Southend, Essex & Thurrock(SET)

Procedures Statement

For
Mental Capacity Act 2005
&
Deprivation of Liberty Safeguards

Document Control Sheet

Title of Policy:	**Southend Essex Thurrock Mental Capacity Act 2005 and Deprivation of Liberty Safeguards Procedures**
Purpose of Policy:	**This document provides a guide to assessment of capacity to all those working with adults who may lack capacity including those working in Health and Social Care Practice. The principals are applicable to anyone aged 16 years and above who may lack capacity for MCA and anyone aged 18 years and above who may lack capacity for the DoLS. These guidelines are intended for use by everyone involved in such assessments.**
Target Audience:	**All those working with adults who may lack capacity including those working in SET.**
Implementation Date:	**July 2014**
Action Required:	**This Policy has been agreed by the Essex Safeguarding Adults Board and the Thurrock Safeguarding Adults Partnership Board and the Southend On Sea Safeguarding Vulnerable Adults Board**
This policy supersedes:	**Essex and Thurrock Mental Capacity Act 2005 Joint Policy and Guidance March 2010.**
This policy must be read alongside:	**SET Safeguarding Adults Guidelines, Mental Health Act Policy and Guidelines.**
Policy Leads:	**Stephen Bunford (ECC) & Penny Rogers (NHS)**
Policy Author:	**SET MCA LIN**
Comments to:	**ESAB@essex.gov.uk**

(Southend, Essex & Thurrock) (SET)
MCA & DoLS Procedures

These Procedures should be read in conjunction with the SET Southend, Essex and Thurrock policy Statement on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2007).

The Procedures have been developed in conjunction with the Southend, Essex & Thurrock Mental Capacity Act Local Implementation Network on the behalf of the three local authority boards, which represent the three Council, all Essex provider NHS Trusts, Essex Independent, Essex Care Association, South East Care and Health Association and other Care Providers in Essex are strongly encouraged to use this policy

The Procedures are available on the Southend Borough Council, Essex County Council and Thurrock Council web pages and through all NHS Trusts intranet pages. The Essex County Council website link is:
www.essex.gov.uk/mentalcapacityact

PART 1 – MCA PROCEDURES

Appendices

Section	Document
1	MCA1 Day to Day Decision Form
2	MCA2 Significant Decision Form
3	MCA3 Guide to Assess Capacity
4	MCA4 Southend, Essex and Thurrock MCA Policy
5	MCA5 Guide to Mental Capacity Act
6	MCA6 Advance Decisions Guidance
7	MCA7 Advance Decisions Checklist
8	MCA8 Lasting Power of Attorney Checklist
9	MCA9 Best Interests Checklist
10	MCA10 Best Interests Flowchart
11	MCA11 Capacity and Finances
12	MCA12 Planning for the Future Leaflet
13	MCA13 MCA Information Leaflet
14	MCA14 MCA2 Samples
15	MCA15 MCA2 Quality Checklist

Link to Forms:-

http://www.essex.gov.uk/Business-Partners/Partners/Adult-Social-Care-providers/Pages/Mental-Capacity-Act-for-professionals.aspx#mca

1. Introduction

This document contains the following information:

Procedures for working in Southend, Essex & Thurrock to follow in the event of concerns to assess capacity. This is supplemented with supporting literature and advice taken from the Mental Capacity Act (2005), the Mental Capacity Act Code of Practice (2007) and the Southend, Essex & Thurrock MCA Local Implementation Network.

The contents of these documents will be reviewed on an annual basis through the Southend, Essex & Thurrock MCA Local Implementation Network and are subject to change in line with National and local policy and service requirements.

2. Assessing Capacity

If you are concerned that a person aged 16 or over MAY NOT have the capacity to make a specific decision, then an assessment of capacity MUST be conducted and documented in both the individual's case notes and on their electronic record – e.g. SWIFT/CAREBASE/CARE FIRST/IAS or similar.

All adults (aged 16 and over) must be presumed to have capacity unless proven otherwise. Adults must be facilitated to make whatever decisions they can make for themselves, and all practical do-able steps must be taken to facilitate an individual in an assessment of capacity to achieve optimum performance.

Where you are required to assess Capacity for a Child or Young Person under the age of 16, you should follow your agency / organisation policy or procedures. Young People under the age of 16 may have capacity (be Gillick-Competent), however the law does not presume capacity for any young person under the age of 16.

Young People (aged 16 – 18) who have capacity may not have any decision they have made over-ruled by a parent/carer who holds parental responsibility. Where a young person (aged 16 – 18) is assessed as lacking capacity to consent to a decision (e.g. regarding medical treatment), their parent may consent on their behalf. An MCA2 assessment must be completed for any young person aged 16 – 18, before it is concluded that they do not have capacity.

All assessments of capacity must be conducted by the Decision-Maker-this is the person taking the decision or action.

Day-to-day decisions

Assessments of capacity in this context can be made solely by the decision-maker. Form **MCA1** must be used for documenting day-to-day assessments of capacity. Where a provider of care has no electronic record system, the MCA1 form must be inserted into the written records.

Significant decisions

A Significant decision is being made if there are concerns that an individual may not have the capacity to:

- Consent to serious medical treatment (see 6.15- 6.19, Code of Practice)
- Consent to an informal admission (to hospital, nursing or care home)
- Consent to all changes of accommodation, e.g. interim or permanent - (e.g. move from inpatient bed to different hospital, nursing or care home & they will stay in hospital for more than 28 days or in care home for more than 8 weeks)
- Request a Tribunal Hearing when detained under the MHA (1983)
- Manage their property or financial affairs, health or welfare
- Consent to their confidentiality being breached – e.g. during SOVA Investigation.

The above list is not exhaustive and professional judgement must be used.

All assessments must follow the five statutory principles and the two-stage test of capacity and comply with the Mental Capacity Act's philosophy.

It must be noted that all assessments of capacity are **Issue Specific;** it is thus probable that an individual may have several different assessments of capacity in respect of different issues and decisions documented both on the electronic record and/or in their case notes.

Assessments of capacity where a significant decision is being taken must be recorded on the MCA2 form.

It is recommended that MCA2 assessments should be completed jointly by two staff, one of whom is a registered professional. It is, however, recognised that it might not always be practical or in the best interests of the service user for the MCA2 to be conducted jointly by two assessors, (for example where the service user might be overwhelmed by the use of two assessors or where an assessment of capacity needs to be completed urgently and resources prevent the availability of two assessors). Where an MCA2 for a significant decision is completed by a single assessor, this must always be completed by the Decision Maker, who must have sufficient training and knowledge of the

MCA (2005) to be able to conduct an assessment of capacity in accordance with the MCA (2005) and must be aware that they may need to justify their assessment in Court.

Where the MCA2 is completed jointly by two staff, they should jointly fulfil the functions of

- One of whom must be the decision maker
- One person having ideally an established relationship with the individual whose capacity is being assessed
- One person must be a registered qualified professional or have sufficient training and knowledge of the MCA (2005) to be able to conduct an assessment of capacity in accordance with the MCA (2005) and must be aware that they may need to justify their assessment in Court.

When an MCA2 should be completed:

The MCA2 should be completed when a decision is being made or action taken for an individual where there a doubts about an individual's capacity to consent.

