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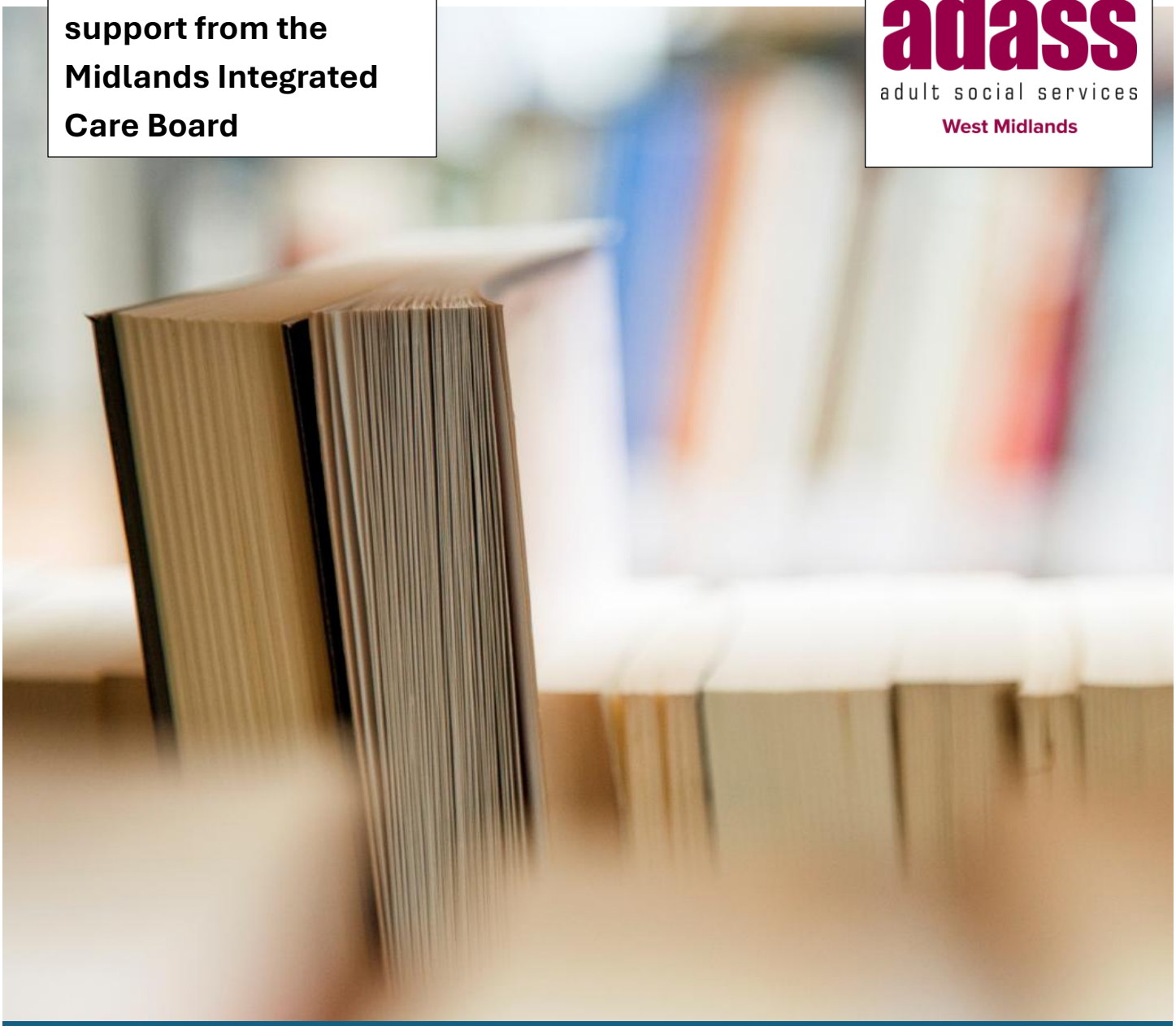

DEPRIVATION OF LIBERTY IN ACUTE HOSPITALS

A Guide for Councils and Acute Hospitals working together to process applications

Lorraine Currie December 2025

This Guide has been developed by Lorraine Currie on behalf of WMADASS

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Deprivation of liberty in Acute Hospitals – A guide to assist Councils and Acute hospitals

There is already a lot of information available in relation to deprivation of liberty and Acute hospitals. This document aims to supplement this with practical advice to assist with appropriate referrals and to signpost to existing materials. This guide is applicable to those people who lack mental capacity in relation to admission, care and treatment and who are being treated for physical health conditions in general acute settings (both NHS and Independent).

