DEPRIVATION OF LIBERTY SAFEGUARDS

CODE OF PRACTICE

November 2019
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# GLOSSARY OF TERMS

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<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>the Act</td>
<td>the Mental Capacity Act (Northern Ireland) 2016</td>
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<tr>
<td>approved social worker</td>
<td>a person appointed under section 280 of the Act</td>
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<td>authorisation</td>
<td>a trust panel authorisation, short-term detention authorisation, extension authorisation or a trust panel extension authorisation</td>
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<td>best interests</td>
<td>a holistic consideration of all relevant factors, including special regard for P’s wishes, feelings, beliefs and values – see Chapter 6</td>
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<td>D</td>
<td>usually the person doing an act</td>
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<tr>
<td>dentist</td>
<td>a person registered in accordance with the Dentists Act 1984</td>
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<td>the Department</td>
<td>the Department of Health (Northern Ireland)</td>
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<td>DoL</td>
<td>deprivation of liberty – see Chapter 2</td>
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<td>DoLS</td>
<td>Deprivation of Liberty Safeguards</td>
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<td>ECHR</td>
<td>European Convention on Human Rights</td>
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<td>emergency</td>
<td>where delaying with a deprivation of liberty to put in place certain additional safeguards would cause an unacceptable risk of harm to P – see Chapter 10</td>
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<td>extension authorisation</td>
<td>authorisation to extend a trust panel authorisation – see Chapter 13</td>
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<td>Term</td>
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<tr>
<td>medical practitioner</td>
<td>a registered person within the Medical Act 1983 who holds a licence to practise</td>
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<td>medical report</td>
<td>a report required for authorisations and for certain additional safeguards</td>
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<td>midwife</td>
<td>a person registered under the Nurses and Midwives Order 2001 by virtue of qualification as a midwife</td>
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<tr>
<td>NP</td>
<td>nominated person – see Chapter 9</td>
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<tr>
<td>nurse</td>
<td>a person registered under the Nurses and Midwives Order 2001 by virtue of qualification as a nurse</td>
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<tr>
<td>occupational therapist</td>
<td>a person registered with the Health and Care Professions Council as an occupational therapist</td>
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<td>P</td>
<td>a person who is over the age of 16 and lacks capacity</td>
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<td>POSH</td>
<td>prevention of serious harm condition</td>
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<tr>
<td>psychologist</td>
<td>a person registered with the Health and Care Professions Council as a practitioner psychologist</td>
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<tr>
<td>protection from liability</td>
<td>a limited protection from civil or criminal liability – see Chapter 4</td>
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<td>RQIA</td>
<td>the Regulation and Quality Improvement Authority</td>
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<td>short-term detention</td>
<td>see Chapter 12</td>
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<tr>
<td>social worker</td>
<td>a person registered with the Northern Ireland Social Care Council as a social worker</td>
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<th>Term</th>
<th>Definition</th>
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<tr>
<td>speech and language</td>
<td>a person registered with the Health and Care Professions Council as a speech and language therapist</td>
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<tr>
<td>statement of incapacity</td>
<td>a statement made during a formal assessment of capacity – see Chapter 5</td>
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<tr>
<td>the Tribunal</td>
<td>the Review Tribunal – see Chapter 15</td>
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<tr>
<td>trust panel</td>
<td>a panel constituted by a trust who receives an application for authorisation – see Chapter 14</td>
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<tr>
<td>trust panel</td>
<td>an authorisation required for all deprivation of liberty where there is no short-term detention authorisation – see Chapter 11</td>
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<tr>
<td>warrant</td>
<td>an order by a Magistrate’s Court for a police constable and medical practitioner (and approved social worker) to enter and remove a person from a private premises – see Chapter 18</td>
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Chapter 1. INTRODUCTION

Introduction

1.1. The Mental Capacity Act (Northern Ireland) 2016 provides a statutory framework for people who lack capacity to make a decision for themselves and for those who now have capacity but wish to make preparations for a time in the future when they lack capacity.

1.2. When the Act is fully commenced the Mental Health (Northern Ireland) Order 1986 (“the 1986 Order”) will be repealed for anyone over the age of 16. To manage the commencement of the Act, the 1986 Order will initially be kept for all and a dual system will exist with both the 1986 Order and the Act providing statutory frameworks for DoL.

1.3. The legal framework provided by the Act is supported by this Code of Practice which provides practical information for how the Act works. This Code supports Phase 1 of the implementation and commencement of the Act only. In particular, this Code focusses on how the provisions relating to Deprivation of Liberty work.

1.4. Section 288 of the Act requires the Department of Health to prepare one or more Codes of Practice which must be laid before the Assembly, which can vote to have the Code(s) withdrawn. This Code meets these requirements.

1.5. Section 289 of the Act provides that the Code has a statutory force, meaning that certain people have a legal obligation to have regard to the Code when
working with people who lack, or may lack, capacity to make decisions for himself or herself.

1.6. This introductory chapter provides a brief overview of the legal status of this Code, how the Code should be used, who it is for and what is in the Code.

The legal status of the Code

1.7. The Act, and therefore this Code, applies to anyone who is present in Northern Ireland, disregarding where a person may be from or where he or she is habitually resident.

1.8. Section 289 of the Act provides that anyone who acts in a professional capacity, for remuneration, as an attorney under an enduring power of attorney or as a trust panel member, must have regard to this Code. This is particularly relevant where the Act requires a person to act reasonably, appropriately or practically, as the Code provides guidance of what this is.

1.9. The Code is not the only support material for people who work with persons who lack, or may lack, capacity. Consideration must also be given to other relevant material from the Department of Health, the Department of Justice, regulatory bodies and employers.

Using the Code of Practice

1.10. Throughout this document the Code of Practice is referred to as “the Code” and the Mental Capacity Act (Northern Ireland) 2016 is referred to as “the Act”. A person who lacks capacity is referred to as “P” and the
person who carries out an act as “D”. A glossary of terms used in the Code can be found immediately after the index, before this chapter.

1.11. This Code provides an overview of the relevant provisions of the Act to help those who need to work with persons who lack, or may lack, capacity in relation to a deprivation of liberty. To help people understand how the Code will apply in real life situations, scenarios have been provided in Annex B. These scenarios provide additional detail using specific examples from specific settings.

**Who is the Code for?**

1.12. The Code is not designed to provide help and support for P or P’s relatives or friends, nor to explain or provide the reasoning behind the provisions of the Act.

1.13. The purpose of the Code is to help those who work with persons who lack, or may lack, capacity in the context of deprivation of liberty. Certain groups of people have a legal obligation to have regard to the Code and may have to explain to a court or tribunal why the Code was not followed. This includes:

   a. anyone working with persons who lack, or may lack capacity in a professional capacity or for remuneration;

   b. attorneys under an enduring power of attorney; and

   c. trust panel members.
Contents of the Code

1.14. The Code provides detail on the relevant provisions of the Act which relate to deprivation of liberty and the required safeguards and procedures which must be adhered to when considering imposing such a restriction on an individual.

1.15. **Chapter 2** explains deprivation of liberty. This includes provisions for what act or combination of acts will amount to a deprivation of liberty.

1.16. **Chapter 3** provides an overview of the underlying principles of the Act which must be taken into account by anyone who is considering the need to carry out a deprivation of liberty in relation to a person who is 16 or over who lacks or may lack capacity.

Protection from Liability

1.17. **Chapter 4** explains how the Act protects people carrying out a deprivation of liberty in relation to a person who lacks capacity.

1.18. **Chapter 5** describes what it means to lack capacity and how to determine if a person has capacity or not.

1.19. **Chapter 6** details the steps required to carry out a best interests determination.

DoL requirements

1.20. **Chapter 7** outlines which safeguards must be met if a deprivation of liberty is considered.

8
Additional Safeguards

1.21. **Chapter 8** explains what a formal assessment of capacity is, who can complete one and what is required before a statement of incapacity can be provided.

1.22. **Chapter 9** provides details on the nominated person role and who this is.

1.23. **Chapter 10** explains the exception of emergencies and how the concept of an emergency in the Act does not have to involve a traumatic event, but rather is a provision applied where some safeguards can be delayed to provide an intervention.

Authorisations

1.24. **Chapter 11** outlines the procedures for a trust panel authorisation, which is required for a deprivation of liberty.

1.25. **Chapter 12** explains what a short-term detention authorisation is and what is required before one can be made.

1.26. **Chapter 13** outlines how a trust panel authorisation can be extended by an authorisation report or by an authorisation by trust panel.

1.27. **Chapter 14** provides a brief guide on the work of the trust panel to aid those applying to the panel.

1.28. **Chapter 15** provides an overview of the Review Tribunal and outlines who can apply to the Tribunal and what decisions the Tribunal can make.
Children & Young People

1.29. **Chapter 16** outlines how the Act applies in relation to deprivation of liberty of children under 16 and young people who are 16 or 17 years old.

Offences and Warrants

1.30. **Chapter 17** outlines the offences in the Act and how they apply to those who interact with persons who lack capacity.

1.31. **Chapter 18** explains warrants.

Annexes – Scenarios and Forms

1.32. **Annex A** provide the statutory and guidance forms.

1.33. **Annex B** provide scenarios to help and support practical application of the Act.
Chapter 2. DEPRIVATION OF LIBERTY

Introduction

2.1. Depriving a person of his or her liberty is one of the most serious infringements on a person’s human rights. The Act therefore treats detention amounting to deprivation of liberty (“DoL”) as one of the most serious interventions that can be done to a person who lacks capacity (“P”).

2.2. To ensure that P’s human rights are protected, the Act defines DoL as having the same meaning as within Article 5(1) of the European Convention on Human Rights (“ECHR”) which provides that:

Everyone has the right to liberty and security of person. No one shall be deprived of his liberty [unless he or she is of an unsound mind] and in accordance with a procedure prescribed by law.

2.3. What this means is that a person can only ever be deprived of his or her liberty in a care or treatment context if he or she is deemed to be of unsound mind. A person who lacks capacity to make a decision about care arrangements that would amount to a deprivation of liberty is of unsound mind and is deprived of liberty if any act or intervention which fits the test below occurs. The only way to be protected from liability when carrying out the act is to follow the statutory procedures and have regard to this Code.

2.4. Conversely, anyone who has the relevant capacity cannot be deprived of their liberty unless expressly provided for under other legislation (e.g. criminal
legislation permitting imprisonment for committing offences).

2.5. This chapter sets out what a DoL is, where a DoL can take place and how DoL interacts with other interventions. In this chapter references to capacity are in regards to a person’s capacity to make decisions in relation to their care arrangements which may amount to a deprivation of liberty.

Testing if a person is subject to a DoL

2.6. To test if a person who lacks capacity is deprived of his or her liberty the following questions must be asked:

   a. is P under continuous supervision and control?
   b. is P free to leave?

2.7. If P is under continuous supervision and control and is not free to leave P is subject to a DoL (see below for examples).

2.8. A DoL must be considered on individual merit and on the particular circumstances of each case; blanket assumption must not be made. Account must be taken of a whole range of criteria such as type, duration, effect and manner of implementation of the measure. This includes the possibility to leave a restricted area, the degree of supervision and control over the person’s movements, the extent of isolation and the availability of social contacts. Bear in mind that whether or not an act amounts to a DoL does not depend on its duration alone. However, an act that is short, time-bound and reactive to an immediate event is likely not to be a DoL but restraint, which is not covered under the first phase of commencement of the Act.
2.9. Being under **continuous supervision and control** depends on the particular circumstances but may include control over who P can have contact with, control over P’s activities or supervision over P’s health and actions.

2.10. Not being **free to leave** may include locked doors that are not unlocked on P’s request, physically preventing P from leaving, not being able to leave the place without supervision and not being free to permanently move residence.

2.11. If a person has capacity to consent he or she can be subject to any arrangements, including arrangements that are of a similar nature to DoL, on a voluntary basis. However, if he or she, at any time, loses capacity to consent such arrangements are no longer voluntary. If a person no longer has capacity to consent to the arrangements all the safeguards of the Act must immediately be put in place. **A person who has capacity cannot consent pre-emptively to a DoL for a time in the future when they may no longer have capacity.**

2.12. Examples of where P **may** be subject to DoL include, but are not limited to:

- a. an acute hospital where P is receiving treatment, is not bed bound and is prevented from leaving by locked doors or forcibly by staff (see below for exceptions for some persons in hospital);

- b. an acute hospital where P is receiving treatment and is bed bound but would be prevented from leaving if he or she had the ability to (even if he or she does not try to leave) (see below for exceptions for some persons in hospital);
c. a care setting where P is subject to seclusion (that goes beyond the remit of restraint);

d. a care home where P is resident and only allowed to leave under supervision;

e. a nursing home where P is resident, the doors are locked with a key pad and P does not know the code or cannot understand that the numbers next to the door is the code;

f. a day care facility which P is not allowed to leave;

g. a setting where P is bed bound and not able to leave and family members (or others) are prevented from removing P even though this is according to P’s wishes;

h. in a private home where P is bed bound, receiving around the clock care (provided by the health and social care system) but would be prevented from leaving if he or she had the ability to; and

i. in supported living or a private home where P is cared for by a carer (who may be a relative) and is prevented from leaving (either by locks, persuasion or coercion) and the carer is financially compensated by the state (for example through direct payments or carers allowance).

2.13. The Courts have found that certain factors are not relevant when considering if P is subject to a DoL. This includes that it does not matter:

a. if P can physically leave;

b. if P is compliant or is not objecting;

c. if the place where P is residing is “normal” for P; and

2.13. The Courts have found that certain factors are not relevant when considering if P is subject to a DoL. This includes that it does not matter:

a. if P can physically leave;

b. if P is compliant or is not objecting;

c. if the place where P is residing is “normal” for P; and
d. what the reason or purpose for the DoL is.

*Situations where P is unable to leave*

2.14. Being unable to leave does not automatically mean that a person is prevented from leaving. That is the case even if the person’s inability to leave is due to treatment or actions by others.

2.15. For example, a person is receiving palliative care which involves strong pain killers. The effect of the pain killers is that the person is physically unable to leave as the medication has a strong sedative effect. The person is then under continuous control and supervision and unable to leave (due to the medication). However, this does not automatically mean the person is not free to leave. The question that must be asked is if the person was able to leave would the person be prevented from leaving. In settings such as palliative care, most people would be allowed to leave, and if the answer to the question is that the person would be allowed to leave there is no deprivation of liberty.

2.16. Similarly, if another person is receiving care and treatment and the person’s physical health has deteriorated to the extent that the person is unable to leave it does not automatically mean that the person is not free to leave. The question that must be asked is if the person could leave would they be allowed to. If the answer is yes, the person is not deprived of liberty.

2.17. The effect of this is that many people who are receiving care and treatment where their physical health has deteriorated to the extent that they are unable to leave are not deprived of liberty as they would be allowed to leave if they were able to.
2.18. This does, of course, not mean that all persons unable to leave are free to leave. Assessments must be made on individual circumstances with the question, if the person was able to leave would he or she be allowed to leave.

**Exception for persons receiving life-saving treatment in hospital**

2.19. In general there is no DoL where the person is receiving life-saving medical treatment in hospital. The courts have found that:

*There is in general no need in the case of physical illness for a person of unsound mind to have the benefit of safeguards against the deprivation of liberty where the treatment is given in good faith and is materially the same treatment as would be given to a person of sound mind with the same physical illness. The treatment is neither arbitrary nor the consequence of her impairment.*

2.20. Therefore if a person is in hospital and is treated for a life-threatening illness, the person is not subject to a DoL if the circumstances of the treatment for the physical illness for the person who lacks capacity is the same as for a person who has capacity, even if the factual circumstances meet the DoL test.