Where a health professional is referring to another health professional for medical treatment (e.g. GP to Acute hospital trust) – there will be one MCA2 regarding the decision to refer (in the service user's best interests). If there is a significant time delay between referral and treatment (e.g. more than 10 working days) then a second MCA2 needs to be completed by the professional providing the treatment (the decision maker) at the time the treatment is to be delivered.

The Decision-Maker should use accessible language within any assessment and must ensure that the assessment occurs at the optimum time for the service user, in accordance with MCA Principle 2 – taking all practical, doable steps.

Who should complete the MCA2 assessment?

In this context a professional is a person who has either a registered qualification or has sufficient training and experience to undertake an assessment of capacity in accordance with the MCA (2005) Code of Practice. In both cases the professional must be able and willing to give evidence in Court. A registered professional will be abiding by a code of practice & code of professional conduct. Registered professionals include medical practitioners, chartered clinical & counselling psychologists, professionals registered with the Health Professional Council, nurses registered with NMC, social workers registered with HCPC (01/08/2012).

Consideration of the skills and experience of those conducting the assessment must occur; for example where the individual has significant

learning disabilities it would be appropriate for a minimum of one of those conducting the assessment to have expertise within this domain.

In many cases, the assessment of capacity is relatively straightforward and, with appropriate guidance, could and should be performed by any competent professional such as the individual's care coordinator together with one other. In significantly more complex cases, for example where the individual's decision-making capacity is borderline, appears to fluctuate or is- by reason of mental disorder- particularly difficult to assess, it may be necessary to obtain the opinion of an experienced professional such as a psychiatrist to assess capacity jointly with the decision-maker who can explain more fully the care decision to be made and the implications of a decision in either direction. It must be noted that although it is good practice to seek the help of an expert, the decision on the person's capacity is the legal responsibility of the Decision-Maker. It is inappropriate to use a family member or friend of an individual of a service user as the second assessor of capacity due to potential conflict of interests.

A family member may only be present in the assessment of capacity where this is clearly in the best interests of the service user. Professionals must be aware that should there be any concern that the presence of a family member in an assessment of capacity could intimidate or coerce the individual, then they may not be present. A family member may only be present where this is requested by the service user.

Wherever possible the two assessors should be from differing professional disciplines as this facilitates a range of professional expertise being employed within the assessment.

Professional judgment must be used to determine whether an assessment of capacity should be repeated if an adult's capacity appears to change in respect of a specific decision – for example where capacity may improve as an adult recovers from an illness.

Where, following an MCA2 joint assessment of capacity by two people, they are unable to agree the outcome, the decision maker's view is legally binding and it is the decision maker who has final responsibility for determining if an individual has capacity to make a specific decision. Should the decision maker think it appropriate, a second opinion must be sought and the relevant local Safeguarding Adults Teams or NHS Trust lead for Safeguarding must be consulted.

Whilst it is recommended that one of the two individuals completing the assessment of capacity for a significant decision should always be a registered professional, it is recognised that there may be situations where it is appropriate for experienced and trained paraprofessionals to complete the assessment of capacity (for a significant decision). Individuals completing assessments of capacity are reminded that the decision maker must always be one of the assessors and that they may need to justify their assessment in a court of law if the assessment is challenged. The decision to use a paraprofessional to assess capacity for a significant decision should only be

made as an exception and with the agreement of the paraprofessional's line manager or supervisor who is responsible for ensuring that they have appropriate training and experience prior to conducting any assessment.

Assessments of capacity for Individuals placed in another Local Authority:

Where an individual's care or treatment has been commissioned outside their placing authority, the assessment of capacity must be conducted by the decision-maker who is planning to make a decision or take an action in respect of the adult who may not have capacity this will be undertaken in accordance with the policies and procedures of the Local authority where the individual is placed (where the body lies).

Where a Local Authority is responsible for the funding of an individual who is placed outside the commissioning authority then it is the responsibility of the Local Authority where the individual is placed (where the body lies) to provide an IMCA service.

Assessments of capacity for individuals placed by Essex, Southend or Thurrock LA's outside their LA must be conducted in accordance with the Southend, Essex & Thurrock MCA Policy (i.e. on form MCA2, with two people, one of whom must be a professional). The decision maker must always be involved in the assessment. If the decision to be made is in respect of a change of accommodation, then the relevant placing LA is the decision-maker and thus a Social Worker from Essex must be one of the assessors of capacity.

Urgent assessments of capacity for significant decisions:

Where a decision needs to be made very urgently or where having two professionals present in the assessment of capacity would be detrimental to the service user (for example where a service user's performance might be negatively impacted upon due to anxiety), then an MCA assessment may be led by a single professional. This must be the decision maker and the recorded assessment must detail why it was in the best interests of the service user to implement an assessment with only a single professional present.

Detailed recording of the process of the assessment of capacity for significant decisions must be recorded on the MCA2. This can be completed by either the Decision Maker or the Second Assessor, but it must be dated, signed and confirmed as an accurate record by both assessors.

It is recommended that MCA2 assessments must not be handwritten, unless writing is clear and legible. This ensures that should an MCA2 be subject to evaluation (e.g. in court or as a consequence of a complaint), the information it contains can be scrutinised and evaluated.

Quality monitoring of MCA2 assessments:

MCA2 assessments must be recorded or written up at the time the assessment is made. A completed signed MCA2 must be recorded in the individual service user's electronic record and/or their written case record no later than 48 hours after the assessment.

In NHS Trusts & NHS Organisations copies of all MCA2 assessments must be provided to the relevant Safeguarding Leads for quality monitoring and data collection purposes.

In ECC, all MCA2 assessments must be quality monitored by the respective Team Manager (or their nominated deputy) and a copy must be sent to Safeguarding Essex for data collection purposes.

In both Southend & Thurrock Local Authority, all MCA2 assessments must be quality monitored by the respective Team Manager (or their nominated deputy) and a copy or notification of completion must be sent to respective LA lead for Safeguarding Adults for data collection purposes.

In all agencies, quality monitoring of completed MCA2 assessments must occur within 5 working days of the completion of the assessment.

All individual agencies must ensure that they have an internal system which enables prompt quality management of completed MCA2 assessments and audit.

3. Consultations and further advice

Within Essex not all professionals will routinely come into contact with adults who may lack capacity. All staff, however. Must be familiar with the Mental Capacity Act Code of Practice (2007) and have access to their manager should they have any concerns. Clearly, some managers will have considerable involvement or experience with assessing capacity, while others may not. Levels of expertise will consequently vary and it is not expected that all will have high level of expertise.

Where consultation or advice is required or sought regarding an assessment of capacity, this must be sought from your line manager, an experienced colleague or from the agency Safeguarding Essex.

Professionals should ensure that they are aware of recent case law in this domain. Information regarding recent case law is provided to professionals through the ECC Risk and Enablement Bulletin, NHS Safeguarding Newsletters or equivalent sources of information.

4. Principles of Assessing Mental Capacity Assessment

Capacity must be judged in relation to a specific decision – some decisions are easier to make than others.

4.1 A person (aged 16 and above) must be assumed to have capacity unless it is established that he or she lacks capacity – all assessments of capacity are issue-specific.

4.2 A person is not to be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken

4.3 A person is not to be treated as unable to make decision merely because he or she makes a decision that others believe to be unwise. It is important to note that a mentally competent adult has an absolute right to refuse to consent to any intervention or medical treatment, even where that decision may lead to his or her own death. Staff may wish to take legal advice or to consult with the courts in such cases

4.4 An act done or decision made, for or on behalf of a person who lacks capacity must be done, or made, in his or her best interests.