What does it mean to be deprived of liberty

Article 5 of the European Convention on Human Rights (ECHR) protects a person's right to liberty. It states that no one shall be deprived of their liberty except in certain situations and then only if the decision is made by following a legal procedure. There are generally three routes in England which are applied:

1. The Mental Health Act 1983 (as amended in 2007)
2. The deprivation of liberty safeguards, which are part of the Mental Capacity Act 2005
3. A court order (usually from the Court of Protection)

This document is about the deprivation of liberty safeguards, when and how they apply in an Acute hospital setting.

The Deprivation of Liberty Safeguards (DoLS)

The safeguards were introduced in 2009 but a Supreme Court decision in 2014[1] gave a definition or an acid test of the meaning of confinement in the context of a deprivation of liberty; this meant that the safeguards applied to many more people.

The acid test applies to someone who has a mental disorder and lacks mental capacity to make the decision whether or not to be accommodated in a hospital (or care home) for the purpose of care or treatment.

If they are under complete or continuous supervision and control and not free to leave then they are deprived of liberty. This means a lawful procedure must be used to safeguard them. There are exceptions to this in Intensive Care settings, though the scope is not yet well defined and further advice may be needed. After a decision in 2017(often known as Ferreira[2]) there is a carve out from the general rule about when the acid test applies. This is where the person is so unwell that they are at immediate risk of dying anywhere other than in hospital and the arrangements for delivering treatment are the same as they would be if the patient could agree[3]

[1] P v Cheshire West and Chester Council & Anor [2014] UKSC 19 commonly known as 'Cheshire West'
[2] R(Ferreira) v HM Senior Coroner for Inner South London [2017] EWCA Civ 31
[3] MIDNIGHT LAW - DoLS V2.pdf

General

Factors that are likely to be taken into account when considering whether a deprivation of liberty is taking place in the hospital generally setting include[4]:

- continuous monitoring
- 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 (this is not about trying to leave or being physically able to leave but rather it is about what you would do if someone tried to remove them from Hospital or if they asked to leave)

Acute ward

The following are examples of potential restrictions that may be found in an acute ward:

- physical restraint, this can include using chairs, tables and other furniture to prevent a person moving around
- 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 used out of necessity but also used to prevent a person getting out of bed
- Low or high beds which prevent a person getting out of bed
- 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 they do, they will be returned to the ward
- The use of sedative medication for control of the persons behaviour (chemical restraint)
- The use of a 1:1 support, nurse of sometimes security staff

[4] Understanding when someone is deprived of their liberty | The Law Society

Questions for frontline staff

These questions may help to work out whether a patient is deprived of their liberty in hospital:

1. General considerations
    - Are there any restrictions in place
    - Would these restrictions be the same for everyone or are they needed because of the person's cognitive impairment (If so, the Ferreira exception may apply, depending on the nature of the treatment and how liberally the case should be interpreted)'
    - When are they required
    - How long are they in place
    - How do the restrictions/restraint affect the person
    - How does the person feel about the restrictions in place
    - What are the views of the family or any carers
    - Have less restrictive options been considered
2. Admission
    - Was force or restraint (including sedation) used to admit the patient because they were resisting admission
    - Was the decision to admit the patient opposed by relatives or carers who live with the patient