2.21. For example, this may be a person in intensive care who is chemically restrained due to the physical illness they are being treated for, and thus not free to leave and is subject to continuous supervision and control. However, if the reason for the restraint is the physical illness and not the lack of capacity, the person is not
deprived of his or her liberty and the additional safeguards outlined in this Code do not apply.

2.22. The Courts have explained that it is not the precise setting which is determinative, but the nature of the treatment. It may be that a person is getting that urgent life-saving treatment outside Intensive Care, at which point there is most likely not a deprivation of liberty, unless there is some unusual feature about the person’s care. Conversely, it may be that there cases in Intensive Care where the arrangements go beyond those which would ordinarily be in place and the circumstances should be considered as a deprivation of liberty.

Detention amounting to DoL under the Act

2.23. In a situation where a person fulfils the test on DoL the Act applies if:

a. P is 16 or over; and

b. P lacks capacity in relation to the detention amounting to DoL.
Chapter 3. PRINCIPLES

Introduction

3.1. Sections 1 and 2 of the Act set out the statutory principles, i.e. the values that underpin the legal requirements in the Act and which must be taken account of in relation to any DoL. The Act is intended to protect people’s autonomy and support those who lack capacity to make decisions for themselves. Therefore, any deprivation of liberty carried out in relation to a person who lacks or may lack capacity must adhere to these principles.

3.2. The statutory principles are:

a. Principle 1 – A person is not to be treated as lacking capacity unless it is established that the person lacks capacity in relation to the matter in question.

b. Principle 2 – The question if a person is able to make a decision for himself or herself can only be determined by considering the requirements of the Act and no assumptions can be made merely on the basis of any condition that the person has or any other characteristics of the person.

c. Principle 3 – A person is not to be treated as unable to make a decision for himself or herself unless all practicable help and support to enable the person to make the decision has been given without success.

d. Principle 4 – A person is not to be treated as unable to make a decision merely because the person makes an unwise decision.
e. Principle 5 – Any act done, or decision made, must be made in the person’s best interests.

3.3. This chapter provides guidance on how the principles should be interpreted and applied in relation to deprivations of liberty.

3.4. Failure to comply with the principles could render a deprivation of liberty unlawful and could lead to liability, both criminal and civil, for the person carrying out the act. It is therefore important to take note of the principles and apply them when considering and/or carrying out any deprivation of liberty in relation to a person who lacks, or may lack, capacity.

**Principle 1 – No one should be treated as lacking capacity unless established that they do**

3.5. The first principle is founded on personal autonomy. This principle means that a lack of capacity is always a matter that must be established. It can never be assumed. It requires anyone who is considering care arrangements which would deprive P of liberty to consider P’s decision making capacity carefully.

3.6. There is no substitute for evidence when P’s capacity is being considered. Treating a person who lacks capacity as being able to make a decision about his or her care arrangements, based on a mere assumption that he or she has capacity to do so, could give rise to civil liability, for example, in negligence if a person suffers harm as a result.
Principle 2 – No assumptions can be made

3.7. The second principle is closely interlinked with the first. It requires anyone who is considering if a person lacks capacity to only consider the criteria in section 4(1)(a) to (d) of the Act. These criteria state that the person must:

a. not be able to understand the information relevant to the decision;

b. not be able to retain that information for the time required to make the decision;

c. not be able to appreciate the relevance of that information and to use and weigh that information as part of the process of making the decision; or

d. not be able to communicate his or her decision (whether by talking, using sign language or any other means).

3.8. This principle requires anyone considering capacity to only consider the above and forbids any assumptions based merely on any condition that the person has or any other characteristics of the person. Such a condition or characteristic may be a disability, age, appearance, physical or mental illness or anything else. Just because a person presents symptoms of a condition that often, or sometimes, can suggest a person lacks capacity cannot be used as the reasoning for establishing or concluding that the person lacks capacity. More information on how to determine capacity can be found in Chapter 5.
Principle 3 – Help and support must be provided

3.9. The third principle provides that a person is not to be treated as unable to make a decision for himself or herself unless all practicable help and support to enable the person to make the decision for themselves has been given without success.

3.10. This principle requires that anyone who is considering whether a person lacks capacity must consider and provide all practicable help and support to allow the person to make their own decision. No determination of lack of capacity can be done until all practicable help and support has been provided. This is to stop people being automatically labelled as lacking capacity to make some decisions when they could make them if they were supported during the decision making process. This helps individuals to play as big a role as possible in the decision making process and retain as much autonomy as possible.

3.11. If after all practicable help and support has been given to the person he or she is still unable to make a decision on their care arrangements which would result in a detention amounting to a DoL, and therefore is determined to lack capacity, the Act provides the framework for making the decision in relation to P. This is to ensure that those persons who lack capacity and cannot make a decision for themselves are protected through a robust legal system.
Principle 4 – No assumptions can be made because of unwise decisions

3.12. The fourth principle provides that a person is not to be treated as lacking capacity to make a decision simply because he or she makes what others consider to be an unwise decision.

3.13. All persons have their own wishes, feelings, beliefs and values. No one should be assumed to lack capacity just because they make a decision that to others may appear unwise. This applies even if family members, friends, health and social care staff or others are unhappy with the decision. Unwise decisions are even allowed if the decision is one that could have negative effects on the person making the decision.

3.14. If a person repeatedly makes unwise decisions that put them at risk of harm, exploitation or abuse, or if he or she makes an unwise decision that is obviously irrational, out of character or that the person cannot explain, it may be cause for concern. This, however, cannot be used as sole evidence that the person lacks capacity, but it may give cause to investigate whether the person has capacity to make the decision in question. Such reasons to investigate capacity may be made stronger if the person has recently developed a medical condition or disorder that may affect their capacity. It is important to note though that unless it has been found that the person lacks capacity to make a decision (as provided in principle 1) the person must be allowed to make unwise decisions.
**Principle 5 – Any act done on behalf of a person who lacks capacity must be in his or her best interests**

3.15. The fifth principle requires any act done or decision made on behalf of a person who is 16 or over and lacks capacity, to be in that person’s best interests.

3.16. It is impossible to provide a definition of what a person’s best interests are as it will differ significantly from person to person depending on the individual circumstances. However, section 7 of the Act provides details on how to determine best interests, and further information on this can be found in Chapter 5 of this Code.

3.17. A determination of what is in a person who lacks capacity’s best interests must not be based merely on the person’s age, appearance, or any other characteristic, including any condition. Rather all relevant circumstances must be considered.

3.18. Importantly, the person determining best interests is required, so far as is practicable, to encourage and help the person to participate as fully as possible in the decision making process. Special regard must be given to past and present wishes and feelings and, in particular, any relevant written statement made by the person when he or she had capacity, as well as their beliefs and values and any other factors that would likely influence the person’s decision if he or she had capacity, in so far as they are reasonably ascertainable. In that way best interests under the Act is different from a clinical best interests assessment as it requires a holistic approach; **what may appear to be in a person’s best interests from a clinical point of view may not be what is in the person’s overall best interests.**
3.19. The person determining best interests must also, where practicable and appropriate, consult with others and take into account their views as to what would be in the best interests of the person who lacks capacity. This could include consulting with the nominated person, anyone named by the person to be consulted on the matter, anyone engaged in the person’s care or interested in his or her welfare and any attorney appointed under an enduring power of attorney.

3.20. The person determining best interests must also have regard to any less restrictive alternatives to the proposed deprivation of liberty, and consider whether failure to do the act is likely to result in harm to other people, which could ultimately have harmful consequences for the person who lacks capacity.
Chapter 4. PROTECTION FROM LIABILITY

Introduction

4.1. Part 2 of the Act provides the legal framework to allow a deprivation of liberty to be carried out with regards to a person who lacks capacity. Section 9 introduces the concept of “protection from liability”.

4.2. Protection from liability is a protection for a person (“D”) doing an act in relation to a person (“P”), aged 16 and over, who lacks capacity to consent to the act. The protection will only apply where all safeguards have been put in place to ensure that the rights and interests of P are preserved.

Other authority to act

4.3. The protection from liability does not apply where the person has authority to act, either under provisions provided in the Act or in any other legal provisions, and that authority is not dependent upon the consent of P. This includes, for example, the police powers of arrest.

Emergencies

4.4. The protection from liability only applies where the relevant safeguards are put in place. However, there will be times when a person may need deprived of their liberty without delay. In these situations, there may not be time to put some or all of the additional safeguards in place (reasonable belief that P lacks capacity and that the act is in P’s best interests must always be met,
as well as the prevention of serious harm condition for DoL), or even to establish if the additional safeguards have already been put in place. Delaying the act until this has been established, or until the safeguards are met, may result in an unacceptable risk of harm to P.

4.5. An “unacceptable” risk of harm is determined by weighing up the likelihood of harm being caused to P as a result of any delay in the act and the seriousness of that harm, against the risk of harm to P caused by not complying with the additional safeguard(s) in question. If the former outweighs the latter, provided there has not been an unreasonable failure to take steps to put the safeguard in place, then the situation can be regarded as an emergency and there is protection from liability even although all the additional safeguards are not in place.

4.6. However, it is important that the relevant safeguards are put in place as soon as practicable, as D will not be able to continue to rely on the emergency provisions indefinitely. More information on emergencies can be found in Chapter 10.
Chapter 5. CAPACITY

Introduction

5.1. Chapter 3 of this Code highlighted the guiding principles set out in the Act (Section 1). This chapter looks specifically at the principle of capacity and how to assess capacity.

Meaning of “lacks capacity”

5.2. A person is not to be treated as lacking capacity in relation to a DoL unless it is established that the person lacks capacity. A person (“P”) lacks capacity in relation to a DoL if P is:

unable to make a decision for himself or herself about the matter, because of an impairment of, or a disturbance in the functioning of, the mind or brain.

Figure 1 - Meaning of lack of capacity
5.3. There are therefore three elements, unable to make decision, impairment or disturbance and a causal link, in determining a person’s capacity and more detail on each of these elements is provided below. It should be noted that all three elements are equally important and all three elements must be present for the person to lack capacity.

5.4. It is worth noting at this point that ‘the decision’ in this instance is whether P is able to make a decision in relation to the care arrangements that would amount to a deprivation of liberty.
Establish if the person can make the decision (the functional test)

5.5. When assessing capacity it has to be established if P is unable to make a decision. This is known as the functional test. A person is therefore unable to make a decision for him or herself if he or she is unable to do at least one of the following:

(a) **understand** the information relevant to the decision
(b) **retain** that information for the time required to make the decision;
(c) **appreciate** the relevance of that information and **use and weigh** it as part of the decision making process
(d) **communicate** his or her decision

*Figure 2 - Meaning of unable to make a decision*

Understand the information

5.6. Understanding the information means being able to take the information required and comprehend what it is, including any reasonably foreseeable consequences of the decision. It is not necessary to understand all the details of the decision or its consequences, as long as what is important for the person is understood.
5.7. When considering the understanding of the information it is important not to assess a person before they have been given the information in a suitable way, as far as practicable. Every effort must be made to provide information in a way that is most appropriate to help the person to understand (e.g. via use of visual aids, or simple language).

Retain the information

5.8. The person must be able to retain the information in their mind long enough to use it to make an effective decision. However, a person who can only retain information for a short while must not automatically be assumed to lack the capacity to decide, it depends on what is necessary for the decision. Many persons can be supported to retain information. It is therefore important to consider tools for this, such as notebooks, video or sound recordings or photographs.

Appreciate and use and weigh the information

5.9. For a person to have capacity, he or she must have the ability to weigh up information and use it to arrive at a decision. This includes analysing the information and using their understanding of the information gained to make an informed decision. Some persons can understand information but an impairment or disturbance stops them using it. In other cases, the impairment or disturbance leads to a person making a specific decision without understanding or using the information, especially in relation to the consequences of the decision. For example, a person may wish to spend all their money on clothing and understands that
the clothing costs money. However, the person may not be able to use and weigh the information to understand the consequences of spending all their money on clothing (i.e. not having money available for food or housing).

5.10. The inclusion of the appreciation element allows for factors such as a lack of insight, delusional or distorted thinking to be taken into account when assessing someone’s ability to make a decision. This is particularly relevant where a person can understand the information and can make a reasoned argument for the consequences, but where such argument lacks appreciation of factors such as other’s feelings, long term effects on health, reasonably foreseeable consequences (including third party risks) and so on. Equally they may not appreciate the relevant information if due to their lack of insight, delusional or distorted thinking they do not believe the relevant information provided.

5.11. Appreciating the relevance of the information together with using and weighing that information means that a person who has cognitive understanding of the decision may still lack capacity if he or she cannot appreciate the effect of the decision or cannot appreciate what the decision entails. This also includes where the person cannot appreciate how an impairment or disturbance is affecting the person’s thinking. This may, for example, be a person who has a cognitive understanding of their severe depression but has failed to appreciate that their depression is leading them to feel suicidal. It could also be applied to a person suffering from anorexia who cannot link his or her feeling of not wanting to eat to starvation leading to death.
5.12. It is important to note that appreciation can be used widely, even when the person appears to be providing a clear answer. A person suffering from delusion may, in accordance with Kraepelin’s description of delusion, appear to make a decision “in complete retention of clearness and order in thinking”. However, if that clearness and order is the delusional effect of an impairment of, or disturbance in the functioning of, mind or brain it is possible to that the person cannot appreciate the information sufficiently to make a decision and may therefore lack capacity. An apparent clarity is not in itself a barrier to determining that a person does not appreciate the information required.

5.13. However, just because a person does not arrive at the same decision as the person carrying out the determination of capacity it does not mean that P cannot appreciate and use and weigh the information. How information is processed depends on many factors, most of which are very personal and reflect individual wishes, feelings, beliefs and values. “Appreciate and use and weigh” is not the ability to make the best clinical decision or to make a decision that most others would make.

Communicate the decision

5.14. Sometimes there is no way for a person to communicate. This may include:

a. people who are unconscious or in a coma; or
b. those with the very rare condition sometimes known as ‘locked-in syndrome’, who are conscious but cannot speak or move at all and who cannot be supported with tools or professionals.
5.15. If a person cannot communicate their decision in any way at all he or she should be treated as being unable to make the specific decision.

5.16. Before deciding that a person is unable to communicate in any way at all it is important to make all practicable efforts to help them communicate. This involves using relevant professionals such as speech and language therapists, other specialists in communication and other non-professionals, including friends or relatives, who can help. It is important to note that some people can communicate using even very small muscle movements, such as moving eyes or squeezing hands. If a person can communicate in any way at all with the person who is assessing capacity it should not be determined that he or she is unable to communicate.

Establish if there is an impairment or disturbance (the impairment or disturbance test)

5.17. When assessing capacity it has to be established that P has an impairment of, or a disturbance in the functioning of, the mind or brain. This is known as the impairment or disturbance test.

5.18. It does not matter what the cause of the impairment or disturbance is (see diagram below for some examples). It may be caused by a disorder or disability but equally it may not. It may also be permanent or temporary.
Causes of impairment or disturbances of the mind or brain

5.19. All of the above reasons could result in a person being found to have an impairment of, or a disturbance in the functioning of, the mind or brain. The above is not exhaustive; however it highlights the wide variety of circumstances which could eventually lead to a person
losing capacity to make a decision for himself or herself.

5.20. There is no need for a formal diagnosis or formal results to determine if a person has an impairment of, or a disturbance in the functioning of, the mind or brain. As long as the person assessing capacity has reasonable belief that there is an impairment or disturbance the impairment or disturbance test is satisfied. What is reasonable will depend on the individual circumstances in each case; it may include:

a. speaking to the person (if the person is conscious it would be expected that the person is spoken to);

b. examining the person;

c. examining case notes;

d. running tests; or

e. speaking to others.