4.5 Before such an act is done, or decision made, regard must be had whether the purpose for which it is needed, can be as effectively achieved in a way that is less invasive or restrictive of the persons rights and freedom of action.

5. Demonstrating Decision-Making Capacity

In order to demonstrate that an individual lacks decision-making capacity, a person must have an impairment or disorder of the mind or brain and be unable to complete one of the following:

- Understand the information relevant to the decision, including the purpose of a proposed course of action,
- Discuss and weigh up the main benefits, risks and alternatives, and the consequences of refusing to follow a proposed course of action and/or failing to make a decision.
- Retain that information for long enough to make a decision.
- Communicate his or her decision, whether by speech, sign language or any other means.

6. Determining an Individual's Best Interests

Before commencing the Best Interests process, consideration needs to be given to the following:

1. Is there a relevant, specific court order in respect of this individual controlling the decision that needs to be made?

2. Does another person hold a valid and applicable Lasting Power of Attorney to make the decision that needs to be made?

3. Is there a valid applicable advanced decision to refuse the treatment being considered? Professionals must be aware of the difference

between an advanced decision and an advance statement. Detailed information can be found in the MCA7.

4. Where there is doubt the decision maker must take the appropriate and least restrictive action especially in life threatening situations.

After consideration of the above, in determining what is in a person's best interests, encompassing medical, emotional and all other welfare issues, the following must be considered:

- Whether the person is likely, at some point in the future, to recover his or her decision-making capacity in relation to the matter in question.
- The ascertainable past and present wishes and feelings of the person, and the beliefs, values and other factors that would likely to influence him or her if he or she had capacity (including any advance statements).
- The need to allow and encourage the person to participate as fully as possible in any act done for, and any decision affecting, him or her.
- The views of other people whom it is appropriate and practical to consult about the person's wishes and feelings, and what would be in their best interests.
- Whether the purpose for which any action or decision is required can be effectively achieved in a manner that is less invasive or restrictive of the person's freedom of action.
- In cases of a medical treatment, that treatment must be necessary to save life, prevent deterioration or ensure an improvement in the patients physical or mental health and should be consistent within a reasonable body of current medical opinion (the "Bolam" test).
  (Bolam v Friern Hospital Management Committee, 1957 1 WLR 582) essentially holds that "if a doctor meets the standard of a responsible body of medical opinion, he is not negligent" - put another way, if a group of medical colleagues would reach the same conclusion, then you can not be found negligent.
- Where there is a Statutory Requirement to involve an IMCA, it is unlawful to make a Best Interest Decision, without the involvement of the IMCA except in life-threatening situations (6.35, MCA Code of Practice), where the failure to provide urgent treatment would lead to harm.

MCA10 Contains a Best interests Flowchart for professionals

MCA9 provides a Checklist that may be used by professionals to document the decision-making process when making a decision for an adult who lacks capacity in their best interests.

7. Documentation

All assessment of an individual's capacity must be recorded in the individual's case notes and on the individual's electronic database. A format for recording such assessments is included (Forms MCA1 & MCA2).

ALL Completed MCA2 forms MUST be sent to the respective Agency lead or Named Professional for the MCA or Safeguarding Team for monitoring and governance purposes.

8. Independent Mental Capacity Advocates

Independent Mental Capacity Advocate (IMCA)

An IMCA is someone appointed to support a person who lacks capacity and has no one to speak for them, such as family friends.

There is a **statutory duty** to provide an independent Mental Capacity Advocate where an individual **does not have capacity in respect of a specific decision and is unbefriended**, and the decision is about either or any of the following:

- **Change of accommodation** (to care home for 8 weeks or more, or admission to hospital where admission is likely to last 28 days or more)
- **Serious medical treatment**

In the above situations there is a legal duty to provide an IMCA.

Referral to an IMCA must be facilitated wherever a significant decision - Serious Medical Treatment or Change of Accommodation - is being considered for an incapacitated, unbefriended adult. This includes where an individual in a hospital bed is being discharged to alternative accommodation, even where that change of accommodation may not last more than a few days.

- **Adult Safeguarding Investigation** involving friend/family as the alleged abuser or where the individual is the alleged abuser and the family/friend is the alleged victim. This will include any Safeguarding Investigation (where a SETSAF has been raised), including allegations of financial abuse.

This is a discretionary power exercised by the Decision-Maker where it is considered that the service of an IMCA would be of benefit to the service user

Unbefriended adults who lack capacity and are subject to a care review (or CPA review) or accommodation review may lawfully be provided with an IMCA. This must be offered to any adult subject to these procedures even

where they also have an existing generic advocate who is acting on their behalf.

The role of the IMCA is to make representations about the persons' wishes, feelings, beliefs and values, at the same time as bringing to the attention of the decision-maker all factors that are relevant to the decision.

The IMCA can challenge the decision-maker on behalf of the person lacking capacity if necessary. The Decision Maker can not be over-ridden by the IMCA although the IMCA can take a case to Court of Protection where there is disagreement about a decision being made.

The IMCA provides a report to the decision maker. This report must be provided to the decision-maker within one calendar month of the IMCA being commissioned. In extremely complex cases, the IMCA provider may need to discuss with the commissioner of their service an extension to this timetable

The IMCA has various rights (s.35 (6) – CoP)- these include access to and the right to take copies of relevant professional records, to be able to interview the individual in private and the right to request a second medical opinion. The Decision Maker must make themselves available to the IMCA and report back to the IMCA what the final decision is (this information is required by IMCA providers who have to submit reports to the Department of Health).

The IMCA may also need to meet with professionals and paid carers who are providing care or treatment for the person who lacks capacity.

Where an adult who lacks capacity and does have friend or family, but their family/friend are unwilling or unable to contribute to the decision-making process – then professional discretion must be used regarding the decision to involve an IMCA in the individuals best interests. Care must be taken when deciding to instruct an IMCA as to do this could imply that the family/friend is inappropriate to consult and the decision maker may have to defend this decision in a legal challenge, (see sect. 5.67 of Code of Practice). Thus, where family or friends are unwilling or unable to contribute to a decision-making process, their consent must be sought regarding the decision to appoint an IMCA. Wherever possible no adult without capacity should remain without an individual (whether friend, family or IMCA) who is able to advocate on their behalf.

How to access an IMCA:- Please refer to Appendix 2

Where an IMCA is required urgently – for example where a decision needs to be made about serious medical treatment for an unbefriended, incapacitated adult, then the referral should be sent direct to the IMCA and copied at the same time to Essex County Council Safeguarding Essex, Southend Safeguarding Adults & Thurrock Safeguarding Adults Team. In such circumstances, the IMCA provider must respond on the same working day.

There must be local negotiation in such circumstances about the time-scale in which a response is required from the IMCA provider to ensure that no ill-harm occurs to the service user.

In accordance with s6.35 MCA Code of Practice – where a service user requires urgent medical treatment to save their life or prevent them from serious harm. In these situations, what steps are 'reasonable' will differ to those in non-urgent cases. In emergencies, it will almost always be in the person's best interest to give urgent treatment, without delay. One exception to this is when the healthcare staff giving treatment are satisfied that an advance decision to refuse treatment exists. Where healthcare professionals have determined that urgent treatment is required to prevent serious harm, and an IMCA has not been instructed, the reason for non-instruction must be recorded within the service user's clinical record.

