Editorial

Journal of the Intensive Care Society
0(0) 1–2

DOI: 10.1177/1751143715625346
jics.sagepub.com

Deprivation of Liberty in Intensive Care: an update

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The requirements for deprivation of liberty safeguards (DoLS) in the intensive care setting remain confused. A recent judicial review which considered the relevance of DoLS when a patient is admitted to intensive care points towards a less restrictive approach.[1]

The Law Society offered guidance in April 2015.[2] This sets out the "acid test" required to determine if a deprivation of liberty is occurring. If the patient lacks capacity *and* is under continuous supervision and control *and* is "not free to leave," then they are deemed to be deprived of liberty. The guidance gives specific examples in the intensive care setting. For the minority of patients who can give prior consent to being treated in ICU, a deprivation is unlikely. For the remainder, lack of capacity will frequently mean a deprivation could be occurring. For occasional patients who are ambulant in ICU and are being visibly held against their wishes, it is pretty obvious they are "not free to leave."

For most patients in ICU who are not ambulant, "not free to leave" is difficult to assess and potentially problematic. The Law Society guidance advises us to consider our response to the theoretical question "what would we do if a relative asked to take the patient away (e.g. home)?" In patients who are being actively treated in intensive care, it would be unwise for them to go home and a relative keen to do this would potentially put the patient at risk. It would therefore seem illogical to consider our response to such an unwise request.

On the 29 October 2015, the judgement of an appeal court case involving an intensive care patient was published.[1] In R vs Senior HM Coroner, a patient with Down's syndrome died in the ICU despite previous reluctance to be in hospital. The Coroner elected not to request a jury for the inquest because he considered that the patient was not "in state detention" (implying no Deprivation of Liberty had occurred). Both judges rejected the case against the coroner and agreed that no deprivation had occurred. Both judges were highly critical of the Law Society guidance's approach used to determine if a deprivation was occurring.

Lord Justice Gross said:

> It is fanciful in this case to suppose that the Claimant would have sought to remove Maria from the hospital . . . and therefore idle to consider what the hospital's response would have been. . . . I cannot accept that, as submitted by Ms Butler-Cole and suggested by the *Law Society Practical Guide*, the hospital's potential response to an unasked question – and one which could not sensibly have been asked – by itself constitutes or evidences a deprivation of liberty.

He goes on to suggest that a requirement for DOLS would be "unnecessary and potentially very damaging to our therapeutic relationship."

Mr Justice Charles says that he does not "agree that this hypothetical question needs to be put in each case" (what would we do if the relatives sought to remove the patient?). He goes on to say that if we are in agreement with the relatives regarding best interest treatments, then the "need for additional checks (DoLS applications) does not apply. . . and could have damaging consequences."

These are very strong words for a legal judgement, and it is clear that neither judge approves of the previous approach.

It is likely that this case will at some stage be reviewed in the appeal court with potential for a further change in guidance. In the meantime, we need to use a pragmatic approach to our current situation. There is an alternative to using the relatives in deciding whether our patients are "not free to leave." We could consider in theory how we deal with the situation if one of our patients was found to have an advanced directive requesting not to be treated in ICU. Alternatively, we could consider our response should our patient briefly regain capacity and decline ICU treatment. If in these theoretical situations, we would accede to the patient's wish then we could safely argue that they weren't "not free to leave." This would be similar to the situation where patients make the potentially unwise decision to refuse blood transfusion but are allowed not to be transfused. If

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this approach were used, then there would be few situations in ICU where we acted in the patient's best interests but were required to seek a DoLS application.

As it stands, the Law remains unclear and clinicians fear the legal consequences of not making DoLS applications. If we continue to treat patients in their best interest, then it is unlikely we will suffer serious legal harm. Even if we were found to have breached the patient's right to freedom, the best interest would still have to be followed and lack of DoLS application would not have materially affected treatment. Any such Breach would be deemed "procedural" and it is likely that any fine (to the Hospital) would be trivial.

We conclude that we should continue to act in our patients best interests and follow GMC guidance in dealing with medical decisions in those that lack capacity. For the vast majority of our patients further safeguards would seem unnecessary.

References

1. R (on the application of LF) v HM Senior Coroner for Inner South London Queen's Bench Division, Divisional Court Judge: Gross LJ and Charles J Neutral Citation Number: [2015] EWHC 2990 Case No: CO/1302/2015.
2. Identifying a deprivation of liberty: a practical guide April 2015 Law Society, www.lawsociety.org.uk/Support-services/documents/Deprivation-of-liberty—a-practical-guide/ (accessed 17 December 2015).