The Causal link

5.21. When assessing capacity a link between the two tests detailed above must be established: a person must be unable to make a decision because he or she has an impairment of, or a disturbance in the functioning of, the mind or brain. If there is no causal link they do not lack capacity and a decision cannot be made on their behalf.

5.22. A lack of capacity cannot also be established solely on the basis of any characteristics of a person which could lead people to make unjustified assumptions, for example, the way someone may dress, or whether
someone happens to exhibit extrovert or introvert behaviour.

5.23. The material cause of not being able to make a decision must be the impairment or disturbance. Other factors may render a person unable to make a decision. This may include general indecision, duress or undue influence. In such cases the person does not lack capacity even though he or she may be unable to make a decision. The true question is whether the impairment of, or the disturbance in the functioning of, the mind or brain is an effective, material or operative cause. Only if it is the cause of the incapacity, even when other factors come into play, can a person be determined to lack capacity.

Persons at risk of harm

5.24. Some persons are at risk of harm and may be subject to undue influence or duress. It is often the first instinct to try to help such persons and therefore make decisions on the person’s behalf. However, if the person has capacity the person cannot be deprived of liberty.

5.25. That does not mean that persons at risk of harm should be left without support. It may be relevant to involve others, such as the police, to ensure that the person is safe. For further advice on persons at risk of harm see other Departmental policy and guidance, as well as professional and employer guidance.

Fluctuating capacity

5.26. In some circumstances P’s capacity may be fluctuating. If P has the capacity to make a decision no act can be
done on his or her behalf, even if the capacity is only temporary. However, if P is suffering from an illness that causes capacity to fluctuate and, during more capacitous times, P does not understand that he or she is likely to lack capacity in the immediate future, it is very possible that P is actually unable to make a decision about the care arrangements that amounts to a deprivation of liberty as he or she does not appreciate the complicated nature of his or her illness.

5.27. When assessing whether a person has capacity in relation to the deprivation of liberty all available evidence must therefore be considered. If it is determined that P does not appreciate how his or her capacity is fluctuating it is possible to determine that P is unable to appreciate the information and therefore lack capacity in relation to the care arrangements that amounts to a deprivation of liberty.

Establishing lack of capacity

5.28. A person cannot be treated as lacking capacity unless it has been established that he or she lacks capacity in relation to the decision. It is not for the person whose capacity is in question to prove they have capacity to make the decision. The onus is on the person (“D”) intending to carry out the deprivation of liberty to properly establish that capacity is really lacking in relation to that particular intervention.

5.29. It is the responsibility of D to be satisfied that a lack of capacity has been properly established in relation to the DoL. Where there is more than one person involved in P’s care, for example, in a hospital setting, while D must be assured that a lack of capacity has been
established in relation to a DoL (and at all times have a reasonable belief that this remains the case), it may be other members of the multidisciplinary team who carry out the formal assessment of capacity.

5.30. For example, a medical practitioner may be the person making the determination of capacity, but a nurse or social worker may be person who carries out the DoL and therefore must have reasonable belief of lack of capacity, which can be based on the determination made by the consultant. However, if D, for any reason and at any time, does not have reasonable belief that the person lacks capacity the act should not be carried out as the protection from liability will not apply. This may be the case if, for example, there are insufficient notes from the consultant, or the person does not present, or no longer presents, in a way that the notes describe.

Making assumptions and unwise decisions

5.31. Proceeding on the basis of a mere assumption that the person has capacity to make a decision, where there is doubt, could end in D acting unlawfully and therefore incurring liability, if in fact the person lacks capacity; and may result in a vulnerable individual being denied the safeguards that the Act provides.

5.32. If there are any doubts surrounding the person’s capacity, D must take steps to firstly support that person to make the decision and if that does not work, then secondly, to establish if the person lacks capacity, before continuing.

5.33. Similarly, D must not make unjustified assumptions that a person lacks capacity either. A determination by
D regarding a person’s lack of capacity must not be made by reference to anything other than consideration of the 4 elements of the functional test, and that a failure to meet one or more of these elements is because of an impairment of, or a disturbance in the functioning of the mind or brain. The fact that a person has a certain condition or a particular characteristic must not be the sole basis for D to conclude that the person lacks capacity. If D were to continue on that basis, D may be acting unlawfully, or incur civil or criminal liability.

5.34. When establishing capacity this must be based on the facts at the time the decision has to be made. It is not possible to rely on previous assessments or diagnoses. However, previous assessments or knowledge of the person may aid an assessor’s understanding of a person’s circumstances when they come to determine the person’s current capacity in relation to the decision.

5.35. In considering a person’s capacity to make the decision, it is important to understand that just because a person makes what others might see as an unwise decision, this does not mean that the person lacks capacity. Everyone has the right to make unwise decisions, or indeed make decisions which may not seem to others to be in their best interests. If a person has capacity, any decision is theirs to make, regardless if someone else has a different opinion.
Chapter 6. BEST INTERESTS

Introduction

6.1. The Act puts in place the principle of best interests. Where it has been established under the Act that a person (“P”) lacks capacity regarding a DoL (see Chapter 5), any act done or decision made for or on behalf of P must be done or made in P’s best interests.

6.2. If used properly, the best interests principle, as set out in section 7 of the Act, is a powerful safeguard for the person lacking capacity. Proper and full consideration of best interests guarantees that P’s rights, will and preferences are respected in line with obligations set out under The UN Convention on the Rights of Persons with Disabilities. This chapter looks at how the best interests principle should be used in practice; and the steps that should be followed.

Best interests principle

6.3. The principle of best interests applies to any proposed deprivation of liberty in relation to P before the act can lawfully proceed. It is more than a clinical or medical best interests test; it is a holistic consideration of all relevant factors that would be reasonable to consider under the circumstances. The best interests is not what the professional would do or agree to if he or she was in the same shoes or what the relatives think they would do. A best interests determination starts with consideration of what decision P would have made if P had capacity to make the decision.
6.4. The term best interests is purposely not defined, because it has such a wide application to different individuals.

6.5. The Act provides a checklist of common factors that must be taken into account in each best interests determination; however, this list is not exhaustive. All relevant information must be weighed up and given careful consideration by the person (“D”) when determining which course of action would be in P’s best interests. See below for what is included in the checklist.

**Figure 4 - Best interests checklist**
Who must make a best interests determination?

6.6. The person (“D”) who carries out the act in relation to P has responsibility for making sure that the act is in P’s best interests. However, where there is more than one person involved in P’s care, for example, in a hospital setting, while D will have responsibility for ensuring that the act is in P’s best interests, it may be other members of the multidisciplinary team who carry out certain steps that must be done as part of the best interests determination.

6.7. For example, a hospital consultant may be the person making the best interests determination based on the information available to him or her, including seeking input from other professional specialists as necessary, but a nurse or social worker in the multidisciplinary team may be the person who actually contacts and consults with relevant others. The person making the determination will use this information in the process of determining P’s best interests. It could be the case that a number of people are equally involved in making the best interests determination, reaching agreement through consultation and discussion of the case and the relevant factors.

6.8. For the remainder of this chapter, reference is made to the person making the best interests determination. No matter who this person actually is or how many people were involved in the best interest determination, the ultimate responsibility for reasonable belief of best interests lies with the person who is carrying out the deprivation of liberty, D. D can be a care worker, health and social care professional or someone else. D must satisfy himself or herself that the act is in P’s best interests to be protected from liability, regardless of
whether D has made the best interests determination independently or on the basis of evidence provided by others. There is no collective responsibility. D is the individual who is preventing P from leaving and D can personally be held liable unless D is personally satisfied that the deprivation of liberty is in P’s best interests and that all safeguards are met.

How is best interests determined?

6.9. A best interests determination will involve consideration of all known factors and information that are relevant to P and the act, weighing up the advantages and disadvantages of different options and reaching a conclusion based on that analysis. Special regard must be had to P’s past and present wishes, feelings, beliefs and values and anything else P would have considered. This shifts the focus away from a clinical or medical decision to what would P have done if P had capacity to make the decision.

Relevant factors

6.10. The person making the best interests determination must take into account all relevant factors, of which he or she is aware, when balancing what is in the best interests of P. Relevant factors could be anything that P would consider important to the decision. The weight that should be given to a particular factor will depend on the circumstances in question; no one factor should be solely relied upon without taking account of the bigger picture. Communicating with family, carers and friends of P will be important in ascertaining what
relevant factors should be taken into account; and how much weight should be given to them.

6.11. If, after a best interests determination has been made it transpires that not all relevant factors were taken into account, D may still be protected from liability if he or she was reasonably unaware of that fact. However, if D deliberately ignored or overlooked something that was relevant and may have affected the best interests determination, D may not be protected from liability.

Unjustified assumptions

6.12. Best interests may not be based merely on the basis of P’s age or appearance, or on any other characteristic or condition of P which might cause other people to make unjustified assumptions.

6.13. Appearance refers to all aspects of physical appearance, including skin colour, mode of dress and any visible medical problems or other disabilities. A person’s condition also covers a range of factors including physical disabilities, learning disabilities, age-related illness or temporary conditions (such as drunkenness or unconsciousness).

6.14. Likewise, a person’s age should not be the sole deciding factor when making a best interests determination. For example it cannot be assumed that it is in an elderly person’s best interests to be moved into a residential care or nursing home, merely because of the person’s age.
The best interests steps

6.15. When determining best interests a number of steps must be taken. Following these steps will ensure that the decision is based on what P would have done if P had capacity to make the decision.

Consider if there are reasons why the deprivation of liberty is not in P’s best interests

6.16. The first consideration when considering best interests should be if there are reasons why the DoL is not in P’s best interests. By considering why a DoL should not take place the reasons why it would be in P’s best interests are tested. This will help reducing DoLs to only where it is required.

Consider whether it is likely that the person will have capacity at some time in the near future to make the decision themselves

6.17. If P lacks capacity because of a short-term condition, for example, unconsciousness due to general anaesthetic, and a decision does not have to be taken immediately, it will probably be in the person’s best interests to wait until the anaesthetic wears off and they regain capacity to make the decision themselves.

6.18. Some factors which may indicate that a person may regain or develop capacity in the future are that:

a. the lack of capacity may be of a temporary nature (for example, where it is caused by the effects of
medication or alcohol, or following a sudden shock);
b. P may learn new skills or be subject to new experiences which increases their understanding and ability to make certain decisions;
c. P may experience fluctuating capacity so it may be possible to arrange for the decision to be made by P during a time when P has capacity; and
d. P, who was previously unable to communicate, may gain or regain communication skills, perhaps by learning a new form of communication.

6.19. Sometimes, it might not be known when or if P will regain capacity. In this case, a judgment has to be made, weighing up the risks of delaying the DoL for an unspecified time versus the benefits of proceeding with the intervention sooner.

As far as practicable, encourage and help P to participate as fully as possible in the determination of their best interests

6.20. Often when a person lacks capacity regarding a certain decision, that person is able to give an indication of his or her views or feelings regarding a decision. To enable a person to participate as fully as possible help and support must be given to him or her. This may include the involvement of a speech and language therapist, an advocate specialising in certain conditions or the provision of alternative formats of information that are more suitable to a person’s needs, for example, flash cards, or easy read leaflets, explaining the options available.
6.21. Small adjustments to the way in which information is relayed to P, for example, by speaking slowly, taking the time to explain things, or using simple language rather than medical terminology, can also have a positive impact on P’s ability to understand the matter in question and help P become more involved in the best interests determination.

*Have special regard to past and present wishes, feelings, beliefs, values and any other factors*

6.22. The best interests of P are what P would have done if he or she had capacity to make the decision, if that would be practically possible. It is therefore important to consider P’s past and present wishes and feelings, beliefs and values and other factors that P would have considered if he or she were able to do so.

6.23. If P previously expressed particular preferences or views relevant to the current situation, this would be a strong indicator of how P would likely have reacted to the current situation and also may give a strong indication as to the decision that P would have made if he or she had capacity. If the person making the best interests determination is aware of this, special regard must be given to this expressed preference, if it is relevant to the current matter.

6.24. **Special regard** means giving top priority to the wishes, feelings, beliefs, values and any other factors that P would have considered relevant. It is the primary factor when determining what is in P’s best interests. To put it another way, when weighing up the considerations that are taken into account when determining P’s best interests, not all considerations are equally relevant.
Past and present wishes, feelings, beliefs, values and other factors P would have considered must be at the top of the consideration hierarchy and given the most weight when determining what is in P’s best interests. The person making the best interests consideration must actively try to ascertain this. He or she could do this by:

a. speaking to P, family and friends or other professionals;

b. determining if any written statements have been made by P;

c. determining if P has previously experienced a similar situation to the current matter and how P reacted to it at the time; or

d. any other means the person making the best interests determination feels would be appropriate.

6.25. **Special regard** is stronger than merely having regard to or considering; and the person making the best interests determination must have good reasons to justify going against P’s previously stated wishes, feelings, beliefs or values if they relate to the current situation. Special regard should not be interpreted to mean allowing P’s wishes to tip the balance. It is much more than that. However, special regard is not absolute; it does not mean that P’s past or present wishes and feelings, beliefs, values must be adhered to, particularly if there are practical reasons why they cannot. Persons making best interests determinations should be aware of the increased need to justify a best interests decision that is made contrary to P’s past and present wishes and feelings, beliefs and values.
6.26. Other factors that may be taken into account by the person making the determination include those that P would have taken into account if he or she were making the decision themselves, such as the effects of any potential outcome on P’s relatives, if P would have thought that to be important.

*Consult and take into account the views of relevant people*

6.27. Often the people closest to P may be best placed to advise on what P would have wanted, if P had capacity. The person making the determination should consult with all relevant people, in so far as he or she is reasonably able to do so. This is more than just a cursory check; the person making the determination is also required to take the views of the relevant people into account when making the best interests assessment.

6.28. Relevant people includes the nominated person, anybody named by P as someone to be consulted, anyone caring for P, or interested in P’s welfare and an attorney acting under an Enduring Power of Attorney.

6.29. Relevant people should only be consulted as far as it is practicable and appropriate to do so. If, for example, a family member cannot be contacted because they cannot be reached, or there are no known contact details for that person, then it would be acceptable not to consult with that person, because it has not been practical to do so in the time available to make the best interests determination.
6.30. Where P lacks capacity regarding care arrangements which amount to a DoL the person making the best interests determination must consider all alternative available options and the effectiveness of those options. P’s human rights must always be at the forefront of any such decision-making. Where there is a choice of two or more options, which are thought to have similar effects or outcomes, the first consideration must be to P’s past and present wishes, feelings, beliefs and values and if then two or more options still remain, the least restrictive option should be selected as this will constitute a lesser infringement on P’s rights and freedom of actions, and preserve P’s human rights as far as possible.

6.31. There are many ways to avoid a deprivation of liberty. This may include using technology, such as sensors or GPS trackers, or using staff, by providing personalised care. If such options are realistic they must be considered before a DoL is put in place. However, it is worth noting that the best interests considers all available options, and does not require arrangements that are impossible or that would not normally be put in place.

Have regard to whether failure to do the act is likely to result in harm to others with resulting harm to the person lacking capacity.

6.32. The person making the best interests determination must consider if P poses a risk of harm to other persons, which could then result in harm to P. Resulting
harm to P includes indirect harm such as losing contact with people or being subject to the criminal justice system because of harm caused to others.