The only situation where the duty to instruct an IMCA need not be followed is when an urgent decision is needed (for example to save a persons life). The decision not to instruct an IMCA must be recorded with the reason for non-referral. Responsible bodies will still need to instruct an IMCA for any serious treatment that follows emergency treatment (10.46, COP).

Responsible bodies do not have to instruct an IMCA for individuals detained under the MHA (1983) if:

- The treatment proposed is for mental disorder, and
- They can give it without the individual's consent under the Act

If the serious medical treatment proposed for a detained patient is not for their mental disorder, then the individual does have a right to an IMCA, as long as they meet the MCA requirements.

Where a person is to be detained or required to live in a certain place under the MHA (1983), an IMCA will not be required since safeguards available under that Act will apply (10.65, Code of Practice).

9. Advance Decisions to Refuse Treatment

The Act creates statutory rules with clear safeguards so that people may make a decision in advance to refuse treatment if they should lack capacity in the future. The Act sets out two important safeguards of validity and applicability in relation to advance decision. Where an advance decision concerns treatment that is necessary to sustain life, strict formalities must be complied with in order for the advance decision to be applicable. These formalities are that the decision must be in writing, signed and witnessed. In addition, there must be an express statement that the decision stands "even if life is at risk" which must also be in writing, signed and witnessed. People have been able to make advance decisions from October 2007.

Documentation and guidance for individuals in respect of Advance Decision making is developed.

- **MCA6**: Provides detailed guidance on Advance Decisions, Advance Directives and Living Wills
- **MCA12**: Provides a leaflet to be provided to individuals on Living Wills (including Advance Directories and Advance Decisions)
- **MCA9**: Provides a checklist for Advance Decisions to help Professionals when assessing the validity of an Advance Decision.

10. Restraint

Section 6 of the Act sets out limitations on section 5. It defines restraint as the use or threat of force where a person who lacks capacity resists, and any restriction of liberty or movement whether or not the person resists. Restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm to the person who lacks capacity, and if the restraint used is a proportionate response to the likelihood and seriousness of harm. This section does not extend to deprivation of liberty within meaning of Article 5(1) of the European Convention on Human Rights. Additional safeguards for people who lack capacity and are deprived of their liberty (the Deprivation of Liberty Safeguards) were implemented on 1 April 2009. These are subject to separate procedures.

11. Finances

The Mental Capacity Act (2005) introduced new powers including Lasting Power of Attorney (LPA) that replaces the previous system of Enduring Powers of Attorney (EPA).

- **MCA 11**: Provides detailed guidance on the new Lasting Power of Attorney Property and Finance.
- **MCA8**: Provides a checklist for professionals wishing to confirm the validity of an LPA (Personal Welfare).

MCA11 includes detailed information about the questions that should be explored in detail when assessing an individual's capacity to manage their finances

12. Lasting Power of Attorney

No employee of any organisation in Southend, Essex or Thurrock should act as Lasting Power of Attorney (LPA) for an individual for whom their organisation holds a responsibility.

LPA is a legal document that appoints one or more people to act for a person, if in the future that person becomes incapable of managing for themselves. It must be created while the person has capacity and is capable of understanding the nature and effect of an LPA.

If an individual wishes someone to act for them now and to be able to continue to act for them if they should become mentally incapable some time in the future, then they should consider appointing someone as a donee of LPA. The donee of LPA must act in the best interests of the individual and in accordance with the MCA.

Alternatively, they can set up an LPA to allow someone to act for them only if they become mentally incapable of making their own decisions. LPAs are a new power introduced by the Mental Capacity Act and replace Enduring Powers of Attorney (EPA). No new EPA can be set up after 1st October 2007, but pre-existing ones are still valid. A pre-existing EPA can still be registered after 1st October 2007 (see section 4 below).

There are two types of LPA:

1. A Property and affairs LPA- which gives the attorney authority to make decisions about financial affairs;
2. A personal welfare LPA- which gives the attorney authority to make decisions about healthcare and personal welfare.

An important distinction between the two types is that a property and affairs LPA can be used by the Attorney even when the Donor still has mental capacity to make their own decisions; a personal welfare LPA can only be used once the donor has lost capacity to make the relevant decisions themselves.

The LPA system is wider ranging than the previous system of EPAs as an EPA can only cover financial decisions, not decision on health care or personal welfare.

There are separate forms for creating the two different types of LPA; one form for **personal welfare LPAs** and one for **property and affair LPAs**. If a person wants to give their Attorney the power to make both types of decision, they will have to set up two separate LPAs, even where the same person is appointed as attorney for both types of decision.

Both types of a LPA document must be registered at the office of the Public Guardian (OPG) before they can be used. This can be done before or after the donor loses mental capacity. If wished, the donor can register the LPA whilst they still have capacity, to avoid any delay when it needs to be used. If a person loses capacity before the LPA is registered, their attorney will need to register it. There is a fee for registering the LPA (see Section 3.7).

Any existing EPA can now be revoked and LPA set up instead under the new system as long as the donor still has mental capacity to do so at the point the LPA is created. If an EPA has already been registered, it will continue. See section 4 below for information on registering an EPA that was made before 1st October 2007.

- **MCA 11:** Provides detailed guidance on the new Lasting Power of Attorney and Finance.
- **MCA8:** Provides a checklist for professionals wishing to confirm the validity of an LPA of an LPA (Personal Welfare).

13. Court of Protection

If the individual can no longer manage their financial affairs (does not have capacity to manage their own finances) and has not previously made an individual a donee of a Lasting Power of Attorney then an application for an order of the court may need to be made to the Court of Protection.

The Court of Protection is an office of the Supreme Court. It exists to protect the property and financial affairs of people who are mentally incapable of dealing with their own affairs. From 1st October 2007, the Court can also deal with decisions on the personal welfare and Healthcare of people who lack the capacity to make their own decisions. The Court jurisdiction extends to England and Wales. Separate arrangements exist for Scotland and Northern Ireland.

MCA11 includes detailed information on the Court of Protection.

14. Sources of Information

There is wealth of published advice and guidance on assessment of mental capacity, including the BMA Consent Toolkit (2003), the joint publication of the BMA and The Law Society " Assessment of Mental Capacity" (Second edition, 2004), The Medical Defence Unions Guide to Consent to Treatment (1999) and the Mental Capacity Act (2005) and the MCA Code of Practice (2007). The advice in this document represents a summary of guidelines for assessing mental capacity outlined in publications such as these (see Appendix 6). This summary is intended to assist professionals in making an assessment. It is not intended to replace any of the published guidance.

15. References

- Mental Capacity Act (2005) and Mental Capacity Act – Code of Practice (2007) www.publicguardian.gov.uk
- BMA Consent Toolkit (Second Edition, February 2003) www.bma.org.uk
- GMC Guidance
- SCIE Guidance
- NMC Guidance
- Michael Mandelstam (2009)"Safeguarding vulnerable adults and the law";(Chapter 6) Jessica Kingsley Publications.

PART II

Deprivation of Liberty Safeguards (DoLS) PROCEDURES

This summary guidance is only designed to give a broad overview of the MCA DOLS and reference should be made to the legal framework in Schedule A1 of the Mental Capacity Act 2005 and the accompanying Mental Capacity Act Deprivation of Liberty Safeguards (MCA DOLS) Code of Practice for more details. The MCA DOLS Code of Practice can be downloaded from:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

Please refer to Essex DOLS Practice Guidance and Procedures for step by step information on local Deprivation of Liberty Safeguards processes. These can be downloaded from http://www.essexcountycouncil/mentalcapacityact and follow the Deprivation of Liberty Safeguards (DOLS) link.

