.3 As a starting point, we should emphasise that emergency life-sustaining interventions and the provision of emergency care to a patient lacking consent to such treatment **should always be given** as clinically required and **there should never be any delay** for prior deprivation of liberty authorisation to be sought. We acknowledge that this means that there may – in some cases – be situations in which the question of whether a person is deprived of their liberty (and if so, how that deprivation of liberty is to be authorised) cannot be resolved prior to the administration of such treatment.
- 4.4 As noted at paragraph 3.33 above, the acid test set out in the Supreme Court in *Cheshire West*, i.e. continuous (or complete) supervision and control’ and ‘lack of freedom to leave, did not address the situations of those in Accident and Emergency (‘A&E’) departments, hospices or intensive care units. There is no case-law at the time of writing this guidance that deals specifically with deprivation of liberty in these settings,² and it is not absolutely clear how the courts will approach these questions.
- 4.5 However, in very broad terms, and although this has not been tested before the courts, we consider that:
- 4.5.1 It is likely that the immediate provision of life-sustaining treatment to an incapacitated patient in a true emergency situation will not be considered to be a deprivation of liberty (either in the ambulance or in the A&E setting);³
- But that:
- 4.5.2 As the patient transitions from the initial emergency treatment to on-going care the risk of deprivation of liberty increases with the increasing duration of such treatment (or other such treatment as identified as clinically necessary).

1 Sections 6(1)-(3) MCA 2005.

2 Although the case of *NHS Trust & Ors v FG* [2014] EWCOP 30 suggests that the ‘acid test’ may well be satisfied in the context of the delivery of obstetric care to a person incapable of consenting to it.

3 For a fuller discussion on this see M. Crews et al, *Deprivation of Liberty in Intensive Care*, Journal of the Intensive Care Society, October 2014.

- 4.6 As soon as a deprivation of liberty has been identified, appropriate steps should be taken to obtain authorisation, either under Schedule A1 to the MCA 2005 (a ‘DOLS authorisation’⁴), under the MHA 1983, or from the Court of Protection.⁵ We should highlight here that, in the event that a person suffering from a mental disorder within the meaning of the MHA 1983 requires assessment and treatment for that disorder and wishes to leave the hospital before the assessment has been carried out, consideration should be given to the use of the powers of detention contained in the MHA 1983 to ensure that the person does not leave the hospital (see Chapter 5) before that assessment has been carried out.⁶

B: The acid test and the hospital setting

- 4.7 When considering whether a patient is ‘free to leave’ for the purpose of the acid test the focus should not be on whether a patient is actually physically capable of leaving, but rather upon what actions hospital staff would take if for example family members, properly interested in their care, sought to remove them from the hospital.
- 4.8 In addressing the ‘acid test’ it is also particularly important in a hospital setting to consider the following:
- 4.8.1 Whether the deprivation of liberty is likely to last for more than a negligible period of time;
 - 4.8.2 Whether the person is able to give consent to what amounts to the ‘objective’ deprivation of their liberty; and
 - 4.8.3 Whether the deprivation is imputable to the State.
- 4.9 The scenarios below attempt to distinguish those situations:
- In which we consider the individuals in question to be deprived of their liberty;
 - Where there may be a potential deprivation of liberty; and
 - Where individuals are subject to restrictions in their freedom of movement not amounting to a deprivation of liberty.
- 4.10 Because, as set out above, the legal position regarding what amounts to a deprivation of liberty in hospital settings is unclear, it is essential that Trusts put in place policies which define for their purposes who they consider to be deprived of their liberty; and how they propose to authorise the same.

C: ‘Imputable to the state’

- 4.11 A deprivation of liberty only falls within the scope of Article 5(1) ECHR if it is ‘imputable’ to the state. This will inevitably be satisfied in an NHS hospital setting. Care may also be arranged or commissioned by a Clinical Commissioning Group (‘CCG’) or Local Health Board to be

⁴ Most likely an urgent authorisation in the first instance, although note that an urgent authorisations should only be granted if the situation giving rise to the deprivation of liberty could not have been anticipated in sufficient time to enable a standard authorisation to be sought: see *NHS Trust & Ors v FG*, footnote 2 above, at paragraph 101.