6.33. The concept of harm to others with resulting harm to P means that other persons’ interests can be considered when determining best interests, **if there is a risk of resulting harm to P**. It may be that failure to carry out the DoL would cause harm to other persons with resulting harm to P and therefore their interests can be considered.

6.34. However, just because the failure to do the act could cause harm to others with resulting harm to P it does not mean that doing the act is in P’s best interests. All factors must be considered and as with all best interests determinations, special regard must be had to P’s past and present wishes, feelings, beliefs and values.

**Working out best interests and protection from liability**

6.35. If the person making the best interests determination reasonably believes that the intervention is in P’s best interests and has complied with the steps in the best interests checklist, that person will be protected from liability.

6.36. This is the case even where it subsequently transpires that the intervention was not in P’s best interests. As long as the steps have been followed and an objective, well-founded, determination regarding P’s best interests was made, which can be justified if challenged, the protection from liability will still apply.
6.37. A best interests statement must be made and signed by the person who determines the best interests. This must be done on Form 2. Form 2 must be attached to:

a. an application for trust panel authorisation;

b. an extension report;

c. an application for trust panel extension authorisation; and

d. a short-term detention authorisation report.
Chapter 7. DEPRIVATION OF LIBERTY SAFEGUARDS

Mental Health (Northern Ireland) Order 1986

7.1. When the Act is fully commenced the Mental Health (Northern Ireland) Order 1986 (“the 1986 Order”) will be repealed for anyone over the age of 16. To manage the commencement of the Act, the 1986 Order will initially be kept for all and a dual system will exists with both the 1986 Order and the Act providing statutory frameworks for DoL.

7.2. During phase 1 of the Act, the 1986 Order will continue to operate alongside the Act. Therefore, if a person would normally be detained under the 1986 Order, then the 1986 Order framework must be applied.

Requirements under the Act when the measure is detention amounting to DoL

7.3. To be protected from liability when depriving a person of his or her liberty there must always be a reasonable belief of lack of capacity and best interests. A number of additional safeguards must also be in place. These include:

   a. formal assessment of capacity (see 0);

   b. nominated person (see Chapter 9);

   c. prevention of serious harm condition (see below); and
d. authorisation (see below, Chapter 11 and Chapter 12).

7.4. The flowchart at the end of the chapter provides an overview on the process of detention amounting to DoL.

7.5. When a deprivation of liberty occurs, or is ended, information must also be provided to P and to other persons. At the end of this chapter there is an outline of what information must be provided and when.

**Prevention of serious harm condition**

7.6. The prevention of serious harm condition (“POSH”) requires the person carrying out the detention amounting to DoL to believe that failure to detain P would create a risk of serious harm to P or risk of serious physical harm to others. In addition the likelihood of harm and the seriousness of the harm must be proportionate to the detention.

7.7. Depriving a person from his or her liberty is a limitation of their human rights which may have a significant impact on their day to day life, mental state and their future life chances. The inclusion of POSH recognises this and the purpose is to ensure that P is not deprived of his or her liberty arbitrarily and that the detention is proportionate.

7.8. When determining if POSH is satisfied only the circumstances that are relevant to the case may be considered. When considering if there is risk of serious harm to P, all available factors can be considered, including harm to others with resulting harm to P (see paragraph 6.32).
7.9. When considering POSH in relation to serious physical harm to others two limbs of the test can be devised. The first considers the reality of the harm. When making this consideration only violent acts towards others and acts that put other persons in reasonable fear of serious physical harm can be taken into account. For example, if P in conversation with a professional expresses a threat of serious harm to a third person (“X”) and X is not aware of threat, the conversation cannot be used when considering the first limb of the test as X has not been put in reasonable fear or harm.

7.10. The threat of harm where no one has been put in fear can be used when considering the second limb of the test; the likelihood and seriousness of the harm. On presumption that there has been some past violence or people placed in fear, the contemporary threat is relevant to the likelihood and seriousness of harm. There is no limitation on the type of evidence that may be used for the second limb of POSH.

7.11. It is important to note that anyone that is made aware of expressed threats of harm to others can report this, using existing procedures, such as contacting the police.

Authorisation

7.12. Authorisation for a detention amounting to DoL can be sought in two ways under the Act; trust panel authorisation (under schedule 1 of the Act - see Chapter 11) or short-term detention authorisation in hospital for examination or examination followed by treatment or care (under schedule 2 of the Act – see Chapter 12). A trust panel authorisation can last for a
maximum of 6 months and may be extended, initially for six months and then for one year at a time (see Chapter 13). A short-term detention authorisation can last for a maximum of 28 days. Any authorisation can be challenged at the Review Tribunal (see Chapter 15).

7.13. It is important to note that a short-term detention authorisation can only authorise the detention of P in a hospital. A short-term detention authorisation cannot be used in any other setting. A short-term detention authorisation must also include an element of examination, or examination followed by other treatment and care.

7.14. An authorisation under the Act is not a power to detain a person. It is part of the system of safeguards which must be in place for the protection from liability to apply. If, at any time during a detention amounting to DoL, any of the conditions (lack of capacity, best interests, POSH and availability of care and treatment in the place of detention) are no longer met the detention amounting to a deprivation of liberty must end. That means that a person carrying out an act of DoL must have reasonable belief of lack of capacity and best interests and must know that the additional safeguards are in place to be protected from liability. The existence of an authorisation is not, in itself, sufficient to protect that person.

Discharge from detention

7.15. As noted above, when any of the conditions (lack of capacity, best interests, POSH or the availability of care and treatment in the place of detention) are no longer met the detention must end. In such circumstances
can be **discharged from detention**. The discharge is a formal end of the authorisation. After a person has been discharged from detention the authorisation that was relied upon cannot be relied upon again, even if there is time left on the authorisation. If a new detention amounting to deprivation of liberty is required after a discharge a new authorisation must be sought. On the other hand, if a person has not been discharged from detention the authorisation is still valid, even if the person has not been continually subject to a DoL.

7.16. **When P is discharged from detention he or she must be notified of the discharge in writing on Form 21.** Any person P has asked to be informed must also be notified. There is no requirement to notify the NP of P’s discharge, as it would be expected that in the event of a discharge P in most cases would have regained capacity and sharing such information can only be done with P’s consent.

**Emergencies**

7.17. In an emergency situation a detention amounting to DoL can be done without all of the safeguards being in place. The safeguards of formal assessment of capacity, nominated person and authorisation can be delayed if the risk of harm to P of waiting outweighs the risk of harm to P of carrying out the detention amounting to DoL without the safeguards. The additional safeguard of **POSH must always be applied**. See Chapter 10 on what constitutes an emergency.

7.18. In some circumstances it may be appropriate to rely on the emergency provisions for a longer time as not to do
so would create an unacceptable risk of harm to P. If there is a need to deprive a person of his or her liberty and a short-term detention authorisation is not possible the emergency provisions allowing detention amounting to DoL without authorisation may be relied upon while an application is made for a trust panel authorisation and until the trust panel has reached a decision. Whether the situation is an emergency or not fully depends on the individual circumstances of the particular situation. The criteria for detention amounting to DoL and emergency have to be met at all times and P’s human rights must always be under consideration. If the emergency provisions are relied upon the safeguards must be put in place as soon as possible; an application to the trust panel must be made without undue delay.

7.19. An example of this may be where P is a resident in a care home and P’s condition has drastically changed in a way that P now lacks capacity and would be at risk of serious harm to self if not detained. A short-term detention is not possible as P is not in hospital and waiting for a trust panel authorisation would create an unacceptable risk of harm to P. As long as all other safeguards are met P may be detained using the emergency provisions while a trust panel authorisation is applied for and a decision is made.

7.20. Another example of this may be where P is an in-patient in hospital, subject to a short-term detention and is due to be discharged into a care home. It has been determined that it is in P’s best interests to be subject to a DoL in the care home. At the time of the discharge it has not been possible to make an application and get trust panel authorisation. If it would be best for P to be discharged from hospital and
admitted into the care home it would normally cause an unacceptable risk of harm for P to remain in hospital. The emergency provisions can then be used to ensure that there is no delay in the discharge from hospital.

**In what setting does the Act allow a DoL?**

7.21. A trust panel authorisation must specify where P will be detained and it can only be a place or places where care or treatment is available to P. This may be in a hospital, a care or nursing home, day centre, respite facility, any other health or social care setting or in a private home. If no care or treatment is available for P in that place, a detention amounting to a DoL cannot lawfully be carried out there.

7.22. An emergency detention amounting to DoL must also be in a place or places where care or treatment is available for P.

7.23. A short-term detention authorisation can only authorise a detention in a hospital. This may be a hospital managed by an HSC trust or an independent hospital as defined in Part 3 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

**Taking, and retaking, a person to a place of detention amounting to DoL**

7.24. P can be taken to the place where a detention amounting to DoL is to be carried out if there is an authorisation for the detention, or reliance on emergency provisions if appropriate.
7.25. P can be taken to the place where he or she can be deprived of his or her liberty for the first time. P can also be taken back to the place if he or she has left the place (whether with permission or not). This can happen even if P resists and force can be used.

7.26. The Act puts no limitations on who can take P to a place of DoL. This may be a family member, a health and social care worker including staff in the ambulance service, a police officer or anyone else.

**Permission for absence**

7.27. If P is subject to a detention amounting to DoL he or she may get permission from the person depriving P of his or her liberty to be absent from the place where the DoL is taking place. There are no formalities around permission for absence as a DoL authorisation is not a power. If the person(s) caring for P believe it to be in P’s best interests to be absent such absence should be allowed. There are no time limits to permission for absence.

7.28. When P is absent with permission, conditions can be imposed on P, even if those conditions in themselves amount to a DoL. However, such conditions can only authorise a related DoL for up to seven days after which a separate authorisation is required. This applies to both short-term detentions and trust panel authorisations.

7.29. Permission for absence and DoL requirements when a person is absent can be used when a person must be taken to a different place than where the DoL normally takes place. This can include when a person who is normally resident in a nursing home and is subject to a
DoL authorised by trust panel has to go to hospital for treatment. The first seven days in hospital is covered by the trust panel authorisation. A new authorisation is only required from day eight onwards. Similarly a person may be subject to short-term detention in hospital but is transferred to a different hospital for a short period of time (for example to undergo treatment). For the first seven days of this period the person is covered by the original short-term detention authorisation.

7.30. Acts can also be done to ensure that P complies with the conditions and, if required and appropriate, P may be recalled, with force if necessary, to the place where he or she is detained.

7.31. No conditions can be imposed on P if P has left Northern Ireland and protection from liability in the Act cannot be relied upon for acts done in other jurisdictions. However, statutory provisions in other jurisdictions may provide remedies for persons who lack capacity in those places.

**Restraint**

7.32. Restraint and detention amounting to DoL are closely interlinked as it relates to compulsory limitations to a person’s liberty. Restraint is not covered by the first phase commencement of the Act. However, restraint that is ongoing, planned or regular will most likely become DoL.

7.33. The interface between restraint and DoL can sometimes be overlapping. For example bed rails may be used to prevent a person falling out of bed, but they will be removed if the person wants to leave. In this
case it is restraint. However, if the bed rails are used to prevent the person leaving it is a DoL.

7.34. In general, if the act is short-term, reactive and for a particular purpose it is most likely restraint. If it is long-term, planned and general limitations to the person it is most likely DoL. For example, a person who is being restrained to receive a particular treatment is most likely subject to restraint. However, when the specific treatment is finished, and the person is still restrained, it is most likely a DoL.

Disregard of certain detentions

7.35. Whilst the disregard of a detention is of most interest and direct relevance to P, it is useful to note that in some circumstances a person who has in the past been subject to a DoL does not have to declare such detentions. To qualify the detention must:

   a. have been a short-term detention in hospital under emergency provisions or a short-term detention authorised by a short-term detention authorisation; and
   
   b. not have continued as a trust panel authorisation in hospital at the end of the initial short-term detention.

7.36. If a person qualifies he or she can disregard the detention when declaring previous health matters in all circumstances apart from in judicial proceedings. Therefore a person cannot be punished for failing to disclose such detention and the failure to disclose cannot be used for dismissal or for excluding a person
from any office, profession, occupation or employment.

7.37. It may be prudent and helpful to advise P of this fact as a point of reassurance in the event that they may have concerns with any perceived implications of being deprived of their liberty.

**Information to be provided in relation to deprivation of liberty**

7.38. When a person is detained in circumstances amounting to deprivation of liberty it is important that he or she is aware of what is happening. P, the NP and others P wants to be informed must be kept informed on what is happening.

7.39. In particular, when P is detained, even if the situation is an emergency and no authorisation has yet been made, **P, the NP and anyone P has asked to be informed must immediately be notified that P is detained, under what provisions of the Act P is detained, P’s rights under the Act and information about the Review Tribunal.** The information must be in writing and must be approved by the Department. However, the information can be generic and take the form of leaflets or general guidance.

7.40. When P is **discharged from detention**, P and anyone P has asked to be informed must immediately be notified that P is discharged from detention. This notification must be made on **Form 21**.

7.41. Information about detention and discharge from detention must be provided in writing and orally to P.
7.42. At all steps of the authorisations processes P, and others, must also be kept informed. This relates to applications for trust panel authorisations and trust panel extension authorisations, trust panel decisions, short-term detention authorisations and extension reports. A table of all requirements for information, and who must be informed can be found below.

<table>
<thead>
<tr>
<th>Event</th>
<th>Who to be informed</th>
<th>What information</th>
<th>How to inform</th>
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<td>• Under what provisions P is detained</td>
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<td>• Anyone P has asked to be informed</td>
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<td>• P</td>
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<td><strong>Application for trust panel authorisation or trust panel extension authorisations</strong></td>
<td><strong>Application</strong></td>
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<td>Decision by trust panel</td>
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<td>Authorisation is provided</td>
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<td>• NP</td>
<td>• The managing authority</td>
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<td>• Anyone P has asked to be informed</td>
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<td>Actor/Extension</td>
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<td>Role</td>
<td>Additional Information</td>
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<tr>
<td>Authorisation</td>
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<td>Form 7 statement is made</td>
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<td>Notification</td>
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<td>P</td>
<td>Notification of extension</td>
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<td>Extension report</td>
<td>NP</td>
<td>A person’s rights under the Act</td>
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<tr>
<td>Extension report</td>
<td>Anyone P has asked to be informed</td>
<td>Information on the Review Tribunal</td>
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<td>Extension report</td>
<td>The managing authority</td>
<td>Information to facilitate the DoL</td>
<td>Trust specific</td>
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<tr>
<td>Form 7 statement is made</td>
<td>Attorney General</td>
<td>Notification</td>
<td>Notification with all information</td>
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</tbody>
</table>
Flowchart 1 - Deprivation of Liberty

Deprivation of Liberty
- A person is subject to DoL if he or she is under continuous control and supervision and not free to leave.

Can the Mental Health Order be used to detain the person?
- If it can the DoLS cannot be used.

Is the situation an emergency?
- A person can be deprived of liberty whilst some safeguards are in the process of being put in place if it would cause an unacceptable risk of harm to wait for the safeguards.

Does P lack capacity?
- P must lack capacity.
- Form 1 must be completed.

Is the DoL in P’s best interests?
- The DoL must be in P’s best interests.
- A NP must be in place and consulted (if practicable and appropriate) when considering best interests.
- Form 2 must be completed.

Is POSH met?
- POSH must be met at all times.
- Evidence of POSH must be on Form 2 and 6.

Is there an existing DoL authorisation?
- A person can be deprived of liberty in a different place from an existing authorisation for up to 7 days without a new authorisation.

Is the DoL in hospital?
- If it is, a short-term detention authorisation must be used if possible.