    NB: in many cases like this, the Court may need to be asked to approve the proposed care plan as a whole, prior to admission.
3. Discharge/attempts to leave
    - Has a relative or carer asked for the person to be discharged to their care and was the request opposed or denied
    - Is the person persistently trying to leave
    - Is force being used to prevent a patient leaving
    - Is the patient prevented from leaving by distraction, locked doors (or those with keypads/baffle locks), restraint, or because they are led to believe that they would be prevented from leaving if they tried
    - Is the patient prevented from going outside the hospital (escorted or otherwise
4. Monitoring and wider restrictions
    - Are the patient's movements restricted within the care setting

- Is the patient constantly monitored and observed throughout the day and night
- Is the patient's behaviour and movement 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
- Are family, friends or carers, prevented from moving the patient to another care setting or prevented from taking them out at all
- Is access to the patient by relatives or carers being severely restricted
- Do staff exercise complete control over the care and movement of the person for a significant period

When and how to make a DoLS referral

There are some important steps to take before requesting a DoLS authorisation, mainly to examine the restrictions and why they are in place but these should not delay an application for a DoLS authorisation where it is appropriate.

Some suggested questions to consider are

- Are the restrictions necessary to prevent harm, proportionate to the likelihood and severity of harm and in the person's best interest
- Have less restrictive options been explored
- Are there policies and procedures in place for the prevention of restrictive practice

The most important thing to note is that blanket referrals should never be made. There is no reason to think, for example, that everyone with dementia needs a DoLS authorisation, or that everyone on a certain ward needs a DoLS authorisation. Decisions should always be made on a person-by-person basis.

A good starting point is noting those people who you know have a condition which might be treated as a mental disorder, for example:

- Stroke
- Learning disability
- Brain injury
- Dementia

Although the mental disorder will be confirmed later by a doctor you should believe it is likely that one exists.

The next thing to consider is whether there is any reason to doubt the person's capacity to make their own decision regarding admission for treatment.

If there is no cause for doubt and the person has consented validly to their admission to hospital, then a DoLS authorisation is not needed.

Once you have identified a person or persons that you think may need the protection of the safeguards you need to consider the arrangements in place for them.

This means looking at all or any of the restrictions listed above and asking whether the combination of all the necessary restrictions in place means that the acid test is met i.e. that the person is under complete or continuous supervision and control and not free to leave.

For example, if you are using side rails for the persons safety, they do not have the capacity to consent to this, but there are no other restrictions in place. If this is a necessary restriction to allow their nursing care and it is proportional to the likelihood of harm otherwise then it is unlikely that a DoLS authorisation will be needed as the MCA can be relied on for this. It is important to always make sure that the acid test isn't met due to other factors.

On the other hand, if you are using side rails for the patients safety along with a number of other restrictions such as: you may be preventing them from leaving and using sedation or a one-to-one nurse, then this is much more likely to need a DoLS authorisation.

Once you have worked out whether the person is deprived of liberty you must believe it is likely that all six requirements for a DoLS authorisation apply. These will subsequently all be assessed by two assessors; one is called a Best Interests Assessor (BIA) and the other is a Mental Health Assessor (MHA).

The six requirements are:

1. **Age** – Is the person 18 or over? The safeguards in this form are only available for those 18 or over, for those under 18 there is a different route.
2. **Lack of decision specific mental capacity** – Is the person unable to make the decision whether or not to be accommodated in the hospital for care or treatment because they have a mental impairment (this can be any kind of mental impairment, it doesn't need to be a specific diagnosis at this point)
3. **Mental Disorder**- You should consider it likely that the person will meet this requirement so although maybe not yet fully diagnosed you would expect a diagnosis of a Mental Disorder when applying for an authorisation (this will subsequently need to be confirmed by the Mental Health assessor)
4. **No Refusals** – Has the person made an advance decision to refuse the treatment that is being proposed or have they (or the Court) appointed anyone to make health and Welfare decisions (LPA/Deputy) who objects to any of the care/treatment arrangements.
5. **Best Interests** – Are the arrangements in their best interests, even though they meet the acid test? Are the arrangements necessary to prevent harm to the person and proportionate to how likely the harm is and how severe it would be otherwise. This will be tested by the BIA.
6. **Eligibility** – Is the person ineligible for DoLS because they have some requirements under the Mental Health Act which causes a conflict? This will be tested by the MHA.