⁵ For further discussion, see the paper entitled: *Deprivation of Liberty in a Hospital Setting* by Alex Ruck Keene and Catherine Dobson: http://www.39essex.com/docs/articles/deprivation_of_liberty_in_the_hospital_settingv3.pdf

⁶ See ss.136, 5(2) and 5(4) of MHA 1983. Section 5 of the MHA 1983 only applies to patients who have been admitted to hospital. The Accident and Emergency Department waiting area of a hospital is considered a public place for the purpose of section 136 MHA 1983 - *R (Sessay) v (1) South London & Maudsley NHS Foundation Trust (2) The Commissioner of Police for the Metropolis* [2011] EWHC 2617 (QB) at paragraph 39.



provided by an independent healthcare provider⁷ and in these circumstances, except for situations where the person is being cared for in the community, the Deprivation of Liberty Safeguards will also apply. There will also be circumstances where a patient is being cared for in a hospital and receiving treatment from a private provider and the arrangements are privately funded and not made by the State. The DOLS Code makes it clear that even though these situations are outside the scope of Article 5(1) ECHR, they are to be treated as if they were within its scope, such that managing authorities of such institutions are required to apply for an authorisation if the care and treatment of their patient meets the acid test.⁸

- 4.12 It is therefore necessary to consider whether the totality of the care and treatment arrangements amount to a deprivation of liberty, whether the person is being treated in an NHS hospital or by an independent healthcare provider and whether the care is arranged and commissioned by a CCG or privately.

D: Conveyance by ambulance to or from hospital

- 4.13 Transporting a person who lacks capacity from their home, or another location to a hospital by ambulance in an emergency will not usually amount to a deprivation of liberty. In almost all cases, it is likely that a person can be lawfully taken to a hospital or care home by ambulance under the wider provisions of the Act, as long as it is considered that being in the hospital or care home will be in their best interests.⁹
- 4.14 The DOLS Code suggests¹⁰ that there may be exceptional circumstances where taking a person to a hospital or a care home amounts to a deprivation of liberty. We suggest that the following situations which include, but go beyond those discussed in the Code, may give rise to the need to seek authorisation to ensure that the measures taken are lawful:
- Where it is or may be necessary to arrange for the assistance of the police and/or other statutory services to gain entry into the person's home and assist in the removal of the person from their home and into the ambulance;
 - Where it is or may be necessary to do more than persuade or provide transient forcible physical restraint of the person during the transportation;
 - Where the person may have to be sedated for the purpose of transportation; or
 - Where the journey is exceptionally long.

7 See paragraph 2.50. Independent healthcare providers are private, voluntary or non-profit individuals or organisations that are not owned or managed by the NHS. Their services may be contracted by the NHS, may be paid for by an individual or funded through healthcare insurance schemes. Some providers deliver services both privately and for the NHS. Independent providers deliver a wide range of services to both adults and children. There are 276 independent acute hospitals and 47 independent treatment centres registered with the Care Quality Commission. The Care Quality Commission does not currently oversee the regulation of the independent healthcare services that deliver secondary and tertiary care, but proposes to begin doing so in 2015.

8 Paragraph 1.21 of the DOLS Code, available at http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf

9 Paragraph 2.14 of the DOLS Code.

10 Paragraph 2.15.



- 4.15 Whilst we do not in general in this guidance address how authority is to be sought for deprivation of liberty in particular cases, we consider that we should make clear that, as the law stands, an authorisation under Schedule A1 cannot be used to authorise a deprivation of liberty on the way to the place where the patient will be treated.¹¹ If there is a real risk that cannot be sensibly ignored that the transport of the patient will amount to a deprivation of their liberty, it will be necessary to obtain an order from the Court of Protection.¹² It is less clear whether an authorisation granted in respect of one hospital can be used to authorise a deprivation of liberty that may arise in respect of a patient being transferred from that hospital to another,¹³ and legal advice should be sought where it appears clear that there will be a deprivation of liberty in such a case. We would also emphasise that, in such a case, it will be necessary to ensure in advance that there is a standard authorisation in place in the second hospital (assuming that the circumstances in which the patient will be treated will also amount to a deprivation of liberty).¹⁴

Transportation by Ambulance: a deprivation of liberty

- 4.16 The measures in the following scenario are likely to amount to a deprivation of liberty:

Jane is 35 years old and lives alone in a rented property. Jane has moderate learning difficulties and can be uncooperative and violent. Jane has given birth to 2 children. They have both been taken into care shortly after birth. By chance Jane's social worker, Alice, meets Jane at the local shopping centre. Alice notices that Jane appears to be about 7 months pregnant. Alice is very concerned because Jane has not been engaging with social services, and has not to her knowledge received any antenatal care. Jane denies that she is pregnant and tells Alice that she is buying new clothes because she 'is getting fat', and that 'anyway they will take the baby away'. Jane had experienced difficulties with her last pregnancy that resulted in an emergency admission to hospital and the baby being delivered by caesarean section. Despite all attempts by the statutory services, Jane refuses to engage and does not attend appointments aimed at monitoring the pregnancy and providing obstetric care. Both social services, and the acute trust that will provide obstetric care to Jane and deliver her child, wish to make arrangements for Jane to be brought into hospital for an ante-natal assessment, blood tests and placental location ultrasound scan and to plan the delivery of her child. The Trust has taken advice and if Jane is not compliant a plan has been devised that provides for the police to assist in gaining entry to Jane's property and for Jane to be transferred from home by ambulance accompanied by professionals employed by the Trust and an anaesthetist. In the event that Jane cannot be persuaded to get into the ambulance she will be given mild sedation and taken from her home using physical restraint. The journey to hospital will take over an hour and during this time both physical and chemical restraint (as appropriate) may be used.