The MCA DOLS are not about detention or compulsory treatment under the Mental Health Act 1983. The Mental Health Act 1983 Act is primarily about people who are diagnosed as having a mental health problem and who need to be detained or treated for their own well-being or to protect other people.

The Supreme Court ruling on Deprivation of Liberty Safeguards (19th March 2014) (P v Cheshire West and Chester Council and another; P and Q v Surrey County Council) is significant in the determination of whether arrangements made for the care and/or treatment of an individual lacking capacity to consent to those arrangements amount to a deprivation of liberty. The full judgment can be found on the Supreme Court's website at the following link:

http://supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf

The judgement from the Supreme Court has clarified that there is a deprivation of liberty for the purposes of Article 5 of the European Convention on Human Rights in the following circumstances:

- The person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements.

The Supreme Court held that factors which are NOT relevant to determining whether there is a deprivation of liberty include the person's compliance or lack of objection and the reason or purpose behind a particular placement1. It was also held that the relative normality of the placement, given the person's needs, was not relevant. This means that the person should not be compared with anyone else in determining whether there is a deprivation of liberty.

However, young persons aged 16 or 17 should be compared to persons of a similar age and maturity without disabilities.

Key terms used in the MCA DOLS legislation include:

- Supervisory Body: this refers to local authorities
- Managing Authority: this is the person or body with management responsibility for the hospital or care home in which a person is being, or may be, deprived of liberty
- Standard authorisation: this permits lawful deprivation of liberty and is issued by a Supervisory Body
- Urgent authorisation: this permits lawful deprivation of liberty and is issued by a Managing Authority Relevant person : this is the person who needs to be deprived of liberty
- Relevant person's representative : this is the person who represents the relevant person
- Best interests assessor: this is the person who assesses whether or not deprivation of liberty is in the person's best interests
- Best interest assessment: to assess if a deprivation of liberty is necessary to prevent harm to the person and is a proportionate response to the likelihood and seriousness of that harm and is in the persons best interests
- Mental health assessor: Section 12 doctor who has completed relevant training on deprivation of liberty safeguards
- Advance decision: this is a decision to refuse specified treatment made in advance by a person who has capacity to do so. The decision will then apply at a future time when that person lacks capacity to consent to, or refuse, the specified treatment. Specific rules apply to advance decisions to refuse life sustaining treatment
- Donee of Lasting Power of Attorney: this is the person appointed under a Lasting Power of Attorney who has the legal right to make decisions within the scope of their authority on behalf of the person (the donor) who made them Lasting Power of Attorney
- Independent Mental Capacity Advocate (IMCA): this is a person who provides support and representation for a person who lacks capacity to make specific decisions in certain defined circumstances. The IMCA was established by the Mental Capacity Act and is not the same as an ordinary advocacy service

1. Training

All clinicians and practitioners working who have contact with adults will undertake training on the Deprivation of Liberty Safeguards within their mandatory training on Safeguarding Adults. This will include familiarisation with and compliance with the East of England MCA RIN guidance on DoLS in Psychiatric Hospitals.

2. Admissions to a Mental Health Hospital Bed

Any individual who is admitted to a mental health hospital bed informally (s131 MHA, 1983) has the right to come and go as they please. Where a service user admitted to a mental health bed is deprived of their liberty or prevented from coming and going as they please and they do not have capacity to consent to this then, by default, they may be deprived of their liberty. An application for DoLS must be considered. Professionals must act in accordance with the MCA RIN Guidance on Psychiatric Inpatients.

Where an application could be made under the MHA (1983) this always takes precedence and priority. DoLS Authorisations should only be made for service user's who are in mental health hospital beds, where a MHA application has been unsuccessful or it is considered that the service user would not meet the threshold for detention under the MHA (1983).

Individual's who lack capacity to consent to admission into a hospital bed or to the arrangements for their care and/or treatment will in almost all circumstances be under continuous supervision and control and not free to leave. Thus where an individual who lacks capacity to consent to admission but is not detained under the MHA, an urgent application for DoLS (together with Standard) should be considered. Where this is not applied for the rationale should be recorded in the service user's clinical record.

3. What is the Mental Capacity Act 2005 Deprivation of Liberty Safeguards?

3.1 The MCA DOLS provide legal protection for vulnerable people who may be deprived of their liberty within the meaning of Article 5 of the European Convention on Human Rights (ECHR) in a hospital (other than under the Mental Health Act 1983) or care home, whether placed there under public or private arrangements.

They were introduced following the legal judgment given by the European Court of Human Rights (ECtHR) in the case of HL v United Kingdom (commonly referred to as the Bournewood judgment). This case concerned an autistic man (HL) with a learning disability who lacked the capacity to decide whether he should be admitted to hospital for treatment. He was admitted to hospital on an informal basis under common law but was prevented from leaving the hospital with his carers. This decision was challenged by HL's carers and the ECtHR found that there had been a breach of HL's rights under the European Convention
on Human Rights (ECHR). The reasons given by the ECtHR were that:

- HL had been deprived of his liberty and the deprivation of liberty had not been in accordance with 'a procedure prescribed by law' and was, therefore, in breach of Article 5(1) of the ECHR

- There had been a contravention of Article 5(4) of the ECHR because HL had no means of applying quickly to a court to see if the deprivation of liberty was lawful.

3.2 The MCA DOLS were introduced to prevent further breaches of the ECHR, and to ensure that deprivation of liberty can only take place when it is in the best interests of the person concerned and when it is authorised by a supervisory body. The MCA DOLS also give legal protection to the relevant person, including the right to:

- an independent representative to act on their behalf
- the support of an Independent Mental Capacity Advocate (IMCA)
- have their deprivation of liberty reviewed and monitored on a regular basis
- challenge their deprivation of liberty in the Court of Protection.

4. Who can be deprived of their liberty under the MCA DOLS?

In order to come within the scope of the MCA DOLS, when depriving a person of their liberty in a hospital or care home, **all of the six qualifying requirements** must be met:-

- the age requirement
- the no refusals requirement
- the mental capacity requirement
- the mental health requirement
- the eligibility requirement
- the best interests requirement.

Assessments must be undertaken to establish whether the relevant person meets these requirements. If the assessments show that all the requirements are met, the supervisory body must then issue a deprivation of liberty authorisation.

It is impossible to predict exactly which individuals might come within the scope of the MCA DOLS and each application for an authorisation must be considered in view of the particular circumstances. Deprivation of liberty should be avoided whenever possible, and should only be authorised in cases where it is in the relevant person's best interests, the only way to protect them from harm and is the least restrictive option. The MCA DOLS are not to be used as a form of punishment, or for the convenience of professionals, carers, or anyone else.

It is anticipated that the majority of people who will require the protection of the MCA DOLS are:

- those with more severe learning disabilities
- older people with the range of dementias
- people with neurological conditions such as brain injuries

- people with mental health conditions who lack capacity to consent to admission into a mental health hospital bed.

Deprivation of liberty in "domestic" settings

The Supreme Court has held that a deprivation of liberty can occur in domestic settings where the State is responsible for imposing such arrangements. This will include a placement in a supported living arrangement in the community. Hence, where there is, or is likely to be, a deprivation of liberty in such placements that must be authorised by the Court of Protection.