You must then make a further decision about which kind of authorisation is needed.

1. **An urgent authorisation**: this is an authorisation granted by the hospital, by whoever completes and signs it for the hospital and it lasts for 7 days initially and can be extended for a further seven. It is really important to note that by signing this it **grants** an authorisation. There should always be an expectation that a standard will be required i.e. that the conditions will be met beyond the 7 or 14 days. An Urgent authorisation should be granted when there are sudden unforeseen situations requiring restrictions which meet the acid test. This means that the restrictions need to be imposed immediately and cannot wait for a Standard authorisation to be processed. There must always be a request for a Standard authorisation submitted when an Urgent is granted.
2. **A standard authorisation**: A standard authorisation can be requested up to 28 days before it is needed and the safeguards require it to be processed within 21 days. However local authorities are still experiencing huge delays in processing applications and it is rare that the 21 days' timeframe is met. You can use a Standard authorisation when you are planning an admission to hospital and you know it will require restrictions that the person cannot consent to and it meets all the requirements described above.

Which Forms to use

A standard is usually requested using Form 1 however some local variations may exist. Some Councils may have online portals and these forms will contain all the detail of a Form 1 but be described as 'application for a DoLS authorisation' or similar.

An Urgent is also **granted** using Form 1 (as above) and can be extended for a further 7 days using the same Form 1. Often the practice is to request the extension at the same time as the application to provide further protection for the person. The supervisory body can grant an extension if there are exceptional reasons why it has not been possible for the initial request to be processed. Since the decision in Cheshire West and the resulting waiting lists an extension is almost always granted.

If the request is processed before the patient is discharged then two assessors will visit, they will carry out the assessments and this will be followed by scrutiny and an authorisation will be granted (or not granted).

If the patient is still in the hospital towards the end date on the authorisation granted then a further authorisation is needed. Send the Form 2 for a further authorisation 28 days before it is needed, as with Form 1 an online portal may be used and may not describe Form 2 but might simply say 'Renewal of a DoLS'

How much detail is needed on Form 1 and can the forms be completed with the same information for everyone

Form 1(or request for a DoLS authorisation-standard and urgent) is a crucial form as the process cannot begin without it, in fact the council cannot give a standard authorisation unless the managing authority (hospital) has requested it.

The MCA specifies that a request for an authorisation must include the information required by regulations and there are regulations (in England) which specify all the detail needed. This information has been carefully included in Form 1; the regulations also require any relevant care plans and or a needs assessments to be provided.

If using the WMADASS forms DoLS forms | WMADASS then the first three pages constitute the request for a standard authorisation, page four is for monitoring purposes and page five is to be completed if you are **granting** an Urgent authorisation.

The end of the Form is used if an Urgent needs to be extended for up to a further seven days.

The form asks initially for some standard information such as name and date of birth.

The request for authorisation asks for **relevant** medical history which means anything relating to a mental impairment or a mental disorder or aspects of the medical diagnosis which result in the need for restrictions. The DoLS process protects the rights of those with a mental disorder so any information to explain the diagnosis or treatment is useful but you do not need to include lots of physical medical conditions.

Communication needs are very important and will help the assessors who are allocated. Please explain anything here about how the person's communication can be supported.

The purpose for which you require the authorisation is the key information. This should never be a cut and paste or the same information repeated for all patients. You should describe here an outline of the treatment plan and the nursing interventions. Most importantly you should describe the restrictions which are in place to provide the care and treatment, why this amounts to complete or continuous supervision and control and why the person is not free to leave.

Examples

The following is useful and is accompanied by a care plan.

Relevant Medical History (*including diagnosis of mental disorder if known*) *Advanced dementia*			
Sensory Loss		Communication Requirements	*Cannot communicate verbally in a way that is relevant to questions asked. She can express feelings by smiling and she does talk a lot about things that are unconnected to the conversation.*

The following Form 1 is not very helpful.

Relevant Medical History (*including diagnosis of mental disorder if known*) *Arthritis, Congestive heart failure, Anaemia*			
Sensory Loss		Communication Requirements	*Uses English language*

What the MCA allows and what to do whilst waiting for a DoLS authorisation.