11 *GJ v The Foundation Trust* [2009] EWHC 2972 (Fam) at paragraph 9: "The new provisions in the MCA [i.e. in Schedule A1] do not cover taking a person to a care home or a hospital. But they can be given before the relevant person arrives there so that they take effect on arrival (see for example paragraph 52 of Schedule A1 to the MCA)."

12 Court of Protection judges are available, in suitably urgent cases, to hear cases 24 hours a day 365 days a year. The guidance at paragraph 23(a) of the Annex to the judgment in *NHS Trust & Ors v FG* [2014] EWCOP 30 contains details of as to matters to be considered when arranging ambulance transfers, relevant beyond the context with which that case is concerned.

13 The question is as to the point at which it can properly be said that the patient ceases to be a 'detained resident' in the first hospital. Up until that point, it appears that an authorisation granted in respect of that first hospital may provide authority to deprive the patient whilst they are on 'leave' from the hospital: *Re P (Scope of Schedule A1)* (30 June 2010) (Unreported) (Mostyn J). Once the patient ceases to be a detained resident

14 See *NHS Trust & Ors v FG* [2014] EWCOP 30 at paragraph 101.



Key factors pointing to a deprivation of liberty:

- *the potential involvement of the police and that Jane may be taken to hospital against her will*
- *the potential use of sedation and physical restraint to get Jane into the ambulance*
- *the potential use of physical and chemical restraint for a period lasting potentially over an hour.*

Transportation by ambulance: potential deprivation of liberty

4.17 We suggest that the measures in the following scenario may give rise to a deprivation of liberty:

Ahmed has a serious head injury caused by a road traffic accident. He has been assessed as lacking capacity to make decisions about his care and treatment. He has been admitted to a local Trauma Unit for stabilisation but then requires transfer to the regional Trauma Centre at a hospital 100 miles away. Ahmed is heavily sedated, intubated and ventilated. Because of poor visibility it is not possible for Ahmed to be airlifted to the Trauma Centre. The journey will therefore have to be undertaken by ambulance which will have to travel slowly because of the severity of Ahmed's head injuries and may take up to 5 hours to complete the journey. Ahmed will require continuous care, monitoring and supervision during the course of the journey.

Key factors pointing to a potential deprivation of liberty:

- *the length of the ambulance journey (which is significantly longer than usual for such a transfer)*
- *the degree of monitoring and supervision required.*

Note: we accept that this scenario is one that may provoke discussion amongst practitioners, and have deliberately included it so that specific consideration can be given by Trusts in the formulation of policies as to the potential for a deprivation of liberty to arise in such cases.

Transportation by ambulance: not a deprivation of liberty

4.18 We suggest that the following scenario is unlikely to amount to a deprivation of liberty:

Trisha lives at home with support. She suffers from dementia which has recently become worse. While making a cup of tea she knocks over a kettle of boiling water that scalds her leg. The care team do their best to treat her leg but it is quite clear that the burn will require medical attention. An ambulance is called by her care worker. Trisha is in a great deal of pain and is reluctant to get into the ambulance. After some coaxing she gets into the ambulance. The ambulance crew with the assistance of her care worker persuade her to take some medication to ease the pain while she is transported to a nearby hospital Accident and Emergency Department. Trisha becomes agitated during the journey and the ambulance crew have to restrain her briefly during the short journey to avoid her injuring herself further.

Key factor pointing away from deprivation of liberty:

- *the short length of the journey and the short duration of the restraint*

E: Accident and Emergency ('A&E')