Short-term detention in hospital:
- An authorisation on Form 8 must be made.
- Form 8 must include Forms 1, 2 and 6 and Forms 7 and 9 if required.

Trust panel authorisation:
- An application for trust panel authorisation on Form 5 must be made.
- Form 5 must include Forms 1, 2, 4 and 6 and Form 7 if required.
Chapter 8. **FORMAL ASSESSMENT OF CAPACITY**

**Introduction**

8.1. The first additional safeguard required for a DoL is a formal assessment of capacity. This chapter outlines when a formal assessment of capacity is required, what a statement of incapacity is, who can carry out a formal assessment of capacity and what to do about disagreements. A flowchart outlining the process for a formal assessment of capacity is attached at the end of the chapter.

**Formal assessment of capacity**

8.2. If a DoL is proposed to be carried out in relation to a person who lacks capacity ("P") a formal assessment of capacity must be carried out and a statement of incapacity provided for the protection from liability to apply.

8.3. A formal assessment of capacity has to be carried out recently enough prior to the DoL being carried out. In the application process for a DoL the formal assessment of capacity can be relied upon for the whole authorisation period. However, if there is any indication or suspicion that the person has regained capacity at any point during the authorisation period a **new capacity assessment must be made**.

8.4. Capacity is time and decision specific and it would often therefore not be appropriate to rely on old capacity
assessments. Although, previous experience and knowledge of P may help in the understanding and assessment if P now lacks capacity.

8.5. A formal assessment of capacity consists of the same elements of assessment as a determination of capacity (see Chapter 5). The difference is when carrying out a formal assessment of capacity a statement of incapacity must be provided and the professions of persons who can carry out the assessment are regulated by law.

**Statement of incapacity**

8.6. A statement of incapacity is a statement in writing by the person who carried out the formal assessment of capacity, recording who carried out the assessment and when, certifying that, in the opinion of the assessor, P lacks capacity in relation to the DoL and specifying which part of the functional test P is unable to do and how it is connected to the impairment or disturbance element. The statement must also certify that help and support have unsuccessfully been given to P to help him or her make the decision.

8.7. In relation to a DoL, a Statement of incapacity form (Form 1) must be completed and included in:

a. an application for trust panel authorisation;

b. an extension report;

c. an application for trust panel extension authorisation; and

d. a short-term detention authorisation report.
8.8. To be protected from liability the person carrying out the act must be able to show how he or she had reasonable belief that P lacks capacity.

Who can carry out a formal assessment of capacity?

8.9. A formal assessment of capacity and a statement of incapacity may be carried out by the following people:

   a. social worker;
   b. medical practitioner;
   c. nurse or midwife;
   d. occupational therapist;
   e. speech and language therapist;
   f. dentist; and
   g. practitioner psychologist.

8.10. In addition, a person carrying out a formal assessment of capacity must have received training on formal capacity assessments approved by the Department of Health within the 36 months immediately prior to the assessment taking place, must have at least two years’ experience in working with persons who lack capacity and must be designated by his or her employer as a person to carry out formal assessments of capacity.

What if the person refuses to cooperate?

8.11. No one can be forced to participate in an assessment of capacity. Where P refuses to participate, efforts should be made to understand their reasoning and provide
support and information to encourage their participation.

8.12. If P still refuses to participate, it may still be possible to establish a reasonable belief regarding their capacity as long as reasonable steps to establish P’s capacity in relation to the DoL have been taken. These steps may include, for example, previous contact and discussions with P, P’s medical history and diagnosis, and discussions with P’s carers and others involved in the care and treatment of P.

8.13. If someone refuses to open the door to their home or refuses to attend an appointment, force may not be used. In very serious circumstances it may be possible to obtain a warrant to enter premises to assess the person (see Chapter 18). However, these extreme measures should only be used in exceptional circumstances.

8.14. P’s refusal to participate in an assessment of their capacity must never in itself be used as the basis for a conclusion that P lacks capacity.
Is the situation an emergency?
• A person can be deprived of liberty without a formal assessment of capacity if it would cause an unacceptable risk of harm to wait for the safeguard.

Has the time and place of the decision been considered and has the person been supported to make the decision by themselves?
• A person must be given all practicable help and support.

The functional test:
• Is the person unable to:
  • understand the decision?
  • retain the information long enough?
  • appreciate and use and weigh the information?
  • communicate the decision?

The impairment or disturbance test:
• In your opinion does the person have an impairment of, or disturbance in the functioning of, mind or brain?
• It does not matter if it is permanent or temporary.
• There is no need for a formal diagnosis.

Causal link:
• Is the person unable to make a decision because of an impairment of, or disturbance in the functioning of, mind or brain?

The person lacks capacity.
• A statement of incapacity can be made.
• Form 1 must be used.
Chapter 9. NOMINATED PERSON

Introduction

9.1. The Act requires a nominated person (“NP”) to be consulted when the best interests are considered in relation to a DoL. Under the Act, the person who lacks capacity (“P”) is empowered to choose and appoint a NP, if P has capacity to do so.

9.2. This chapter provides more detail on NP; the role and functions of the NP under the Act, the formalities for appointment and how the safeguard will work in practice.

What is a nominated person?

9.3. A NP is a person aged 16 or over. The NP is not a decision maker but has an important role to play in safeguarding P’s best interests regarding a DoL. The NP must be consulted if it is practicable and appropriate to do so and, where P is subject to an authorisation, the NP can, in some circumstances, apply to the Tribunal on behalf of P for a review of that authorisation.

9.4. Where a DoL is being proposed, D will not be protected from liability unless a NP has been consulted, if it would be practicable and appropriate to consult with the NP.

9.5. The only exception to the requirement of consulting with the NP is if the situation is an emergency (see Chapter 10). If waiting to put in place or consult with the NP would create an unacceptable risk of harm to P the act can be done without a NP. However, the NP should be involved as soon as possible.
9.6. The consultation with the nominated person should normally be included on Form 2 – best interests statement and Form 6 – medical report. This is as both those forms must include a consideration of best interest. As the NP should be consulted as part of the best interests determination the details of the NP must be noted on the Forms where this is considered. In some circumstances the NP is consulted outside these processes. For such circumstances an additional form (Form 3 – consultation with NP) has been provided. However, it should be noted that Form 3 is for guidance only.

Appointment of nominated person by P

9.7. In most circumstances the NP is taken from a default list. However, where P has capacity to do so, he or she can appoint any person aged 16 or over to be his or her NP by making an appointment in writing. Capacity is decision specific, so even if P does not have capacity regarding the DoL they may have capacity to appoint a NP. The NP can be appointed at any time and the appointment is valid until revoked or until the NP resigns. When a NP is appointed by P it must be recorded in P’s notes or care plan and the appointment document should be retained.

9.8. The NP’s agreement to being NP must be in writing and is required either prior to the appointment document being made, in which case the appointment takes effect as soon as the document is made; or at the same time as, or after, the document is made, in which case the appointment takes effect as soon as the agreement is given. If the NP is taken from the default list there is no need to have agreement in writing from the NP.
9.9. The NP may resign as P’s NP at any time, by giving notice in writing to P.

9.10. Where a person has capacity (and is aged 16 or over), he or she can also make a declaration that a certain person or persons are not to be his or her NP. The declaration can also be revoked if the person has capacity to do so.

Formalities

9.11. Any appointment (creation of appointment document), revocation, declarations or revocation of declaration by P in relation to NP must be:

a. in writing and signed by P; and

b. witnessed by person who certifies that in his or her opinion:

   (1) P understands the effect of the appointment, revocation or declaration;

   (2) P has not been subjected to any undue pressure in making that appointment, revocation or declaration; and

   (3) where relevant, that P understands that the appointment of the NP may result in personal information, including sensitive personal information, being disclosed to the NP.

9.12. A person can act as a witness if he or she lives in Northern Ireland, is not the nominated person and is unconnected to P. That means the person cannot:
Figure 5 - Unconnected with in relation to nominated persons

9.13. A person who is physically unable to sign a document can still make an appointment, revocation or declaration. If this is the case an addition sheet should be added by a person unconnected with P, stating that P is unable to sign and that in the opinion of the person making the declaration P has capacity to make the decision. The statement needs to be signed and witnessed by one additional person, also unconnected with P.

9.14. There are no requirements on what form an appointment, revocation, declaration or revocation of declaration can take. A form (Form 22) is provided for guidance.

Appointment by the Review Tribunal

9.15. In some circumstances the Review Tribunal can appoint a NP. This is where:

   a. the person who is P’s NP is not suitable to act as NP;

   b. there is no-one who falls within the categories on the default list;

   c. it is not practicable to establish whether there is a NP; or

   d. P has a NP, but it is not practicable to establish who that is.
9.16. A qualifying person can apply to the Review Tribunal to appoint a person to take on the role of NP. A qualifying person is:

a. a healthcare professional that is qualified to make formal assessments of capacity;

b. the managing authority of a hospital or care home where P is currently residing;

c. an attorney under an enduring power of attorney;

d. any relative of P; or

e. any person interested in P’s welfare.

9.17. If the applicant is a healthcare professional or the managing authority the applicant must also send a copy of the application to the Regulation and Quality Improvement Authority (“RQIA”) as soon as practicable.

9.18. When determining if a person is to be considered not suitable to act as a NP, consideration may be given to whether the person has behaved, is behaving or proposes to behave in a way that is not in P’s best interests.

9.19. A person appointed as NP by the Tribunal may resign as NP by giving notice in writing to that effect to P.

9.20. If the Tribunal has appointed a NP and P then regains capacity to make decisions about who should be the NP, P may at any time while he or she has capacity to do so, apply to the Tribunal for revocation of the appointment. The Tribunal must then make an order revoking the appointment unless it considers that P no longer has capacity to make decisions about who should be his or her nominated person.
9.21. If P or the Review Tribunal has not appointed a NP one is selected from the default list. The person who falls highest up the list is P’s default NP, as long as he or she is over 16 and is not to be disregarded as a result of a declaration by P or an order by the Review Tribunal.

9.22. A carer is someone who is aged 16 or over and is not under a contract of employment, or any other contract with any person in relation to P, or as a volunteer for a voluntary organisation.

9.23. If there are two or more persons falling within the same category, the default NP will be the oldest of the persons. However, if falling within the same category,
whole blood relationships are to be preferred over half-blood or step relationships regardless of age. Adoptive children or parents are to be treated as whole blood children or parents.

9.24. The person can refuse the role by giving notice in writing to P. That person can withdraw the notice of decline by giving a further notice in writing to P.

Mistakes

9.25. There may be circumstances where D proceeds with the intervention on the mistaken but reasonable belief that a particular person is the NP, when in fact, the NP is someone else. D will be protected from liability as long as all reasonable steps were taken to establish the identity of the NP.

Difficulties in establishing if there is a NP

9.26. Other than in an emergency, D is not protected from liability in proceeding with a deprivation of liberty without having a NP in place simply because he cannot establish who the NP is or believes that P has no NP. An application should be made to the Tribunal to have a NP appointed.
Chapter 10. EMERGENCIES

Introduction

10.1. When a person who lacks capacity (‘P’) is to be deprived of liberty, additional safeguards are required before the protection from liability (see Chapter 4) can be relied upon. This is to ensure that P’s rights are protected.

10.2. The Act provides that in some circumstances waiting until all the required safeguards are met would create an unacceptable risk of harm to P and thus waiting would risk greater harm to P than the risk of doing the act without the safeguards. It may then be possible to rely on the emergency provisions under the Act. This chapter sets out what emergency under the Act is and when it can be used. At the end of the chapter a flowchart provides an outline of the emergency provisions.

Safeguards and conditions that cannot be disregarded

10.3. For the protection of liability to apply in relation to DoL there must always be a reasonable belief of lack of capacity and the care arrangements being in P’s best interests, even if the situation is an emergency. If there is not a reasonable belief of lack of capacity and best interests D will never be protected from liability.

10.4. The prevention of serious harm (POSH) condition must also always be met when a DoL is carried out, even when the situation is an emergency.
Emergency

10.5. Emergency has a specific meaning for the purposes of the Act. For a situation to be an emergency there does not have to be a crisis and the place of the emergency is irrelevant; it may be in an Emergency Department, but it may also be in a care home, in a private house or anywhere else where an act must be done for P.

10.6. For a situation to be an emergency two conditions have to be met:

   a. that D knows that an additional safeguard is not met, or that D does not know whether the safeguard is met; and

   b. waiting until the safeguard is met, or waiting to establish if the safeguard is met, would create an unacceptable risk of harm to P.

10.7. What is unacceptable risk of harm to P depends on the circumstances in the individual situation. In general, a risk is unacceptable if the seriousness of the harm of waiting and the likelihood of that harm is such as to outweigh the risk of harm to P in not complying with the safeguard.

10.8. An emergency does not require the harm to be serious or physical; it can be a relatively minor harm and it can be psychological, financial or any other kind of harm. Normally, if an act has been deemed in P’s best interests it would mean an unacceptable risk of harm to P if the act is not carried out.

10.9. **Purposefully delaying an additional safeguard for any other reason than risk of harm to P is not acceptable.** If any safeguard is not met for any reason other than emergency the protection from liability does not apply
and D may be held responsible in Court for his or her actions. **If there is no risk of harm to P by delaying the DoL to ensure that the safeguards are in place then the DoL cannot be done until the safeguards are in place.**

10.10. If the DoL is carried out without a relevant safeguard using the emergency provisions the safeguard must be put in place as soon as it is practicable. **Any delay** in securing the safeguard may mean that the protection from liability cannot be relied upon and D may be held responsible in Court for his or her actions.

### Additional safeguards that can be disregarded in emergency

10.11. The emergency provisions apply to a number of, **but not all**, the additional safeguards required in relation to a DoL. Safeguards that can be disregarded in an emergency include:

a. formal assessment of capacity;

b. the requirement to put in place and consult a nominated person;

c. authorisation (by either trust panel or for short-term detention) for deprivation of liberty; and

d. authorisation to take a person to a place for a deprivation of liberty.

10.12. Circumstances amounting to emergency may allow one, or more, of the above safeguards to be delayed to avoid creating an unacceptable risk of harm to P. It is important to note that just because it would create an unacceptable risk of harm to P to wait for one of the safeguards **it does not mean that all safeguards can be delayed.**
10.13. For example, DoL requires a formal assessment of capacity, nominated person and authorisation. It may be that not detaining P in circumstances amounting to a DoL while waiting for a trust panel authorisation (who have up to 7 working days to make a decision after receiving the application), would create an unacceptable risk of harm to P but waiting a number of hours while the other safeguards are met would not. In such a situation, if all the safeguards were ignored D would not be protected from liability, whereas he or she would be protected if the formal assessment of capacity and nominated person safeguards were met.

10.14. Another example of this may be where P is an in-patient in hospital, subject to a short-term detention and is due to be discharged into a care home. It has been determined that it is in P’s best interests to be subject to a DoL in the care home. At the time of the discharge it has not been possible to make an application and get trust panel authorisation. If it would be best for P to be discharged from hospital and admitted into the care home it would normally cause an unacceptable risk of harm for P to remain in hospital. The emergency provisions can then be used to ensure that there is no delay in the discharge from hospital.

10.15. Emergency provisions can also be used to transport a person. This may be for example when a person is in his or her family home and it is deemed that the person should be taken to hospital. It is the view of the professionals at the home that the person meets the criteria for detention, but there is no one qualified to make a short-term detention authorisation available. The person can then be transported to hospital in circumstances amounting to DoL without an
authorisation as long as the persons doing the transportation have a reasonable belief of lack of capacity, best interests and POSH. This equally applies if a person is in a public space and needs to be taken to hospital (and the place of safety provisions in the Mental Health Order cannot be used) or any other setting.