It is important that all staff are familiar with the MCA, in particular sections 5 and 6, which allow for acts to be carried out in connection with care or treatment and also sets out what limitations there are on carrying out these acts.

Section 5 allows acts to be carried out where it is reasonable to believe that the person lacks capacity for the specific decision and it will be in the persons best interests to take the proposed steps.

An example might be taking a necessary blood test; the person is found to lack capacity to consent to the procedure but it is in their best interests for it to be done.

There are, however, some limitations on delivering care or treatment in the absence of consent.

If restraint is required to carry out an act in a person's best interests, then there are some additional requirements.

Section 6 states that if the act requires restraint, then there are two further requirements to be met.

1) The act must be necessary to prevent harm to the person and
2) The act must be proportionate to both the likelihood of harm and the seriousness of it.

An example might be that a person cannot consent to a blood test, the blood test is key to identifying further treatment and there is a significant risk that the persons health will deteriorate without it. Restraint is required for a short period by holding the persons arm to take the blood test.

Evidence must be recorded of the persons lack of capacity, along with a best interests decision and evidence to support why restraint is both necessary and proportionate, then this can proceed under the MCA alone.

In the absence of a DoLS authorisation to safeguard the persons liberty, there are still acts which can be carried out under the MCA alone.

In these circumstances it is important that all decisions are made and recorded in line with the requirements of the MCA and that all essential and appropriate care and treatment is provided in the meantime.

Are there any occasions when a DoLS authorisation is not needed?

There are some specific considerations particularly in Intensive Care settings, after a decision in 2017(often known as Ferreira[5]). As a result of this decision there is a carve out from the general rule about when the acid test applies. This is where the person is so unwell that they are at immediate risk of dying if they were anywhere other than in hospital and the arrangements for delivering lifesaving treatment are the same as they would be if the patient could agree[6].

[5] R(Ferreira) v HM Senior Coroner for Inner South London [2017] EWCA Civ 31

[6] MIDNIGHT LAW - DoLS V2.pdf

Are there any situations where the DoLS scheme cannot be used?

There are often complications where a DoLS application is made in relation to alcohol misuse or alcohol detox' for example. This is because DoLS uses the same definition of a mental disorder as the Mental Health Act, i.e. any disorder or disability of the mind'.

Section 1(3) of the MHA states that dependence on alcohol or drugs is not considered to be a disorder or disability of the mind for the purposes of the definition of mental disorder in the Act. But alcohol or drug dependence may be accompanied by, or associated with, a mental disorder.

It is possible, to detain people who are suffering from mental disorder under the MHA, even though they are also dependent on alcohol or drugs. This is true even if the mental disorder in question results from the person's alcohol or drug dependence.

The same applies to detention under DoLS. If the purpose of the treatment is alcohol related DoLS can only be used if there is a mental disorder (which may be associated with alcohol) if there is no mental disorder DoLS cannot be used.

Is it lawful to deprive a young person of their liberty?

The DoLS scheme only applies to those aged 18 and above but the concept of being deprived of liberty can apply to anyone, including those under 18. There are different routes to authorise the deprivation of liberty from age 16 and there are different considerations in relation to consent. The law relating to children and young people is quite complex and advice should be sought. Parents of younger children can usually consent to the arrangements if it is within the scope of parental decision making but a parent of a 16- and 17-year-old can never consent[7] to a situation which amounts to a deprivation of liberty meaning that any deprivation of liberty of a 16-17 year old can only be authorised by the Court, or detention under the MHA.

Can we use a DoLS authorisation in A and E (Emergency department)

DoLS cannot be used in the Emergency Department; an application for an authorisation can only be made once the person is admitted. It is necessary to consider all restrictions which are being in place in this setting and in particular to consider whether they are both necessary to prevent harm to the person and proportionate to the likelihood and severity of harm that would otherwise occur. It may be possible to proceed under the wider provisions of the MCA however some circumstances may require further consideration in particular whether another legal framework is required. It is important to seek further legal advice if the restrictions in place appear to amount to a deprivation of liberty.[8]

What do we do if the patient who has a DoLS authorisation in place, moves to a different ward or to a different setting which is still part of the same hospital?