- 4.19 It is of paramount importance that clinicians and hospital staff act in the best interests of their incapacitated patient and that the patient concerned receives appropriate and timely care and treatment.
- 4.20 As set out at paragraph 4.2 above the majority of people who lack capacity to make decisions about their care, treatment and admission to or discharge from hospital can be treated in their best interests under s.5 MCA 2005.
- 4.21 Although most people's stay in A&E is of short duration, as the scenarios below show, this does not of itself mean that a deprivation of liberty cannot occur during such a stay.¹⁵ The more intensive the restraint upon the person (whether physical or chemical) and the more the person is able to perceive what is happening and become distressed or resistant, the shorter will be the period of time before liberty-restricting measures taken in relation to the patient amount to a deprivation of liberty.
- 4.22 There may be circumstances in which staff consider that there may be a deprivation of liberty but that there is, in fact, nothing that can be done about it by way of obtaining authorisation within a sufficiently short period of time. We note in this regard that caution should be adopted in relation to paragraph 6.4 of the Deprivation of Liberty Safeguards Code of Practice which suggests that an urgent deprivation of liberty authorisation should not be granted if a person is in A&E "*and it is anticipated that within a matter of a few hours or a few days the person will no longer be within that environment.*" As set out in paragraphs 3.29-3.32, there may well be cases in which a person is in fact deprived of their liberty within that period of time.
- 4.23 We recognise that the situation set out above is not a happy state of affairs. It is particularly important that Trusts put in place policies that address such situations so that staff are not distracted from the delivery of care to patients but can instead have a clear indication of what they should be doing, parallel to the delivery of that care, to obtain authorisation where such is properly possible.
- 4.24 The following are examples of potentially liberty-restricting measures that may be found in an A&E Department:
- Physical restraint and the duration of any restraint;
 - The use of sedation;
 - The use of catheters and/or intravenous drips;
 - The observation and monitoring levels;
 - The requirement for a person to remain in a certain area of the A&E department and restricting the person to that area;
 - The requirement that the person does not leave the A&E department pending further tests or transfer.

¹⁵ The legal reasons why this is so are set out at paragraphs 3.29-3.32.

A&E: a deprivation of liberty

4.25 The measures in the following scenario are likely to amount to a deprivation of liberty:

Dan is brought into the A&E department having taken an overdose of paracetamol. Dan is vomiting, confused and very anxious. He resists attempts by staff to take a blood test and start N-acetylcysteine treatment. He has to be restrained and sedated by members of the hospital staff in order for treatment to be carried out. The treatment will take 24 hours to complete. He tells staff that at the earliest opportunity he will leave the hospital to complete his suicide. Dan is placed in a side room watched by a member of staff while his treatment is carried out and he is forcibly restrained and prevented from leaving during the 24 hour period.

Key factors pointing to a deprivation of liberty:

- *the monitoring of Dan whilst in the A&E department (in his clinical interests)*
- *the use of restraint and sedation to carry out the treatment*
- *the use of forcible restraint to prevent him leaving.*
- *that Dan is aware of and is resistant to the measures being carried out upon him which will, in combination with the use of forcible restraint, compress the relevant time-frame for a deprivation of liberty to occur*

Note: this situation is one in which consideration should undoubtedly be given to admitting Dan for admission for assessment under the provisions of the MHA 1983.

A&E: potential deprivation of liberty

4.26 We suggest that the measures in the following scenario may give rise to a deprivation of liberty:

John is a 19 year old, who has gone out with his friends on a Friday night. At 3am, his parents find him showering fully dressed singing at the top of his voice. He has a large bruise and laceration to the left side of his head. His parents take him to hospital. In the A&E Department, John is initially willing to have a skull X-ray and some blood tests. These show a very elevated blood alcohol level and a fracture of the left temporal region of his skull. John then starts getting very argumentative and tells everyone that he is leaving to take a train to the beach. He cannot explain why he has to go to the beach. Clinically, he should have a CT of his brain and probable transfer to a neuro-sciences unit. John is assessed as lacking capacity to make decisions about his care and treatment. The team plans to sedate and ventilate him in order to carry out the transfer. It will take a number of hours for the CT scan to be carried out and thereafter for John to be transferred to the neuro-sciences unit. During this time, John has on one occasion forcibly to be restrained to prevent him assaulting a nurse, he is then administered sedatives and, whilst continuing to be argumentative, he has to be verbally dissuaded from leaving the ward.

Key factors pointing to a potential deprivation of liberty:

- *the monitoring of John whilst in the A&E department (in his clinical interests),*
- *the use of physical restraint and sedation*
- *the key factors in determining whether this is a restriction or a deprivation of John's liberty will be the length of time that they are imposed for and the frequency and intensity of the restrictions.*

A&E – not a deprivation of liberty

4.27 The following scenario is unlikely to amount to a deprivation of liberty:

Olga lives in a rented flat. She has learning difficulties. Her care worker, Sarah, visits her twice daily to support her. On arriving in the morning she finds Olga sitting dazed on the kitchen floor. It appears that she has fallen and knocked her head on the kitchen unit. Sarah asks Olga what happened, but Olga cannot remember. Sarah calls an ambulance and Olga is taken to the A&E Department of the local general hospital. Once at the hospital Olga becomes very agitated because she does not know where she is and she vomits on the floor. She tells Sarah that she wants to go home now. A casualty doctor examines Olga and carries out a basic neurological examination. She explains to Sarah that she would like to keep Olga under observation for a couple of hours in the A&E Department before deciding whether further tests are necessary or sending her back home. Olga does not have capacity to consent to remain in the A&E Department. Sarah and the nursing staff explain to Olga that she needs to stay in hospital for a little longer and that Sarah will stay with her. Olga is pleased that Sarah will stay with her. After 2 hours she is sent home without any further assessments or treatment being necessary.