Where professionals are concerned that an individual is unlawfully deprived of their liberty in a domestic setting, they should urgently seek advice from their respective Local Authority Deprivation of Liberty Safeguards team.

5. Making an application for a DoLS Authorisation

Clinical Staff and Care Home Managers completing an application for a DoLS Authorisation must complete form 4 (standard) and where appropriate form 1 (urgent). These forms can be obtained:- www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103818

The completed documentation together with any accompanying Care Plans, relevant MCA2 assessments, recent CPA review documentation or other information MUST be sent to the relevant DoLS Team. (See appendix 1)

6. Responsibility for ensuring an application has been received

It is the responsibility of the Hospital Ward Manager/Care Home Manager to complete the Authorisation either Form 1 (Urgent) and or Form 4 (Standard) and to check that the paperwork has been received by telephoning the relevant DoLS Team.

Every effort must be made to inform the relevant DoLS Team of an impending application – especially where an application is being made over a weekend or bank holiday as this can help ensure allocation of a BIA at the earliest opportunity. It is not acceptable to post forms to the Supervisory Body.

7. What processes do the MCA DOLS introduce?

Assessment and authorisation

The MCA DOLS make it lawful for a person to be deprived of their liberty, based on a rigorous, standardised assessment and authorisation process. Under the MCA DOLS, hospitals and care homes must apply to their Local Authority for a deprivation of liberty 'authorisation' if they believe the person lacks capacity to decide on where they should be treated or cared for, and

they can only provide care for a person in circumstances that amount to a deprivation of liberty.

There are two types of authorisation: standard and urgent.

Standard authorisations can be issued by supervisory bodies only if the six statutory assessment requirements (listed on page 8, forms 5 - 10) indicate the need to do so. Standard authorisations will be the most common type of authorisation. Wherever possible, they must be applied for in advance of a person being deprived of liberty and only after rigorous care planning has indicated that less restrictive measures cannot meet the person's needs. A standard authorisation can last for up to 12 months, but deprivation of liberty should last only for as long as is necessary. Form 12 issued when standard authorisation given, form 13 when request declined.

Urgent authorisations can be issued by Managing Authorities where there is a need to deprive someone of their liberty immediately in their own best interests to protect them from harm, and are valid for a maximum of seven calendar days. When issuing an urgent authorisation, managing authorities must, if they have not already done so, simultaneously apply to their DOLS Office for a standard authorisation to be issued within the period of the urgent authorisation. If there are exceptional reasons for doing so, the DOLS Office may extend the duration of an urgent authorisation by up to seven days. Form 1 to be used for this purpose.

- If a Managing Authority believes that deprivation of liberty needs to continue beyond the initial authorisation period, it should seek a new authorisation from the DOLS Office (form 4 to be completed). This will determine, on the basis of further assessments, whether continued deprivation of liberty is in the person's best interests.

- Every effort should be made, in both commissioning and providing care or treatment, to prevent deprivation of liberty occurring. If deprivation of liberty cannot be avoided, it should last for the shortest period possible.

8. The right to have a relevant person's representative (RPR)

The MCA DOLS also make provision for every person deprived of liberty to have a Relevant Person's Representative (RPR) who will represent them in, and be consulted on, all matters connected to their deprivation of liberty, and have ongoing contact with them. The RPR will usually be a family member or friend but can also be a Paid Representative, where the person has no family member or friend to fulfil the role on their behalf. Further information is available in the Department of Health leaflet 'A guide for relevant person's representatives'. Link Below
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_094391.pdf

9. Access to the Court of Protection

Under the MCA DOLS, every person deprived of liberty, or someone acting on their behalf, may challenge their deprivation of liberty authorisation in the Court of Protection. The relevant person and their unpaid representative have a statutory right to the support of an IMCA when making an application to the Court of Protection.

For further information on applying to the Court of Protection please refer to DOLS Code of Practice Chapter 10.

10. Key responsibilities of Supervisory Bodies

Supervisory bodies are responsible for overseeing the MCA DOLS at a local level. It is their role to commission, coordinate and scrutinise the assessment process and appoint assessors. In addition, they are responsible for granting standard authorisations and appointing relevant person's representatives (RPRs) for all people issued with a Deprivation of Liberty Safeguards authorisation.

The DOLS Teams consist of Service Administrators and Best Interests Assessors and Signatories. All teams are located within the respective Safeguarding Departments. Please see contact details in the Appendix 1

11. Record keeping requirements

11.1 There is a statutory requirement for the DOLS Offices (Local Authority) to keep clear and comprehensive records for every person deprived of their liberty. This includes records of applications for authorisations, details of the assessment process, information about the RPR and the documentation related to the termination of the authorisation. Managing Authorities such as care homes or hospitals are also required to keep duplicate records.

11.2 To assist with this record-keeping requirement, and to ensure that the administration of the MCA DOLS system is as straightforward and seamless as possible, the DOLS Offices Southend, Essex and Thurrock use the standard forms for both Supervisory Bodies and Managing Authorities as formulated by the Department of Health. The Department of Health website gives guidance on which forms to use.

11.3 The forms are not a statutory requirement and do not have to be used to support the administration of the MCA DOLS. However, if they are used in their unedited form, these standard forms will help to ensure compliance with the safeguards and promote a consistent approach to record-keeping.

11.4 In addition, the respective DOLS Offices are required to submit data returns on the MCA DOLS to the Information Centre for Health and Social Care. Nearly all the necessary information to complete this form can be taken from the standard forms.

12. On receipt of an Application Form for a Deprivation of Liberty Authorisation

Where a Managing Authority it must **immediately** notify the relevant DOLS Office and immediately proceed with an application for a standard authorisation (form 4).

When the DOLS Office receives a standard authorisation application form (form 4), it will be checked that the form has been appropriately completed. If a standard authorisation referral has key information missing it will be sent back to the referrer for completion.

13. Handling Standard Authorisations

When the DOLS Office receives an application for a standard authorisation, it must consider whether the request is appropriate and whether it should be pursued. The DOLS Office has 21 calendar days to complete the assessment process.

14. Handling Urgent Authorisations

Urgent authorisations last for a maximum of 7 calendar days, and an application for standard authorisation must be made at the same time, if one has not previously been completed. During this period of authorisation the necessary assessments must be completed.

In exceptional circumstances, an urgent authorisation can be extended by the DOLS Office for an additional seven calendar days. The Managing Authority must inform the Supervisory Body when an extension is needed (form 2) and only one such extension can be granted.

14.1 On receipt of such a request, DOLS Office will need to consider the facts of the case and decide whether an extension is necessary in the circumstances. They must then decide whether or not to grant an extension, which must not exceed seven calendar days. A standard form is available for the DOLS Office to record their decision and inform the Managing Authority (form 3).

14.2 Therefore, it is essential that a dialogue between the DOLS Office and Managing Authorities should be maintained throughout the period of the urgent authorisation.

15. Providing support to the Relevant Person during the Assessment Process

15.1 It is essential that the person in respect of whom the application is being made (the ‘relevant person’) has someone to support them during the assessment process. Managing Authorities must, when applying for an authorisation, notify the DOLS Office if there is no one who can fulfil this role.

15.2 If the relevant person has no one to support them, the DOLS Office must, under section 39A of the Mental Capacity Act 2005, appoint an Independent Mental Capacity Advocate (IMCA) (often known as a section 39A IMCA).