**Medical reports in emergency situations**

10.16. When creating a medical report for the purpose of DoL (be it in regard to an application for trust panel authorisation, short-term detention authorisation, or any other short-term detention reports or trust panel extension authorisation requirements) the nominated person must be consulted if it is practical and appropriate to do so.

10.17. If the situation is an emergency and waiting to complete the medical report until a nominated person is in place would create an unacceptable risk of harm to P, the medical report can be made without a nominated person being consulted.
Are all the additional safeguards met?
• If all the additional safeguards are met the situation is not an emergency.

Would delay applying the additional safeguard(s), or delay to determine if the additional safeguard(s) are in place, cause an unacceptable risk of harm to P?
• If there is no unacceptable risk of harm to P the situation is not an emergency.

Are as many additional safeguards as possible in place?
• It may still be possible to apply some of the additional safeguards.

If all attempts have been made to put the additional safeguards in place but waiting would cause an unacceptable risk of harm to P the situation is an emergency.
• The additional safeguards should be put in place as soon as possible.
Chapter 11. TRUST PANEL AUTHORISATION

Introduction

11.1. A DoL requires the additional safeguard of authorisation. This can be either through a trust panel or a short-term detention authorisation. This chapter sets out the process for a trust panel authorisation.

11.2. During phase 1 of the Mental Capacity Act, the Mental Health (Northern Ireland) Order 1986 will continue to operate alongside the Act. Therefore, if a person can be detained under the 1986 Order, then the 1986 Order framework must be applied.

What is a trust panel authorisation?

11.3. A trust panel authorisation is a process where an application for deprivation of liberty is made to a trust who, in turn, appoints a panel to consider the case. The panel must make a decision within seven working days of the trust receiving the application. Chapter 14 provides details on how the trust panel works. At the end of the chapter a flowchart provides an overview of the trust panel authorisation process.

11.4. If the situation is an emergency (see Chapter 10) a DoL can go ahead before an authorisation is in place, if the criteria and all relevant safeguards have been met. In such cases, the person must, as soon as is practicable, ensure that an authorisation is applied for. What is practicable will differ depending on the individual
circumstances but must be without undue delay. It is unlikely that a period of more than 24 hours without an application for authorisation being started is practicable.

11.5. A trust panel authorisation can be made without first making a short-term detention authorisation. However, if a short-term detention authorisation (see Chapter 12) can be done this must be the first option considered. A trust panel authorisation cannot be granted if a short-term detention authorisation can be made.

Criteria for authorisation

11.6. The criteria for authorisation of a DoL are as follows:

   a. lack of capacity;
   
   b. best interests;
   
   c. appropriate care or treatment is available in the place; and
   
   d. prevention of serious harm condition.

The process of applying for a trust panel authorisation

Who can apply?

11.7. An application to the panel for authorisation can be made by anyone who can make a formal assessment of capacity and is involved in the care or treatment of P; this does not have to be the person who has done the formal assessment of capacity in the particular instance. This includes:
a. a social worker;
b. a medical practitioner;
c. a nurse or midwife;
d. an occupational therapist;
e. a practitioner psychologist;
f. a dentist; and
g. a speech and language therapist

11.8. In addition the person making the application cannot be the same person who provides the medical report and must be unconnected with P. That means that the person cannot:

- receive payments on behalf of P
- be a close relative of P
- be living with P as if a spouse or civil partner for at least six months
- be living with P for at least five years

**Figure 7 - Unconnected with in relation to trust panel applications**

**Form of application**

11.9. An application for trust panel authorisation must be made on Form 5 and include:

a. name and address of P, P’s date of birth and health and social care number (where available);

b. name of the applicant and work details;

c. name and contact details for the person responsible for P’s care or treatment, if different than the applicant;

d. details about the deprivation of liberty; and
e. annexes consisting of:

A. statement of incapacity on Form 1 (see 0);
B. best interests determination statement on Form 2 (see below)
C. care plan on Form 4;
D. medical report on Form 6 (see below);
E. statement whether P has capacity to decide to apply to the Review Tribunal on Form 7 (see below).

11.10. The application must be signed and dated by the applicant. The application must be made and sent to the relevant trust where the proposed DoL is to take place.

**Best interests determination statement**

11.11. A best interests determination must follow the best interests steps (see Chapter 6). A best interests determination statement must be made on Form 2, stating that, in the opinion of the person making the determination, all the relevant factors have been considered and all relevant people consulted. The statement must include details about:

a. the options available including what they are and explanation of the least restrictive option;

b. reasons why the deprivation of liberty may not be in P’s best interests;

c. P’s views on the options;

d. the person’s past and present wishes, feelings, beliefs and values;
e. information about the nominated person and his or her views (if practical and appropriate);

f. the opinions of others that have been consulted, who has been consulted, what their views are and how any disagreements have been dealt with;

g. all relevant circumstances including the social circumstances and views of carers and social workers where their involvement is relevant to the decision; and

h. anything else that is relevant to the decision.

Medical report

11.12. The application must contain a medical report made by a medical practitioner who is unconnected with P. The medical practitioner who makes the report must have examined P no more than two days before making the report and cannot be the same person as made the application. The medical report must be made on Form 6 and include:

a. the name, date of birth, address and health and social care number of P (where available);

b. the name of the medical practitioner and a statement that he or she is unconnected with P;

c. information about the nominated person;

d. how the criteria for authorisation are met (care and treatment available in the place, POSH, lack of capacity and best interests); and

e. a statement noting that in the medical practitioner’s opinion the criteria for authorisation are met.
11.13. The medical practitioner must examine P before making the medical report. If practicable and appropriate the medical practitioner must also consult the nominated person when considering if the DoL is in P’s best interests. If the nominated person has been consulted as part of the best interests determination and not expressed strong views to be consulted by the medical practitioner as well, it is usually not practicable and appropriate to consult with the nominated person when making the medical report.

11.14. When the medical practitioner is making the statement that, in his or her opinion, the criteria for authorisation are met he or she can rely on information provided by others, if he or she is of the opinion that this information is factually accurate and adequate. The medical practitioner does not have to repeat all the information that is in the annexes to the application and can reference them without having to make copies.

11.15. For example, the medical practitioner can rely on the best interests determination carried out by others and trust that the information provided in the determination is factually correct. As long as the medical practitioner is satisfied that the steps carried out to reach the determination were adequate and sufficient, he or she can rely on this to inform his or her opinion.

Care plan

11.16. The application must also include a care plan detailing the care and treatment that is to be provided to P. The care plan must detail what will happen to P during the DoL. The care plan must be made on Form 4.
11.17. When making an application to the panel in relation to a DoL the person making the application must consider if P has the capacity to make a decision whether to apply to the Review Tribunal or not in respect of a panel authorisation. If it is the opinion of the applicant that P does not have such capacity a statement noting this must be noted on Form 7 and be included in the application.

11.18. P can lack capacity to decide on his or her care arrangements, perhaps because of an inability to appreciate particular risks, but still have capacity to decide whether an application should be made to the Review Tribunal for an independent check on the Trust panel authorisation.

11.19. The determination of capacity only relates to the decision on whether or not to apply to the Tribunal. P does not need to have the ability to make an application to the Review Tribunal without help or to conduct the case before the Tribunal.

11.20. The distinction is important. This assessment relates to the capacity to decide whether an application should be made or not. Even if P does not have capacity to understand the details of the Tribunal process, P may still have capacity to decide whether or not to apply for an independent check on care arrangements that amount to a deprivation of liberty.

11.21. The level of decision making ability required in relation to a Tribunal application is in most cases likely to be less than that needed to make a decision about the care arrangements which are being authorised. This is because the decision making process does not, on the
whole, involve weighing information about risk. Other than Tribunal staff and members accessing personal information on confidential basis, there are unlikely to be any negative impacts or risks associated with applying to the Review Tribunal. There is less information for P to appreciate and weigh in the balance.

11.22. If P is able to understand

a. that the care arrangements mean that someone will always be checking on him or her;

b. that he or she cannot leave when he or she wishes to leave; and

c. that a meeting can take place to decide whether or not that should be allowed

then it is likely that P has the capacity to apply to the Review Tribunal.

11.23. P may express strong wishes in relation to the place where the DoL takes place. This is not a matter for the DoL authorisation or an issue that can be determined by the Tribunal. **The Tribunal’s remit relates only to the care arrangements that amount to a DoL; not the place of the DoL or any other issues in relation to the care, treatment or personal welfare of P.**

11.24. If P has capacity whether an application should be made to the Tribunal the statement on Form 7 does not need to be made and a Form 7 should not be filled out. If a Form 7 is filled out and the statement made the Attorney General must be notified if the panel authorises the decision. This will allow the Attorney General to refer the case to the Review Tribunal for consideration.
Trust panel decision

11.25. If the panel considers that the criteria for the intervention are met it must authorise the DoL. If an authorisation is provided the DoL can be carried out, as long as all the other required safeguards are in place and that the criteria for the authorisation are met throughout the authorised period of the DoL.

11.26. If the panel considers that there is a good prospect of it being established that the criteria for authorisation are met but that it would not be possible to provide a final answer within seven working days the panel can provide an interim authorisation which is valid for up to 28 days, by which point the panel must provide a final decision. For example, this may be when the panel wants more information or wants to speak to someone in person.

11.27. **It is important to note that an authorisation under the Act is not a power to act.** It is part of the system of safeguards and conditions which must be in place for the protection from liability to apply. If, at any time during the intervention, any of the safeguards or conditions are no longer met the DoL must end.

11.28. If the panel considers that the criteria for authorisation are not met the panel must not provide an authorisation. If the panel does not provide an authorisation the DoL cannot lawfully be done. Any person carrying out the DoL would not be protected from liability and could be subject to both civil and criminal proceedings.

11.29. The Review Tribunal can review the decision by the panel to authorise the intervention, on application by P or P’s nominated person if P lacks capacity as to
whether an application should be made (or only with P’s consent if he or she has capacity).

**Information in relation to trust panel applications and authorisations**

11.30. As soon as an application for a trust panel authorisation has been received by a trust or the panel has made a decision to grant or refuse an application, information must be provided using Forms 17 and 18. This is in addition to general information regarding the detention, see chapter 7.

11.31. When an application is made P, the NP and any person P has asked to be nominated must be notified on Form 17 and provided with information about the procedures of the panel and the person’s rights under the Act. When a decision has been made the same persons must be notified on Form 18 about the decision and the person’s rights under the Act. If the panel has authorised the deprivation of liberty information about the Review Tribunal must also be provided.

11.32. In addition, the person making the application must always be notified of the outcome of the panel decision and if the deprivation of liberty is authorised the managing authority must also be notified.

11.33. If the person lacks capacity whether to apply to the Tribunal, the AG must be provided with all the information in relation to the deprivation of liberty.
Can the Mental Health Order be used to detain the person?
• If it can the DoLS cannot be used.

Is the situation an emergency?
• A person can be deprived of liberty whilst some safeguards are put in place if it would cause an unacceptable risk of harm to wait for the safeguards.

Does P lack capacity and is the DoL in P's best interests?
• The NP must be consulted and information provided on Form 2 (if practicable and appropriate).
• Forms 1 and 2 must be completed.

Has a medical report been completed?
• The medical practitioner must examine P no more than 2 days before making the report.
• The report must be made on Form 6.

An application can be made for trust panel authorisation.
• The application must be made on Form 5.
• Forms 1, 2, 4 and 6 must be included.
• If P lacks capacity whether to apply to the Tribunal a Form 7 must also be included.

Trust panel authorisation:
• The trust panel has 7 working days from receipt of application to make a decision.

Trust panel decision:
• granting authorisation - 6 months
• refusing authorisation - no DoL can take place
• interim authorisation - 28 days
Chapter 12. SHORT-TERM DETENTION AUTHORIZATION

Introduction

12.1. This chapter sets out the process for a short-term detention authorisation as provided in Schedule 2 of the Act.

12.2. During phase 1 of the Mental Capacity Act, the Mental Health (Northern Ireland) Order 1986 will continue to operate alongside the Act. Therefore, if a person can be detained under the 1986 Order, then the 1986 Order framework must be applied.

What is a short-term detention authorisation?

12.3. A short-term detention authorisation authorises detention amounting to a deprivation of liberty in hospital for the purpose of examination or examination followed by treatment. The short-term detention authorisation can authorise the detention for up to an initial 14 days which can be extended for another 14 days. At the end of the chapter a flowchart provides an overview of the short-term detention authorisation process.

12.4. It is important to note that a short-term detention authorisation authorises detention in hospital only. It cannot be used in any other setting.

12.5. A short-term detention authorisation must also include an element of examination, or examination followed by treatment and care. It is not possible to use a short-
term detention authorisation to authorise detention for the sole purpose to protect P from serious harm to self or serious physical harm to others.

12.6. A short-term detention must always be the preferred option. **If a short-term detention can be made the trust panel cannot authorise a deprivation of liberty under schedule 1 of the Act.**

12.7. A short-term detention authorisation can be appealed to the Review Tribunal by P or by P’s nominated person if P lacks capacity whether an application should be made (or with P’s consent where they have capacity).

12.8. **An authorisation under the Act is not a power to act.** It is part of the system of safeguards and conditions which must be in place for the protection from liability to apply. If at any time during the intervention *any* of the safeguards or conditions are no longer met the intervention must end.

**Persons involved in a short-term detention authorisation**

12.9. A short-term detention authorisation provides that certain persons have rights and duties which must be carried out for the detention to be lawful:

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<tr>
<th>position</th>
<th>requirements</th>
<th>role in short-term detention authorisation</th>
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<tbody>
<tr>
<td>alternative medical practitioner</td>
<td>• not in charge of P’s care in hospital; • must be qualified to be a responsible medical practitioner.</td>
<td>• make exception certificate if responsible medical practitioner is unavailable; • examination on</td>
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<tr>
<td><strong>Appropriate Health Care Professional</strong></td>
<td><strong>Must be an approved social worker; or</strong></td>
<td><strong>Must be a medical practitioner, social worker, nurse or midwife, dentist, occupational therapist, speech and language therapist or psychologist that is designated by the managing authority of the hospital, that has training and has two years experience in the last 10 years working with people who lack capacity.</strong></td>
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<td><em>must be an approved social worker; or</em></td>
<td><strong>authorise a short-term detention authorisation;</strong></td>
<td><strong>must be consulted if the nominated person</strong></td>
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<td><strong>assess if P lacks capacity whether to make a decision to apply to Review Tribunal in respect of the authorisation and provide a statement of this effect to the Attorney General if relevant; and</strong></td>
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<td></td>
<td><strong>provide information to relevant persons upon authorisation.</strong></td>
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<th><strong>Approved Social Worker</strong></th>
<th><strong>Must be appointed by a HSC trust in</strong></th>
<th><strong>Must be consulted if the nominated person</strong></th>
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<th><strong>Admission if responsible medical practitioner not available; and</strong></th>
<th><strong>Make a further report if the responsible medical practitioner is unavailable.</strong></th>
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<td>Objects to the intervention (even if the appropriate healthcare professional is an approved social worker); and</td>
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<td>• can be the appropriate healthcare professional.</td>
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<th>registered person within the meaning of the Medical Act 1983 and who holds a license to practice.</th>
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<td>• make medical report (to be attached to short-term detention authorisation); and</td>
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<td>• examination on admission if responsible medical practitioner and alternative medical practitioner not available – this requires a further admission report within 48 hours.</td>
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<td>• in charge of P’s examination and treatment;</td>
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<tr>
<td>• make exception certificate;</td>
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<td>• make examination on admission; and</td>
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<td>• make a further report.</td>
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<th>responsible medical practitioner</th>
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<td>• make exception certificate;</td>
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Criteria for authorisation

12.10. An appropriate healthcare professional can authorise short-term detention by making a short-term detention authorisation. When making the authorisation the person must be satisfied that the criteria for authorisation are met. The criteria are that:

a. P has an illness or there is reason to suspect that P has an illness;

b. the prevention of serious harm condition is met (see Chapter 7);

c. P lacks capacity in relation to the detention (see Chapter 5); and

d. it would be in P’s best interests to be detained (see Chapter 6).