Key factors pointing away from deprivation of liberty:

- *The short length of the stay in the A&E Department*
- *The absence of physical restraint or the use of medication used to manage or modify her behaviour*

F: Intensive Care Units ('ICU')

4.28 The majority of patients in ICU lack capacity to make decisions about their care and treatment during some or all of their stay in ICU, due to the nature of their injuries, or disease, or level of sedation. Physical, mechanical or chemical restraint is often used to facilitate the care of patients in ICU and their care is closely monitored. The circumstances of patients lacking capacity who are in ICU for more than a negligible period of time may meet the 'acid test' criteria, although further judicial consideration is likely to be required in due course.¹⁶

4.29 We suggest that patients who have capacity to consent to their intensive care arrangements before being admitted to intensive care or whilst on the unit and prior to losing capacity are not considered to be deprived of their liberty because they do not satisfy the subjective

¹⁶ See also here M. Crews et al *Deprivation of Liberty in Intensive Care*, Journal of the Intensive Care Society, October 2014.

element of Article 5(1) of the ECHR.¹⁷ We should emphasise that this will only be the case so long as the circumstances in which they are treated and the length of their stay remain as anticipated at the point at which the patient gave their consent.

- 4.30 It is also important to bear in mind in this care setting that aside from mental incapacity, a patient's deprivation of liberty can only be authorised if they are also 'of unsound mind.'¹⁸ For the purposes of seeking authorisation under Schedule A1 to the MCA 2005, this requires the patient to have a mental disorder within the meaning of the MHA 1983, that is, 'any disorder or disability of the mind.'
- 4.31 The state of unconsciousness, caused by a variety of disorders and injuries, presents a particular problem in the context of deprivation of liberty. The Department of Health has recently advised that it does not consider a state of unconsciousness in itself as being a mental disorder for purposes of Schedule A1 to the MCA 2005.¹⁹
- 4.32 It may be that a patient who is unconscious, but is not otherwise suffering from a mental disorder within the meaning of the MHA 1983, can be the subject of an application to the Court of Protection for an order authorising the deprivation of their liberty,²⁰ but legal advice will be required in such cases and/or Trusts will have to set out a policy (on the basis of such advice) as to how they intend to proceed in relation to such patients.
- 4.33 This is a difficult area and we anticipate that there is likely to be case-law clarifying the position in due course. **However, we reiterate that any questions that may arise in this context of deprivation of liberty should not prevent the delivery of such immediately necessary life-sustaining treatment as continues to be required (and we reiterate again that those delivering such care and treatment will be protected from liability by s.5 MCA 2005 in relation to the delivery of treatment if they reasonably believe that the patient lacks capacity to consent, and that they are acting in the patient's best interests).**
- 4.34 Factors that are likely to be taken into account when considering whether a deprivation of liberty is taking place include:
- Continuous monitoring (almost a certainty in ICU);
 - Length of time sedated and/ or ventilated and/or intubated;
 - The use of restraint to bring about admission;
 - The use of restraint /medication being used forcibly during admission;
 - Staff taking decisions on a person's behalf regarding treatments and contact with visitors;
 - Duration of the restrictions
 - The patient not being free to leave the ICU;
 - The amount of time it is likely to take for the patient to recover capacity once they are extubated/taken off ventilation/ sedation;

¹⁷ The subjective element is discussed at paragraphs 2.27-2.20.

¹⁸ The requirement imposed by Article 5(1)(e) ECHR.

¹⁹ Department of Health Letter to DOLS Leads, 14 January 2015 at <http://www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2014/04/DH-Letter-to-MCA-DOLS-Leads-14-January-2015-FINAL.pdf>

²⁰ Because the Court of Protection does not have to apply the requirement that the individual suffers a mental disorder within the meaning of the MHA 1983, but instead may be able to take a broader approach to the meaning of the phrase 'of unsound mind.'