16. Handling application requests from third parties

16.1 If the relevant person or any relative, friend, carer or other third party believes that they or someone else is being deprived of their liberty without authorisation, they must notify the Managing Authority. If the Managing Authority subsequently fails to resolve the matter informally with the relevant person or third party, or to apply for an authorisation within a reasonable length of time, the notifying party can approach the DOLS Office directly.

16.2 The third party should supply the name of the person they are concerned about, the name of the hospital or care home where the person is, and the reasons why they think the person is being deprived of their liberty. A standard letter is available for this purpose. On receipt of this letter, the DOLS Office must consider whether the request is appropriate and if it should be pursued.

16.3 If the DOLS Office decides to pursue the request, it will appoint a Best Interests Assessor to carry out a preliminary assessment to determine whether a deprivation of liberty is occurring. Form 16 will be used to record receipt of third party notification and the action taken following this notification.

16.4 If the preliminary assessment concludes that an unauthorised deprivation of liberty may be taking place, a full assessment will be organised for a standard authorisation.

16.5 Alternatively, the Managing Authority may change the person's care arrangements so there is no longer any deprivation of liberty. If, however, the Managing Authority considers that the original care regime must continue, it will need to give itself an urgent authorisation. The Supervisory Body must record the outcome of the preliminary assessment and subsequent actions (form 17 & 18).

16.6 By law, the Supervisory Body should also notify:-

- The Third party who made the request
- The Relevant Person
- The Managing Authority of the relevant hospital or care home
- Any Section 39A IMCA involved

Form 18 will be used for this purpose. The DOLS Office will prepare form 18 and the accompanying letters for sign off by the relevant Supervisory Body).

17. What if there is doubt about where the relevant person is ordinarily resident?

Once the DOLS Office receives a request for a standard deprivation of liberty authorisation, it must proceed with the application, even where questions arise over where the relevant person is ordinarily resident. Regulations made under the MCA DOLS state that if a dispute occurs, the Local Authority that receives the request for a Deprivation of Liberty authorisation must act as the Supervisory Body until the dispute is resolved.

18. The Assessment Process

Under the MCA DOLS, a series of six assessment requirements must be met in determining whether the DOLS apply, and whether it is necessary to deprive a person of their liberty in their own best interests to protect them from harm. Once the DOLS Office has received an application for a standard authorisation, and is satisfied that it is valid and correct, they must commission the required assessments. The six required assessments are as follows:

1. **Age assessment**: to assess whether the person being deprived of liberty is aged 18 or over

2. **No refusals assessment**: to ensure that the authorisation being requested does not conflict with a valid decision by a Donee of Lasting Power of Attorney ('an Attorney'), or by a Deputy appointed for the person by the Court of Protection, and is not for the purpose of giving any treatment that would conflict with a valid and applicable advance decision made by the relevant person

3. **Mental capacity assessment**: to assess whether the person being deprived of liberty lacks capacity to decide whether to be admitted to, or remain in, the hospital or care home in which they are being, or will be, deprived of liberty

4. **Mental health assessment**: to assess whether the person being deprived of liberty is suffering from a mental disorder within the meaning of the Mental Health Act 1983, but disregarding any exclusion for people with learning disabilities

5. **Eligibility assessment**: to assess whether the person is eligible to be deprived of liberty under the MCA DOLS. Broadly, a person is eligible unless they:
   - are subject to a requirement under the Mental Health Act 1983 that conflicts with the authorisation being requested
   - object to being in hospital for the purpose of treatment of a mental disorder, or to being given some or all of the treatment in question,

and they meet the criteria for detention under the Mental Health Act 1983. In deciding whether a person objects, their past and present behaviour, wishes, feelings, views, beliefs and values should be considered where relevant

6. **Best Interests Assessment**: to establish whether there is a deprivation of liberty and, if there is, whether it is:

- in the best interests of the person to be subject to the authorisation
- necessary in order to prevent them coming to harm
- a proportionate response to the likelihood of them suffering harm and the
- seriousness of that harm.

Assessors are required by law to keep written records of all the assessments they carry out. Forms 5 to 11 will be made available to assessors for this purpose. .Electronic copies of all assessments must be given to DOLS Office for its records and will be retained by the DOLS Office.

19. Using 'equivalent' assessments

If an 'equivalent assessment' to any of the above assessments already exists for the relevant person, we may use this assessment instead of carrying out a new assessment. For example, a recent Mental Health assessment carried out for the purposes of the Mental Health Act 1983 could serve as a Mental Health Assessment under the MCA DOLS. However, great care should be exercised when deciding to use an equivalent assessment and it will not be done routinely. Form 11 will be used for recording that an equivalent assessment has been used.

20. The Assessors

It is the responsibility of the supervisory body to appoint suitable assessors. Regulations made under the MCA DOLS set out the eligibility requirements for assessors. These stipulate that assessors must:

a) have an applied knowledge of the Mental Capacity Act 2005 and its Code of Practice
b) be proficient in record-keeping, with the ability to write clear and reasoned reports,
c) must have undertaken the relevant training programme for their deprivation of liberty role.

The DOLS Office will only use qualified BIA's and s12 Dr's who have completed the required level of CPD (in accordance with the standards approved by the Easter Region MCA RIN) and who have the requisite CRB clearance. Evidence of their qualifications will be held by the DOLS Office.

The DOLS Office will seek to appoint s12 Dr's with relevant experience to the needs of the service user being assessed – for example if the service user

has a significant learning disability the s12 Dr appointed to complete assessments should be a specialist in learning disability.

A minimum of two assessors are required for each case. An assessor may carry out any assessment for which they are eligible, but the Mental Health Assessment and the Best Interests Assessment must be undertaken by two different people.

21. Once assessments are complete

If any of the assessments conclude that the relevant person does not meet qualifying requirements, the Supervisory Body cannot grant a Deprivation of Liberty Safeguards authorisation (Form13). The DOLS Office must record this decision and will prepare the letters for the Supervisory Body to notify the following people:

a) the Managing Authority
b) the relevant person
c) any relevant person's representative if there is a previous authorisation in force
d) any section 39A Independent Mental Capacity Advocate (IMCA) involved
e) every interested person named by the best interests assessor in their report as somebody they have consulted in carrying out their assessment.

From the moment authorisation is declined, any continuation of deprivation of liberty is unlawful. The Managing Authority should amend the care plan immediately, to avoid further deprivation of liberty.

Issuing a Standard Authorisation

If the outcomes of all assessments are positive, the Supervisory Body must issue a standard Deprivation of Liberty Safeguards Authorisation (form 12)

It is the responsibility of Supervisory Body to set the time period of the standard authorisation. This should be for as short a time as possible, and no longer than the time period suggested by the best interest assessor.

The law requires the Supervisory Body to issue a standard Deprivation of Liberty Safeguards Authorisation in writing and to include certain details, including the purpose of the deprivation of liberty and its duration. It is also required to keep written records of any standard authorisations issued. The DOLS Office will prepare such documentation for the Supervisory Body and keep a written record of all authorisations granted (and declined).

Once issued, the Supervisory Body is required to give a copy of the authorisation to:

a) the Managing Authority

b) the relevant person
c) the Relevant Person's Representative (see below)
d) any section 39A IMCA involved
e) every interested person named by the best interests assessor in their report as somebody they have consulted in carrying out their assessment.

The DOLS Office will prepare such documentation for the Supervisory Body and keep a written record of all authorisations granted (and declined).