12.11. Illness is defined as a disorder, disability or injury that requires treatment or nursing if it, or any of its symptoms or manifestations, could be alleviated or prevented from worsening by treatment or nursing. This could be either a physical illness or a mental illness and it does not matter if the illness is expected to be temporary or permanent.
The process of making a short-term detention authorisation

Who can make a short-term detention authorisation?

12.12. A short-term detention for examination or examination followed by treatment or care can be authorised by the making of a report by an appropriate healthcare professional. To be an appropriate healthcare professional the person must be:

a. an Approved Social Worker (“ASW”); or

b. a person who:

   (1) is a healthcare professional;

   (2) is designated by the managing authority of the admitting hospital as a person who may make short term detention authorisations;

   (3) have successfully completed relevant training as approved by the Department;

   (4) has two years’ experience in the last 10 years in a professional role working with person who lack capacity; and

   (5) has the skills necessary to obtain, evaluate and analyse complex evidence and differing views and to weight them appropriately in decision making.

12.13. The person making the report cannot be the same person who undertook the formal assessment of capacity and made the statement of incapacity relevant to the short term detention. They must also be different from the person who made the medical report included in the authorisation (although that individual can do both the medical report and the
formal assessment of capacity if appropriate), and they must be unconnected with P. That means the person cannot:

Figure 8 - Unconnected with in relation to short-term detentions

12.14. The person making the report must have personally seen P not more than two days prior to making the short term authorisation.

12.15. It is intended that where possible an ASW should make the report authorising the short term detention. However another healthcare professional who meets the criteria in paragraph 12.12 can carry out this role and make the report.

12.16. It is important to note that the short term detention authorisation relates to the detention (deprivation of liberty) only. It does not authorise treatment.

Form of short-term detention authorisation

12.17. A short-term detention authorisation must be made on Form 8. The form must include:

a. P’s name, address, date of birth and health and social care number (if available);

b. name of the person making the short-term detention authorisation, that the person meets the professional requirements and the requirement to be unconnected with P;
c. name and address of the person in charge of P’s care (if known);
d. the hospital where the detention will take place;
e. what examination or examination followed by treatment that will take place; and
f. annexes consisting of:
   A. statement of incapacity on Form 1 (see 0);
   B. best interests determination statement on Form 2 (see below);
   C. medical report on Form 6 (see below);
   D. statement whether P has capacity to decide to apply to the Review Tribunal on Form 7 (see below); and
   E. approved social worker information on Form 9 (see below).

Best interests determination statement

12.18. A best interests determination must follow the best interests steps (see Chapter 6). A best interests determination statement must be made on Form 2, stating that, in the opinion of the person making the determination, all the relevant factors have been considered and all relevant people consulted. The statement must include details about:

   a. the options available including what they are and explanation of the least restrictive option;
   b. reasons why the deprivation of liberty may not be in P’s best interests;
   c. P’s views on the options;
d. the person’s past and present wishes, feelings, beliefs and values;

e. information about the nominated person and his or her views (if practical and appropriate);

f. the opinions of others that have been consulted, who has been consulted, what their views are and how any disagreements have been dealt with;

g. all relevant circumstances including the social circumstances and views of carers and social workers where their involvement is relevant to the decision; and

h. anything else that is relevant to the decision.

Approved social worker information

12.19. If the nominated person provides a reasonable objection to the short-term detention, a short-term detention authorisation cannot be made unless an approved social worker has been consulted. If this is the case Form 9 must be filled in. The requirement to consult with an approved social worker exists even if the person making the short-term detention authorisation is an approved social worker, in which case another approved social worker must be consulted.

Medical report

12.20. The authorisation must contain a medical report made by a medical practitioner who is unconnected with P. The medical practitioner who makes the report must have examined P no more than two days before making
the report. The medical report must be made on Form 6 and must include:

a. the name, date of birth, address and health and social care number of P (where available);

b. the name of the medical practitioner and a statement that he or she is unconnected with P;

c. information about the nominated person;

d. how the criteria for authorisation are met (care and treatment available in the place, POSH, lack of capacity and best interests); and

e. a statement noting that in the medical practitioner’s opinion the criteria for authorisation are met.

12.21. When the medical practitioner is making the statement that, in his or her opinion, the criteria for authorisation are met he or she can rely on information provided by others when forming their opinion, if he or she is of the opinion that this information is factually accurate and adequate. The medical practitioner does not have to repeat all the information that is in the annexes to the authorisation but can reference them without having to make copies.

12.22. For example, the medical practitioner can rely on the best interests determination carried out by others (as provided on Form 2). As long as the medical practitioner is satisfied that the steps carried out to reach the determination were adequate and sufficient, he or she can rely on this to inform his or her opinion.

12.23. The medical practitioner must examine P before making the medical report. If practicable and appropriate the medical practitioner must also consult
the nominated person when considering if the DoL is in P’s best interests. If the nominated person has been consulted as part of the best interests determination and not expressed strong views to be consulted by the medical practitioner as well, it is usually not practicable and appropriate to consult with the nominated person when making the medical report.

Statement of incapacity whether to apply to Tribunal

12.24. When making a short-term detention authorisation report the person making the report must consider if P has the capacity to make a decision whether to apply to the Review Tribunal or not in respect of the authorisation. If it is the opinion of the author that P does not have such capacity a statement noting this must be noted on Form 7 and be included in the authorisation. This is to enable the decision to be reviewed at an early stage even when P lacks the capacity to decide to apply for such a review.

12.25. P can lack capacity to decide on his or her care arrangements, perhaps because of an inability to appreciate particular risks, but still have capacity to decide whether an application should be made to the Review Tribunal for an independent check on the authorisation.

12.26. The determination of capacity only relates to the decision on whether or not to apply to the Tribunal. P does not need to have the ability to make an application to the Review Tribunal without help or to conduct the case before the Tribunal.

12.27. The distinction is important. This assessment relates to the capacity to decide whether an application should
be made or not. Even if P does not have capacity to understand the details of the Tribunal process, P may still have capacity to decide whether or not to apply for an independent check on care arrangements that amount to a deprivation of liberty.

12.28. The level of decision making ability required in relation to a Tribunal application is in most cases likely to be less than that needed to make a decision about the care arrangements which are being authorised. This is because the decision making process does not, on the whole, involve weighing information about risk. Other than Tribunal staff and members accessing personal information on confidential basis, there are unlikely to be any negative impacts or risks associated with applying to the Review Tribunal. There is less information for P to appreciate and weigh in the balance.

12.29. If P is able to understand

a. that the care arrangements mean that someone will always be checking on him or her;

b. that he or she cannot leave when he or she wishes to leave; and

c. that a meeting can take place to decide whether or not that should be allowed

then it is likely that P has the capacity to apply to the Review Tribunal.

12.30. P may express strong wishes in relation to the place where the DoL takes place. This is not a matter for the DoL authorisation or an issue that can be determined by the Tribunal. The Tribunal’s remit relates only to the care arrangements that amount to a DoL; not the
place of the DoL or any other issues in relation to the care, treatment or personal welfare of P.

12.31. If P has capacity whether an application should be made to the Tribunal the statement on Form 7 does not need to be made and a Form 7 should not be filled out. If a Form 7 is filled out and the statement made the Attorney General must be notified. This will allow the Attorney General to refer the case to the Review Tribunal for consideration.

Information on making a short-term detention authorisation

12.32. As soon as practicable after making a short-term detention authorisation the person authorising the detention must provide a copy of Form 19 ("Notification of Short-term Detention") to P, the NP, any persons P has asked the information to be given to, the managing authority of the hospital and if a Form 7 has been filled out (that P lacks capacity as to whether an application should be made to the Review Tribunal), the Attorney General.

The process of a short-term detention

12.33. If, when a short-term detention authorisation is made, P fulfils all the criteria for detention, P can be detained. If, at any time during the detention, P no longer meets the criteria for detention, P must be discharged from detention. Also, if there are any unreasonable delays in any decision making, the authorisation is terminated and the detention must end. What is unreasonable depends on the circumstances but for any delay to be
reasonable there must be good reasons and the reasons must be noted.

12.34. A timeline outlining the steps in a short-term detention can be found below.

![Timeline for short-term detentions]

**Figure 9 - Timeline for short-term detentions**

*Reports during a short-term detention for examination or examination followed by treatment or care*

12.35. There are a number of reports required during a short-term detention, all which have prescribed forms:

<table>
<thead>
<tr>
<th>report name</th>
<th>when is report required</th>
<th>purpose of report</th>
</tr>
</thead>
<tbody>
<tr>
<td>short-term detention authorisation on Form 8</td>
<td>before detention.</td>
<td>authorising a short-term detention for examination or examination followed by treatment or care. Note, this must include a separate medical report (Form</td>
</tr>
<tr>
<td><strong>medical report</strong> Form 6</td>
<td>within 2 days of examining P but before the short-term detention authorisation is made.</td>
<td>must be included in the short-term detention authorisation; provides evidence that the criteria for detention are met.</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>exception certificate</strong> Form 10</td>
<td>before admission (if required and appropriate).</td>
<td>delaying the admission to hospital allowing the admission to be up to 14 days after the short-term detention authorisation is made.</td>
</tr>
<tr>
<td><strong>admission report</strong> Form 11</td>
<td>immediately on admission.</td>
<td>confirming that the criteria for detention are met.</td>
</tr>
<tr>
<td><strong>further admission report</strong> Form 12</td>
<td>within 48 hours of the admission report if the admission report is done by a medical practitioner, rather than a responsible medical practitioner or alternative medical practitioner.</td>
<td>confirming that the criteria for detention are met.</td>
</tr>
<tr>
<td><strong>further report</strong> Form 13</td>
<td>within 14 days beginning with the date of admission.</td>
<td>authorising the continued detention after the initial 14 days.</td>
</tr>
<tr>
<td><strong>notification of short-term detention</strong> Form 19</td>
<td>Immediately upon completion of short-term detention authorisation (Form 8)</td>
<td>notifying P and others that a short-term detention has been authorised.</td>
</tr>
</tbody>
</table>
Admission

12.36. If P is not already an in-patient in hospital when the short-term detention authorisation is being made, P must be admitted to hospital no later than two days after the medical report has been made. If the responsible medical practitioner or alternative medical practitioner believes there to be exceptional circumstances to delay the admission an exception certificate on Form 10 can be made allowing the admission to be delayed by up to 12 days (i.e. admission can take place up to 14 days after the medical report is made).

12.37. An exception certificate can be used where there are exceptional circumstances. This may include where the whereabouts of P are unknown and P cannot be found to be admitted within 2 days. Rather than having to make a new medical report and short-term detention authorisation an exception certificate may be used to delay the admission.

Examination on admission

12.38. Immediately upon admission, or if already an in-patient in hospital as soon as the short-term detention authorisation is made, P must be examined by the responsible medical practitioner, the nominated person must be consulted (by the person making the admission report) and an admission report on Form 11 must be made. The admission report must be made on Form 11 and include a statement that:
a. failure to detain P for the purposes of examination or care would create a risk of serious harm to P or of serious physical harm to other persons;

b. the detention is proportionate to the likelihood of harm and the seriousness of the harm;

c. P lacks capacity in relation to the detention; and

d. it would be in the best interests of P to be detained.

12.39. If the responsible medical practitioner is not available another person who meets the criteria for being a responsible medical practitioner, but who is not in charge of the person’s care (“the alternative medical practitioner”), can make the examination, consult with the nominated person and make the admission report.

12.40. If neither the responsible medical practitioner nor the alternative medical practitioner are available a medical practitioner who is a member of staff at the hospital may make the admission report. In this instance a further admission report on Form 12 by the responsible medical practitioner or by an alternative medical practitioner must be made within 48 hours of the admission report being made. The further admission report must contain the same information as the admission report.

12.41. Both the admission report and further admission report must include the statement noted above and must also include:

a. the name and date of birth of P and P’s home address before detention;
b. the name of the person making the admission report and a statement that he or she is unconnected with P;

c. if the person is the responsible medical practitioner, the alternative medical practitioner or a normal medical practitioner;

d. a statement of incapacity;

e. how the criteria for authorisation are met; and

f. how the nominated person has been consulted.

12.42. Failure to make an admission report, and a further admission report if required, within the required time frame means that the authorisation is terminated and P must no longer be deprived of liberty. If the admission report, and further admission report if one is required, is supporting the detention P can be detained for a maximum of 14 days, beginning with the day of admission. However, if at any time any of the criteria for detention are not met P must not be deprived of liberty (but may remain in the setting voluntarily).

Extension of detention

12.43. After the initial 14 days the authorisation for a short-term detention may be extended for 14 days if P still meets the criteria for detention, the nominated person has been consulted and a further report on Form 13 has been made. The further report can be made by the responsible medical practitioner, or by an alternative medical practitioner, before the end of the initial 14 days if P is still detained. The further report must be made on Form 13 and include a statement that:
a. failure to detain P for the purposes of examination
   or care would create a risk of serious harm to P or
   of serious physical harm to other persons;

b. the detention is proportionate to the likelihood of
   harm and the seriousness of the harm;

c. P lacks capacity in relation to the detention; and

d. it would be in the best interests of P to be
   detained.

12.44. The further report must include information on how
   the nominated person has been consulted by the
   person making the report and also include the same
   information as the admission report and further
   admission report above.

12.45. If a further report is made for P the authorisation is
   valid for 14 days beginning with the day after the date
   of the further report. At the end of the further 14 days
   the short-term detention must be ended and P must be
   discharged from detention unless there are any other
   statutory provisions for detention, such as a trust panel
   authorisation for deprivation of liberty under schedule
   1 of the Act.

12.46. Normally it would not be acceptable to rely on the
   emergency provisions to continue a deprivation of
   liberty at the end of a short-term detention
   authorisation. As the short-term detention
   authorisation is valid for up to 28 days there is
   sufficient time to apply for a trust panel authorisation
   before the short-term detention lapses.
Flowchart 5 - Short-term Detention in Hospital

1. **Can the Mental Health Order be used to detain the person?**
   - If it can, the DoLS cannot be used.

2. **Is the situation an emergency?**
   - A person can be deprived of liberty whilst some safeguards are put in place if it would cause an unacceptable risk of harm to wait for the safeguards.

3. **Does P lack capacity and is the DoL in P’s best interests?**
   - The NP must be consulted and information provided on Form 2 (if practicable and appropriate).
   - Forms 1 and 2 must be completed.

4. **Has a medical report been completed?**
   - The medical practitioner must examine P no more than 2 days before making the report.
   - The report must be made on Form 6.

5. **Is the NP objecting to the DoL?**
   - If the NP is objecting, an ASW must be consulted even if an ASW is making the authorisation.
   - Form 9 must be completed.

6. **A short-term detention authorisation can be made.**
   - It is intended where possible that an ASW completes the authorisation.
   - Form 8 must be completed.
   - If P lacks capacity whether to apply to the Tribunal, a Form 7 must be included.