- The amount of time the patient is likely to remain in the ICU before moving from the ICU to an acute ward, or a rehabilitation ward;
- The package of care taken as a whole

ICU: a deprivation of liberty

4.35 The measures in the following scenario are likely to amount to a deprivation of liberty:

Mr. Smith is a 45 year old man, who had no significant past medical history. While out jogging, he collapsed in front of an off duty nurse. She called for help and started basic life support until the ambulance arrived. The paramedics found that he was in VF and he was shocked back into sinus rhythm. The total downtime was around 12 minutes. On arrival in the Emergency Department his GCS was 3/15. Primary coronary intervention (PCI) demonstrated a lesion of his circumflex artery, which was stented. Following PCI, he has a CT scan of his brain which was reported as normal. Following this, he is admitted to ICU and intubated and ventilated for temperature management. After 24 hours, his temperature is allowed to normalise, and he is ventilated for a further 48 hours (72 in total), after which time it is noted that he had a flexion response to pain, but that he did not localise. The ICU team in consultation with his family decide to perform a tracheostomy to allow early weaning from ventilation and accurate assessment of his neurological function. Following the tracheostomy, his neurology has not changed, but the longer-term prognosis is unclear. A repeat CT does not show any evidence of significant brain injury. A neurological opinion is that there could be significant, possibly complete, recovery, however, any recovery will occur over weeks to months. In the meantime he will have to stay in a hospital environment to optimise his rehabilitation. Mr Smith's family are unhappy that he has to remain in hospital and would like him to return home as soon as possible where they will care for him.

Key factors pointing to deprivation of liberty:

- *the degree of monitoring of Mr Smith's condition*
- *the length of the potential stay in hospital*
- *Mr Smith's family would like him to return home in circumstances where the hospital team consider it necessary that he stay in hospital (if the hospital team, in fact, agreed that he could return home, then there would be no deprivation of liberty)*

ICU: Potential deprivation of liberty

4.36 We suggest that the measures in the following scenario may give rise to a deprivation of liberty:

Tony is 56 years old. He is in an acute ward recovering from the removal of a large meningioma that has left him with some persistent but minor cognitive impairment. While there he suffers a pulmonary embolism and is brought to ICU for monitoring. He wants to leave the ward to have a cigarette and when advised he will have to stay for his own safety, declares he wants to discharge himself. It is anticipated that he will require some form of sedative medication to ensure his compliance with treatment over the next few days.

Key factors pointing to a deprivation of liberty:

- *The degree of supervision and monitoring*
- *That Tony may not be free to leave the ICU: the key question will be what staff will do if he does, in fact, seek to discharge himself*
- *The potential use of sedation*

Note – it is (deliberately) not clear from this scenario whether Tony’s decision-making capacity is impaired (and, if so, how): if the circumstances amount to an objective deprivation of his liberty, an assessment of this will be crucial

ICU: not a deprivation of liberty:

4.37 The following scenario is unlikely to amount to a deprivation of liberty:

Mr Dillett is a 55 year old man, who has been diagnosed with oesophageal cancer. He is suitable for an oesophagectomy and receives adjuvant chemotherapy prior to his operation. He attends a pre-operative clinic and receives information about the operative procedure and his peri-operative management. Included in the information provided are details about the 2 - 3 days he is expected to stay on ICU post-operatively. On admission he signs the consent form for the operation. The operation goes well, and post-operatively he is sedated and ventilated on ICU and his treatment is going according to plan. The consultant expects Mr Dillett to be extubated in a day or two.

Key factors pointing away from a deprivation of liberty:

- *Mr Dillett gave consent to the operation which, by extension, included consent to the consequential treatment plan*
- *the circumstances have not gone beyond those under contemplation at the time of Mr Dillett’s consent*

G: Acute ward

4.38 The following are examples of potentially liberty-restricting measures that may be found in an acute ward:

- Physical restraint;
- Baffle-locks on ward doors;
- Mittens, or forms of restraint used to prevent a patient removing or interfering with a nasogastric feeding tube, or intravenous drip;
- Raised bedrails;
- Catheter bag attached to bed;
- A patient being placed in a chair and being unable to move from the chair without assistance;
- Frequency and intensity of observation and monitoring levels;

- The requirement for a patient to remain in a certain area of the ward;
- The requirement that a patient does not leave the ward, accompanied by a plan that, if he does he will be returned to the ward.

Acute ward: a deprivation of liberty

4.39 The measures in the following scenarios are likely to amount to a deprivation of liberty:

Mrs Jones is an 80 year old lady, who lives on her own in a semi-detached house. One evening her neighbours notice the smell of burning. Not finding anything in their house, they go next door. They find Mrs Jones slumped in her kitchen with the toaster on and a piece of burned charcoal in the toaster. Mrs Jones is admitted to hospital with a diagnosis of severe community acquired pneumonia. She responds well to antibiotics and after a week tells the treating team that she wants to go home. She has been assessed during her admission by the physiotherapy and occupational therapy team, who feel that she has significant problems with her activities of daily living. Their professional opinion is that it would be unsafe for her to return home. The doctors treating her note that she is slightly confused, and she scores 8/10 repeatedly on a mini-mental test. Mrs Jones is adamant that she will not consider anything other than returning home. Her neighbours, who have visited her daily in hospital, are very concerned about her returning home. The treating team considers that she should stay in hospital for further assessment and thereafter a suitable care home should be found for her. She will have to remain on the acute ward until then, and there is no immediate prospect of her returning home.