[7] Re D (A Child) [2019] UKSC 42

[8] Full DOLS guidance updated (5).pdf

This is quite a difficult question, and it seems like one the law didn't consider fully. In general, if the move is within the same hospital site, technically, a request for a new DoLS authorisation is not needed, and the existing one is adequate. However, there can be significant differences between settings, even though they are part of the same hospital. If the environment is different and the restrictions are consequently changed, it is essential to seek a review of the DoLS authorisation that is in place. If the person is moved to a different place of detention (even though the managing authority remains the same) the best advice currently is that this requires a new authorisation.

Is a DoLS authorisation needed if the person is at the end of their life

If there are liberty restricting measures in place which the person cannot consent to, and they have a mental disorder then a legal procedure must always be in place. However, there are some additional considerations when a person is at the end of their life. The balance between causing distress and protecting liberty must be carefully weighed.

After the application is made is there any additional information that would help the Council?

Councils generally prioritise situations which are most urgent. The situation which generally get highest priority are where any of the following are present:

- Active objections from the person (verbal or physical, e.g. repeatedly saying they want to go or packing bags)
- Meaningful, successive attempts to leave not simply leaving due to disorientation.
- Sedation/medication is used frequently PRN to control behaviour (particularly covert medication), this has not been regularly reviewed, and the person is negatively impacted.
- Excessive Physical restraint is used regularly which causes distress to the person and goes beyond what the MCA allows.
- Restrictions on family/friend contact (or other significant Article 8 issue)
- Objections from family or friends or family seeking to move the person in an unplanned way

If any of these were not present when you made an application but occur afterwards you should let the Council know. It is also important to let the Council know as soon as possible if the person is discharged or dies.

Is a DoLS authorisation needed to transport someone from or to hospital

An authorisation is not usually required even in an emergency for transport to and from hospital, this can usually be achieved by reliance ion the MCA alone. There are exceptions to this: if the journey is particularly long or the restrictions required to make that journey so intense, then an authorisation may be needed. Exceptions to this needing further consideration would be:

- When it is necessary to involve the police to gain entry to the person's home to assist with the move

- When it is necessary to do more than persuade or use transient physical restraint of the person during the move so that, for example, force or the threat of force have to be used to overcome the individual's resistance to be transported

- When the person may have to be sedated
- When subterfuge has to be used.

In these circumstances authority will be needed from the Court of Protection, either prior to the removal or (in emergency situations contemplated by Section 4B of the MCA) at the same time as the removal is taking place.

Let's do some myth busting - TRUE or FALSE

1. **Everyone who lacks the capacity to consent to admission requires a DoLS**

FALSE. Not everyone who lacks capacity to consent to admission is deprived of liberty. A person may lack mental capacity very temporarily due to infection or post-operative confusion. They may not have a mental disorder once the temporary episode subsides. They will not meet all six requirements for a DoLS authorisation. This person can usually be treated using the MCA alone. If, however, the temporary impairment continues and/or the restrictions are very intense, a DoLS authorisation may be needed.

2. **There are certain timeframes which require a DoLS e.g. 72 hours of being an inpatient.**

FALSE: The MCA and DoLS requirements are not the same as the Mental Health Act requirements. The questions to be asked are described above. If the person is not being deprived of liberty, there is no need for a DoLS referral, the MCA allows care and treatment for people who cannot consent. Where a patient who lacks capacity is an inpatient it is always a good idea to consider their situation and whether they require a legal framework to be relied on, taking into account all the information in this guide.

3. **There must be a DoLS in place before discharge**

FALSE: Any deprivation of liberty which results in a DoLS referral is for that setting only. It does not affect the future setting, and it cannot be carried over to any other setting. Discharge planning might need to consider whether a DoLS authorisation might be needed at the future placement, but it is not dependent on it. A different setting will have different restrictions and will require decisions under the MCA including best interests decisions. However, it is good practice, where possible for any DoLS authorisation to be obtained in advance as part of care planning.