22. Appointing a Relevant Person's Representative

Every person deprived of their liberty must have a 'Relevant Person's Representative' (RPR) who can represent their interests in all matters connected to their deprivation of liberty authorisation. The DOLS Office will prepare the relevant documentation and forward this to the respective Supervisory body for the appointment of an RPR as soon as possible after a standard authorisation has been granted.

23. The selection of the RPR is a two-stage process:

1) Selection by the Best Interests Assessor

The Best Interest Assessor must nominate someone to the Supervisory Body who they believe is suitable to be the RPR. This selection may be based on the relevant person's own choice of representative. If the relevant person has capacity and chooses an eligible person, that person must be nominated. If the relevant person lacks capacity, the RPR may be:

(a) the Donee of their Lasting Power of Attorney or a Deputy appointed by the Court of Protection (if they have one in place)
(b) someone nominated by the above mentioned Donee or Deputy (if they have the authority to make a nomination)

If no eligible person is identified by either route, the assessor must consider who could be the representative. This could be a family member, friend or carer. Form 24 will be used to assist best interest assessors with selecting a representative and nominating him or her to the Supervisory Body.

Once the Supervisory Body has received the nomination from the best interest assessor, it must invite the person, in writing, to be the Representative. If the person agrees to be the Representative, they must be formally appointed. This must be done in writing and the letter should set out the role and responsibilities of the RPR.

The Supervisory Body must notify the following people of the appointment:
a) the appointed person
b) the relevant person
c) the relevant person's Managing Authority
d) any donee or deputy of the relevant person

e) any section 39A IMCA involved
f) every interested person named by the best interests assessor in their report as somebody they have consulted in carrying out their assessment.

24. Appointing a Paid Representative

Where the relevant person does not have a carer or any family member or friends who can fulfil the role of RPR, and the Best Interests Assessor cannot identify anyone else who is suitable, the Supervisory Body may appoint a Paid Representative to perform the role in a professional capacity. Form 25 will be used to record the appointment of a Paid Representative

The Paid Representative is commissioned to provide 1 hours work with or on behalf of the service user deprived of their liberty every two weeks. A report detailing the content of that work and any subsequent arising concerns should be sent to the DOLS Office within 7 working days of each intervention. The DOLS Office will ensure that the respective ward manager is provided with a copy of the RPR's report for inclusion in the service user's electronic record.

25. Termination of a Representative's appointment

Where the Supervisory Body wishes to terminate a Representative's appointment, it should give notice to them setting out the date on which the appointment terminates and the reasons for the termination. Form 27 will be used for this purpose. The DOLS Office can advise the Supervisory Body what notice period to give. It may be appropriate to give formal notice to the Representative two weeks before the termination date. In certain cases shorter notice could be given if appropriate.

Copies of the notice of termination will be sent by the Supervisory Body to:

a) the relevant person
b) the relevant person's Managing Authority
c) any Donee or Deputy of the relevant person
d) any section 39A IMCA involved
e) every interested person named by the best interests assessor in their report as somebody they may have consulted in carrying out their assessment.

Relevant paperwork will be prepared by the DOLS Office on behalf of the Supervisory Body.

26. Review of a Standard Authorisation

The DOLS Office is responsible for reviewing standard authorisations. They have the discretion to carry out a review at any time if it appears appropriate to them to do so. However, they are legally required to carry out a review where the relevant person, their RPR or the Managing Authority requests one.

A standard form is provided for managing authorities to use for the purpose of

requesting a review (form 14).

In addition to the above, DOLS Office is also legally required review to a authorisation if:

- the relevant person no longer meets the, No Refusals, Mental Capacity, Mental Health or Best Interests requirements
- the relevant person no longer meets the Eligibility requirement because they object to receiving mental health treatment in hospital and they meet the criteria for detention under section 2 or 3 of the Mental Health Act 1983 (see below about arrangements for the suspension of an authorisation when the Eligibility requirement is not met for a short period)
- there has been a change in the relevant person's situation and, because of the change, it would be appropriate to amend an existing conditions of the authorisation or add a new condition
- the reasons why the person now meets the qualifying requirements are different from the reasons recorded at the time that the authorisation was given.

When a request for a review is received, Form 21 will be used to record which, if any, of the qualifying requirements should be reviewed and also its decision. The DOLS Office will then commission the assessments required and inform the relevant person, their Representative and the Managing Authority that a review is being carried out. Form 20 will be used to inform interested parties that a review is being carried out.

The assessment process for a review of the qualifying requirements is the same as for a standard authorisation. The outcome of the assessments should be recorded on Forms 6 to 11 by the assessors and copies provided to the DOLS Office.

Once the DOLS Office has received the assessment results, it must decide whether the person still meets the qualifying requirements for being deprived of their liberty. If the qualifying requirements are not met, the authorisation must be terminated. If the assessments illustrate that deprivation of liberty is still necessary, the Supervisory Body must consider whether the conditions attached to the authorisation need to be amended. Form 21 will be used to record the outcome of the review.

27. Termination of a Standard Authorisation

A standard authorisation will terminate if:

a) it comes to an end of its authorised period, with no fresh authorisation replacing it, or
b) a review concludes that it should be terminated.

The relevant person should cease to be deprived of their liberty immediately. It would be unlawful to continue to deprive someone of their liberty, leaving the Managing Authority open to legal challenge.

If a Managing Authority believes that a person should continue to be deprived of their liberty beyond the period permitted by the authorisation, they should apply for a new authorisation. It is not possible to renew existing Deprivation of Liberty Safeguards authorisation.

If an authorisation is terminated, the following will be notified:

a) the relevant person
b) the Relevant Person's Representative
c) the Managing Authority
d) every interested person named by the Best Interests Assessor in their report as somebody they have consulted in carrying out their assessment

28. Suspension of an Authorisation

It is possible to suspend an authorisation for a period of up to 28 calendar days under exceptional circumstances. This may be necessary, because the relevant person is detained in hospital under the Mental Health Act 1983 and hence the eligibility requirement will no longer be met. Managing Authorities are to use Form 14 to suspend the authorisation, and form 15 when the suspension of the standard authorisation is to be lifted.

APPENDIX 1

Contacts

Essex County Council

Deprivation of Liberty, Adult Safeguarding
Telephone: 0330131028
Fax: 0808 280 0550
Email: Dolforms@essex.gov.uk

Thurrock Council

Safeguarding Adults
Telephone: 01375 652868
Fax: 01375 652760
Email: dol.safeguards@thurrock.gov.uk

Southend On Sea Council

Safeguarding Adults
Telephone: Access Team - 01702 215008
Fax: 0300 123 0779
Out of Hours Referrals
Statutory Agencies – 0300 123 0778
Email: accessteam@southend.gov.uk

NEPFT

North Essex Health DoLS Team
Birchwood
Boxted Road
Colchester
Essex
C04 5HG
Tel 01206 228669
Fax: 01206 228664
Email: nex-tr.DoLS@nhs.net

NEPFT delivers the DoLS service for all service users in hospital beds in West, Mid and North East Essex

APPENDIX 2

How to access the IMCA DoLS Service

Essex County Council

VoiceAbility
Phone: 0845 0175 198
Email: imca@voiceability.org
Website: www.voiceability.org

NEPFT

VoiceAbility
Phone: 0845 0175 198
Email: imca@voiceability.org
Website: www.voiceability.org

Thurrock

Pohwer
PO Box 14043
Birmingham
B6 9PL
www.pohwer.net
Phone: 0300 456 2370
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