Key factors pointing towards a deprivation of liberty:

- *the monitoring and supervision of Mrs Jones on the ward,*
- *the decision of the treating team not to let her leave to return home*
- *the potential that Mrs Jones will have to remain on the ward for a significant period of time.*

Acute Ward: potential deprivation of liberty

4.40 We suggest that the measures in the following scenario may give rise to a deprivation of liberty:

Alex suffered a serious cerebrovascular accident several years ago. He has been diagnosed as being in a minimally conscious state with little chance of recovering any further function. Although he vocalises and can track with his right eye he is inconsistent in his responses but shows some awareness. He is unable to carry out any activities for himself, he receives CANH via a PEG feeding tube. He required 24 hour nursing care and his care and treatment are constantly monitored. Alex is looked after in a long stay ward of a hospital that specialises in neuro-rehabilitation. He receives excellent care and his wife, Rose and children visit him regularly. Rose recalls Alex telling her before his accident that if at any time in the future he was unable to look after himself, he would want to be looked after at home. Rose has informed those treating Alex that she would like to make arrangements for Alex to be cared for at home. Rose has recently been told that such a move would not be in Alex's best interests and is due to have a further meeting with the treating team to discuss his future.

Key factors pointing towards a potential deprivation of liberty:

- *the monitoring of Alex on the ward and the length of his stay*
- *whether he is free to leave will depend upon whether hospital would, in fact, prevent Rose taking him to care for him at home which will depend upon the outcome of the discussions with the treating team*

Acute Ward: not a deprivation of liberty

4.41 The following scenario is unlikely to amount to a deprivation of liberty:

Cheryl brings her brother Daryl into A&E at 2 o'clock in the morning. Daryl is 19 years old and has mild learning difficulties. He has been involved in a fight with a bouncer at a local club. He is examined by the casualty doctor and sent for an X-Ray. He has a broken jaw and a number of broken teeth. Daryl is referred to a maxillofacial surgeon. He needs to operate on him as soon as possible. The operation will take 3 or 4 hours and during that time Daryl will be anaesthetised. After the operation his face will be very sore and his jaw will be held in place by bands in such a way that he will not be able to eat solid food for up to a week after the operation. He will not be able to go home for at least 2 days during which time he will be kept under observation. Daryl is admitted to a surgical ward. The surgeon assesses Daryl as having capacity to make decisions about his medical treatment and care. Daryl gives his consent to the operation. The operation goes as planned and Daryl goes home 2 days after the operation..

Key factors pointing away from deprivation of liberty:

- *that Daryl had capacity to give consent to the operation and the consequential treatment arrangements, including the requirement to stay in hospital for up to 2 days post-operation.*
- *If however Daryl did not have capacity to give consent to the operation and the consequential treatment arrangements, the facts of this scenario may point to a potential deprivation of liberty*

H: Hospices

4.42 Hospice or palliative care is available in a range of settings, for example as a hospital in-patient, as a hospice in-patient, as a patient attending a hospice daily or at home. This part of the guidance concentrates on care provided in a hospice to a person as an in-patient for a terminal illness.

4.43 Provided the proposed treatment and treatment plan is explained to the person on admission and the person consents to the treatment plan when admitted to the hospice then we consider that the subjective element of Article 5(1) ECHR may not be met and the circumstances will not amount to a deprivation of liberty falling within the scope of the Article 5(1).²¹This, however, must be kept under review during the person's stay at the hospice and consideration given as to whether the care and treatment provided to the patient differs from

²¹ The subjective element is discussed further at paragraphs 2.17-2.19.



the agreed treatment plan (because of changes to the patient's condition) to such an extent that the consent given on admission is no longer valid and the person is deprived of their liberty.²²

- 4.44 If the person lacked capacity to make decisions about his care and treatment at the time they were admitted then staff will need to look closely at the factual situation to see if the person's circumstances objectively amount to a deprivation of their liberty.
- 4.45 Most people suffering from a terminal illness are usually only admitted to a hospice for periods of respite or towards the end of their life. Therefore the length of time that a person is subject to constraint is likely to be a factor in whether or not the person is deprived of their liberty within the meaning of Article 5(1) ECHR. Hospices work together with the patient and the family to provide palliative care and do not usually admit people who are resisting admission. A hospice is also unlikely to insist on a person remaining in the hospice if the family wanted him to return home with care provided for the person at home.
- 4.46 There may, still, however, be circumstances that will meet the 'acid test.'
- 4.47 Factors that are likely to be taken into account when considering whether a deprivation of liberty is taking place include:
- That the circumstances are no longer covered by a consent given on admission;
 - Administering sedatives to decrease anxiety and agitation;
 - Chemical restraint;
 - Constant supervision in case of terminal agitation; and
 - Restricting movement of patients who are mobile, so that they are not free to leave the hospice grounds because they may be a danger to themselves
- 4.48 Because we consider that, in very many cases, whether a person is deprived of their liberty will turn on (1) whether, in fact they are free to leave; and (2) whether they have given consent in advance, we offer here only one scenario that amounts to a deprivation of liberty and one that we suggest does not amount to such a deprivation.