4. **Certain medical procedures require DoLS referrals**

FALSE: DoLS never authorises treatment. The authorisation is about being accommodated in the hospital for the purpose of care and treatment, but all treatment decisions require individual consideration under the MCA.

5. **It is a CQC requirement to have DoLS in place for everyone on certain wards**

FALSE: As a regulator, CQC expects providers to meet the requirements set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations, as well as meeting any other requirements set by other relevant legislation. They also monitor the operation of DoLS as part of their assessments.

One of the things they consider is how providers apply the MCA and DoLS in their service. They do not expect everyone on a certain ward to have a DoLS authorisation, as decisions should be made on a case-by-case basis. There is never an argument for blanket referrals whether in a hospital or care home. However, it is an expectation that you will have considered compliance with the MCA including whether a DoLS authorisation is required. It is also a requirement to notify CQC once the outcome of a DoLS application is known or at the point this is no longer needed.

6. **Local Authorities don't proritise DoLS in acute hospitals any more**

FALSE: Most, but not all Councils have waiting lists for DoLS assessments to be completed. Hospitals and Care Homes are the only two settings where an authorisation can be granted. Neither is prioritised based on its designation. All referrals are generally prioritised on the basis of the restrictions in place, the intensity of the restrictions and the persons reaction to being confined.

7. **Once there is a DoLS in place it is safe to apply any restrictions**

FALSE: The assessors will visit to consider all the restrictions in place. They will make a careful finding about the persons best interests based on these restrictions. They will decide if these restrictions meet the acid test. Once an authorisation is granted it will have been based on the necessity and proportionality of these restrictions. If any subsequent restrictions need to be imposed, then there will need to be a review of the original authorisation. Additional restrictions may not be necessary or proportionate and therefore the deprivation of liberty may not be in the persons best interests.

8. **We have to continue to restrict a patient because the DoLS authorisation says so**

FALSE: DoLS is a scheme to safeguard a person's liberty. It grants permission to carry on doing what you need to do to deliver care/treatment BUT it does not make the restrictions mandatory. If you no longer need to restrict a person quite as much or in the same way and you are able to reduce restrictions, then you must do so.

9. **Patients who are under 18 do not need a DoLS authorisation.**

FALSE: The DoLS scheme applies only to those people who are aged 18 and over but this does not mean that legal protection is not required for under 18s. Depending on age there are various routes. Always get advice but do not ignore restrictions which are in place for someone under 18.

DoLS QUCK CHECK			
The person 18 or older		The person is under 18	
The person lacks capacity for decisions and about care and treatment		There is no reason to doubt the persons mental capacity for care and treatment decisions	
There is a diagnosis of a mental disorder or is it likely that the person has one which isn't yet diagnosed fully		The person does not have a mental disorder	
The person has not made any advance decisions to refuse treatment		The person has made an advance decision to refuse the treatment being proposed	
The person is not subject to any provisions of the MHA		The person subject to some aspects of the MHA	

There are restrictions in place which mean the person is subject to continuous supervision and control and not free to leave and these cannot be reduced.		There are only minimal restrictions in place which do not limit liberty	
It's not possible to reduce any of the restrictions		It is possible to reduce some of the restrictions	
NEXT STEPS			
If all the above are green Submit a request for a DoLS authorisation		If any of the above are amber pause to make changes or seek further advice	
		If any of the above are red STOP as DoLS does not seem to be the appropraite route, consider if further advice is needed	

Resources

- Identifying a deprivation of liberty in the hospital setting: quick reference guide | The Law Society
- Deprivation of Liberty in Acute Hospitals - East Safeguarding Learning Platform
- The MCA & Hospital Discharge - Autonomy Project
- CPR Decisions and the MCA - Autonomy Project
- Decision-Making with 16 to 18 Year Olds - Autonomy Project
- bma-deprivation-of-liberty-safeguards-guidance-september-2020.pdf
- 'A Practical Guide to the Law of Deprivation of Liberty' by Ben Troke – Law Brief Publishing