Hospice: a deprivation of liberty

- 4.49 The measures in the following scenarios are likely to amount to a deprivation of liberty:

Mariam is 34 years old. She has a 4 year old daughter and 2 year old son. She has an inoperable primary brain tumour. Some time before admission she had discussed her end of life plan in a general way with her GP, family and staff of the Hope Hospice. She chose Hope Hospice because of its location near to her family home and beautiful gardens. She has agreed with her partner that she will spend weekdays at the Hospice and weekends at home. She had been receiving care at home so that she could spend as much time as possible with her young children, but she has deteriorated more rapidly than had been anticipated. She is now very confused, has become doubly incontinent and suffers from acute headaches that require constant pain relief. In accordance with her previously known wishes she is brought to the hospice by her partner and is admitted to the hospice. At the point of admission she is

²² See also the Department of Health letter to MCA DOLS leads, 14 January 2015, available at <http://www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2014/04/DH-Letter-to-MCA-DoLS-Leads-14-January-2015-FINAL.pdf>.

assessed as lacking capacity to consent to her admission and the proposed treatment plan. Although confused she is still mobile. She requires constant supervision because she wanders out of the hospice into the road where she is at risk of injury. At times she becomes very agitated and wishes to go home to be with her children and has to be restrained by staff to ensure that she remains at the hospice to receive care. Mariam's partner has told Hospice staff that he is unable to cope with Mariam's care at home during the weekends as well as looking after their children. The hospice does not consider it in Mariam's best interests to go home. Mariam is in receipt of palliative care and she is likely to remain at the hospice until her death, which may be some weeks away.

Key factors pointing towards a deprivation of liberty:

- *Mariam is under constant supervision; she is not free to leave (and, additionally, must be restrained to prevent her acting upon her desire to leave)*
- *Mariam is likely to remain at the hospice for a number of weeks.*

Hospice: not a deprivation of liberty

4.50 The following scenario is unlikely to amount to a deprivation of liberty:

Mandeep has stage 4 ovarian cancer which has reached a terminal phase. During most of her illness she has been cared for at home by her mother and sister. Once she became aware that her illness was terminal she visited her local hospice with her sister and agreed that she would go there for care within the next week or two. While there she discussed and agreed an advance care plan that detailed her end of life care wishes and preferences. This plan includes pain relief and the use of sedative medication to manage the symptoms of the terminal phase of her illness and the use of a nurse call system that will activate if she starts to wander. She was told that her family could visit her at any time. When she was admitted to the hospice she gave her agreement to a care package which reflected the terms of the advance care plan. Not long after Mandeep is admitted she loses capacity to make care and treatment decisions. The Hospice continues to care and treat her in accordance with the agreed care package.

Key factors pointing away from a deprivation of liberty:

- *Mandeep gave advanced consent to the care and treatment arrangements that are now in place.*

I: Questions for front-line practitioners

4.51 These questions may help establish whether an individual is deprived of their liberty in this context:

- What liberty-restricting measures are being taken?
- When are they required?
- For what period will they endure?
- What are the effects of any restraint or restrictions?
- What are the views of the person, their family or carers?
- How are any restraints or restrictions to be applied?
- Are there less restrictive options available?
- Is force or restraint (including sedation) being used to admit the patient to a hospital to which the person is resisting admission?
- Is force being used to prevent a patient leaving the hospital, hospice, or ambulance where the person is persistently trying to leave?
- Is the patient prevented from leaving by distraction locked doors, restraint, or because they are led to believe that they would be prevented from leaving if they tried?
- Is access to the patient by relatives or carers being severely restricted?
- Is the decision to admit the patient being opposed by relatives or carers who live with the patient?
- Has a relative or carer asked for the person to be discharged to their care and is the request opposed or has it been denied?
- Are the patient's movements restricted within the care setting?
- Are family, friends or carers, prevented from moving the patient to another care setting or prevented from taking them out at all?
- Is the patient prevented from going outside the hospital or hospice (escorted or otherwise)?
- Is the patient's behaviour and movements being controlled through the regular use of medication or, for example, seating from which the patient cannot get up, or by raised bed rails that prevent the patient leaving their bed?
- Does staff exercise complete control over the care and movement of the person for a significant period?
- Is the patient constantly monitored and observed throughout the day and night?