7. **P must be admitted within 2 days of Form 8.**
   - Admission can be delayed - Form 10 must be used.
   - If P is not admitted, the authorisation terminates.
   - If P is not given all relevant information, the detention terminates.

8. **Has an admission report been completed?**
   - Must be completed immediately on admission.
   - Form 11 must be used.
   - Failure to complete Form 11 terminates the detention.

9. **Was the admission report completed by the RMP or AMP?**
   - If not, a further admission report must be completed within 2 days.
   - Form 12 must be used.
   - Failure to complete Form 12 (if required) terminates the detention.

10. **P can be detained for 14 days.**

11. **Is the detention continuing after 14 days?**
    - A further report is required.
    - Form 13 must be used.
    - Failure to complete Form 13 terminates the detention after the initial 14 days.

12. **The detention terminates after the further 14 days (28 days in total).**
Chapter 13. EXTENSIONS

Introduction

13.1. This chapter sets out the process for extension authorisations and trust panel extension authorisations.

Extensions

13.2. An authorisation (either a trust panel authorisation, extension authorisation or a trust panel extension authorisation) that has not been revoked can, before it comes to an end, be extended. A short-term detention authorisation cannot be extended beyond 28 days. The reason for extension can be (but not limited to) that it would be appropriate to continue the DoL e.g. P has dementia and is detained in a care home to prevent P from serious harm and the initial six month authorisation is coming to an end without any changes to P’s condition.

13.3. Depending on the circumstances extensions can either be done by making an extension authorisation report or by applying to the trust panel for a trust panel extension authorisation. An initial extension (either by an extension authorisation report or by a trust panel extension authorisation) can extend the authorisation for six months and any further extension can extend the authorisation for one year. A flow-chart at the end of the chapter provides an overview of the extension processes.
Extension authorisation (extension by the making of a report)

13.4. A trust panel authorisation can be extended by the making of a report for six months in the first instance if the trust panel authorisation has not been revoked and has not come to an end. Subsequent extensions can be made by the making of a report for one year as long as the extended authorisation has not been revoked and has not come to an end. This type of extension is called extension authorisation.

13.5. An extension authorisation must be made in the case of the first extension in the last month of the current authorisation and in the case of a subsequent extension in the last two months of the current authorisation. The extension authorisation must be made by an appropriate medical practitioner.

13.6. An extension authorisation must be made on Form 14 and must contain:

   a. P’s name, address, date of birth and health and social care number (if known);

   b. name, address and professional role of the person making the extension authorisation;

   c. if it is the first or a subsequent extension;

   d. the length of the extension;

   e. details about the deprivation of liberty;

   f. details of the criteria for continuation (availability of care and treatment, prevention of serious harm condition, lack of capacity and best interests);

   g. information on opinion of the responsible person; and
h. annexes consisting of:
   A. statement of incapacity on Form 1 (see 0);
   B. best interests determination statement on Form 2 (see below);
   C. care plan on Form 4;
   D. statement whether P has capacity to decide to apply to the Review Tribunal on Form 7 (see below); and
   E. responsible person statement on Form 15 (see below).

**Best interests determination statement**

13.7. A best interests determination must follow the best interests steps (see Chapter 6). A best interests determination statement must be on Form 2, stating that in the opinion of the person making the determination all the relevant factors have been considered and all relevant people consulted. The statement must include details about:

   a. the options available including what they are and explanation of the least restrictive option;

   b. reasons why the deprivation of liberty may not be in P’s best interests;

   c. P’s views on the options;

   d. the person’s past and present wishes, feelings, beliefs and values;

   e. information about the nominated person and his or her views (if practical and appropriate);
f. the opinions of others that have been consulted, who has been consulted, what their views are and how any disagreements have been dealt with;

g. all relevant circumstances including the social circumstances and views of carers and social workers where their involvement is relevant to the decision; and

h. anything else that is relevant to the decision.

Statement of Incapacity whether to apply to Tribunal

13.8. When making an extension report the person making the report must consider if P has the capacity to make a decision whether to apply to the Review Tribunal or not in respect of the extension. If it is the opinion of the author that P does not have such capacity a statement noting this must be noted on Form 7 and be included in the report. This is to enable the decision to be reviewed at an early stage even when P lacks the capacity to decide to apply for such a review.

13.9. P can lack capacity to decide on his or her care arrangements, perhaps because of an inability to appreciate particular risks, but still have capacity to decide whether an application should be made to the Review Tribunal for an independent check on the Trust panel authorisation.

13.10. The determination of capacity only relates to the decision on whether or not to apply to the Tribunal. P does not need to have the ability to make an application to the Review Tribunal without help or to conduct the case before the Tribunal.
13.11. The distinction is important. This assessment relates to the capacity to decide whether an application should be made or not. Even if P does not have capacity to understand the details of the Tribunal process, P may still have capacity to decide whether or not to apply for an independent check on care arrangements that amount to a deprivation of liberty.

13.12. The level of decision making ability required in relation to a Tribunal application is in most cases likely to be less than that needed to make a decision about the care arrangements which are being authorised. This is because the decision making process does not, on the whole, involve weighing information about risk. Other than Tribunal staff and members accessing personal information on confidential basis, there are unlikely to be any negative impacts or risks associated with applying to the Review Tribunal. There is less information for P to appreciate and weigh in the balance.

13.13. If P is able to understand

a. that the care arrangements mean that someone will always be checking on him or her;

b. that he or she cannot leave when he or she wishes to leave; and

c. that a meeting can take place to decide whether or not that should be allowed

then it is likely that P has the capacity to apply to the Review Tribunal.

13.14. P may express strong wishes in relation to the place where the DoL takes place. This is not a matter for the DoL authorisation or an issue that can be determined by the Tribunal. The Tribunal’s remit relates only to
the care arrangements that amount to a DoL; not the place of the DoL or any other issues in relation to the care, treatment or personal welfare of P.

13.15. If P has capacity whether an application should be made to the Tribunal the statement on Form 7 does not need to be made and a Form 7 should not be filled out. If a Form 7 is filled out and the statement made the Attorney General must be notified. This will allow the Attorney General to refer the case to the Review Tribunal for consideration.

**Responsible person**

13.16. The responsible person must make a statement on Form 15 that in their opinion that the criteria for continuation are met. The statement must include the words:

“In my opinion, based on the balance of probabilities, the criteria for continuation of the specified measure are met”

13.17. The statement must also include:

a. specifics of the deprivation of liberty,

b. name and address of the responsible person;

c. how the responsible person has met the requirements to be a responsible person;

d. how, in the opinion of the responsible person, the criteria for extension has been met; and

e. signature and the date the statement was made.

13.18. The responsible person must be suitably qualified to make a formal assessment of capacity (see 0), although
they must not be the person who has made the formal assessment of capacity in this particular case. The person must also be:

a. an approved social worker who is involved in the care or treatment of P if the care and treatment where the approved social worker is involved is relevant to the measure sought; or

b. a person designated by the managing authority in the hospital or care home where P is an in-patient or resident or by the Trust in the area where P is deprived of liberty.

13.19. The responsible person must also be unconnected with P. Being unconnected means that the person cannot:

- receive payments on behalf of P
- be a close relative of P
- be living with P as if a spouse or civil partner for at least six months
- be living with P for at least five years

**Figure 10 - Unconnected with in relation to extensions**

13.20. If the responsible person does not agree that the criteria for continuation are met, he or she should still fill out Form 15 and outline why. However, it is important that in such cases the responsible person does not sign the statement at the end of the form.

**Information when making an extension authorisation**

13.21. When an extension authorisation is made the trust in which the DoL will take place must notify P, the Nominated Person; anyone P has asked to be notified. The notification must use Form 20. In addition the
managing authority must also be notified of the making of the report.

13.22. If the extension includes a statement that P lacks capacity as to whether an application should be made to the Tribunal (Form 7) in relation to the extension the Attorney General must be notified of this by the person making the extension authorisation.

**Extension by trust panel authorisation**

13.23. If the responsible person does not agree that the criteria for continuation are met, an extension authorisation by report cannot be made. However, an application can be made under Schedule 3 to the trust for a trust panel to decide whether an extension should be authorised. This is called a **trust panel extension authorisation**.

13.24. The process to apply for a trust panel extension authorisation is the same as the process for a trust panel authorisation application (see Chapter 11) and the panel will operate in the same way (see Chapter 14) with the exception that the panel cannot provide interim authorisations in respect of extensions.

13.25. To apply for a trust panel extension authorisation Form 16 must be used. The information in the application form is the same as for a trust panel authorisation (see Chapter 11) with the exception the application must note if it is a first or subsequent application and what the views of the responsible person are, including the statement by the responsible person (Form 15).

13.26. When an application for a trust panel extension authorisation is made and when the trust panel has
made a decision the trust panel must notify a number of different people using Form 17 and Form 18.

Lapsing of authorisation

13.27. If an authorisation of any kind, including trust panel authorisation, extension authorisation or trust panel extension authorisation, has lapsed it cannot be extended and there is no grace period to “redetain” the person. In such cases a new application for trust panel authorisation has to be made.
Is there a trust panel authorisation?
• A short-term detention authorisation cannot be extended.

Is the trust panel authorisation valid?
• A lapsed or ended trust panel authorisation cannot be extended.

Is the responsible person of the opinion that the criteria for continuation are met?
• If yes, an extension report can be made.
• If no, an application to trust panel can be made

Extension report:
• Form 14 must be completed.
• Forms 1, 2, 4 and 15 and Form 7 if required must be included.

Application to trust panel for extension:
• Form 16 must be completed.
• Forms 1, 2, 4, 6 and 15 and Form 7 if required must be included.
Chapter 14. TRUST PANELS

Introduction

14.1. A trust panel authorisation and trust panel extension authorisation can only be made by a panel appointed by a HSC trust. This chapter provides an outline what the role of the panel is, who can sit on the panel and how the panel works.

The role of the trust panel

14.2. The trust panel’s purpose is to provide a further opinion on the facts surrounding the deprivation of liberty to ensure that the criteria for authorisation are met.

14.3. The panel’s role is more than administrative and it makes determinations on the facts in the case and decides if the authorisation should be granted. A panel is constituted for a specific decision and is not a standing panel.

Membership of the panel

14.4. A trust panel must consist of three members appointed by the HSC trust in which it will operate. The panel must consist of:

   a. one medical practitioner;
   b. one approved social worker; and
   c. one other healthcare professional.
14.5. All three panel members must be suitably qualified to make formal assessments of capacity (see 0) and must have received panel specific training in the 12 months prior to first sitting on a panel. There are no requirements for recurrent training. The members must also not be involved in P’s care or treatment and be unconnected with P. That means they must not:

- receive payments on behalf of P
- be a close relative of P
- be living with P as if a spouse or civil partner for at least six months
- be living with P for at least five years

Figure 11 - Unconnected with in relation to trust panels

How the panel works

14.6. When a HSC trust receives an application for a trust panel authorisation or a trust panel extension authorisation it must convene a panel and appoint one of the members as chair of the panel. All panel members must be present during any proceedings.

14.7. The panel must make a decision, as soon as practicable, to grant or refuse the authorisation or to issue an interim authorisation. It must in any event make its decision no later than 7 working days from receipt of the application (beginning with the working day it is received). If the application is not received on a working day then the time runs from the first working day after that. There are no exceptions to this timeline; the panel must make a decision within seven working days of the trust receiving the application.
14.8. P, P’s nominated person and any other persons P has asked to be notified must be notified as soon as an application has been received by the trust on Form 17.

14.9. When the panel meets all three members must be present. The panel must base its assessment solely on the information provided in the application. If the panel cannot make a unanimous decision a decision can be made by a simple majority.

14.10. The trust panel has a maximum of seven working days to make a decision to grant or refuse the authorisation. If the panel considers that it will not be possible to make a decision within seven working days but there is a good prospect of an authorisation to be granted, an interim authorisation can be granted. An interim authorisation is valid for 28 days. An interim authorisation cannot be granted for trust panel extension authorisations. At the end of an interim authorisation the panel must make a final decision. There are no statutory provisions to extend the interim authorisation further.

14.11. If an authorisation has been refused the DoL which requires an authorisation cannot be done. If the DoL is being done using the emergency provisions (see Chapter 10) the DoL must stop immediately. A person carrying out a DoL when a trust panel has not provided an authorisation for the DoL is not protected from liability and can be held liable in court.

14.12. It is important to note that an authorisation under the Act is not a power to deprive someone of their liberty. It is part of the system of safeguards and conditions which must be in place for the protection from liability to apply. If, at any time during the DoL, any of the
safeguards or conditions are no longer met the DoL must end.

Considerations by the panel

14.13. When the panel meets the role is to determine if the criteria for authorisation are met. If the panel is of the opinion that the criteria are met the panel must authorise the DoL. If the panel is of the opinion that the criteria are not met the panel must refuse to grant the authorisation.

14.14. It is not the role of the panel to examine if forms are filled out correctly or if there are spelling errors. The panel’s duty is to form an opinion as to whether or not, based on the facts presented, there is sufficient evidence to determine if the criteria for authorisation are met.

14.15. The criteria for authorisation are:
   
   a. that care and treatment is available in the place;
   b. POSH
   c. lack of capacity; and
   d. best interests.

14.16. There is no prerequisite for the panel decision that all forms are present, that the right people have made the reports and that timelines have been adhered to. The only consideration that the panel can have is if the criteria for authorisation are met!

14.17. To help and support the panel in the decision making a panel proforma has been created. It can be found in Annex 1 – Forms.
Interim authorisations

14.18. If the panel is of the opinion that there is a good prospect of the criteria are met the panel may authorise an interim authorisation. This lasts 28 days during which time the panel may seek further information to make a decision.

14.19. Within the 28 days the panel can decide to grant an authorisation or refuse to grant an authorisation. If the 28 days lapses the panel can no longer make a final decision and a new application to the trust panel would have to be made.

14.20. A panel is constituted to decide on a case and the panel is constituted until a final decision has been made. That means that the same panel members that authorised the interim authorisation on a case must be reconvened to give their final decision on that case, based on the further information they requested when they granted the interim authorisation. There is also no need to make a new application for the final decision, as the trust panel has yet to arrive at a final decision, further consideration following an interim authorisation is deemed to be part of the original application process.

14.21. An interim authorisation can only be granted if there is a good prospect that the criteria are met. An interim authorisation cannot be granted if the panel is of the opinion that the criteria are met but that there are process errors. If the panel is of the opinion that the criteria for authorisation are met, the panel must authorise the DoL.
**Process errors and missing forms**

14.22. A process error (such as a spelling error or technical error) or a missing form is not in itself a reason why the panel cannot make a decision. If the panel is of the opinion that the criteria for authorisation are met, the panel must authorise the DoL. It is the responsibility of the panel to decide if the error or missing form are of such magnitude that the panel cannot be of the opinion that the criteria for authorisation are met.

14.23. For example, if an application is made to the Trust panel, the person making the application (i.e. the author of Form 5) must consider if the person lacks, or probably lacks, capacity whether an application should be made to the Tribunal. If the author of Form 5 is of the opinion that P does lack such capacity a statement must be included on Form 7.

14.24. The trust panel when considering applications must consider if the criteria for authorisation are met. Having considered the application the panel must either authorise the deprivation of liberty or refuse the authorisation or issue an interim authorisation. After authorising the DoL the panel is of the opinion that a Form 7 should have been included.

14.25. However, the panel when considering the decision should not check if a Form 7 is present. Only after granting an authorisation (or interim authorisation) should the check be done. If, after granting the authorisation, a Form 7 is present the Attorney General should be notified. If there is no Form 7, there is no further action to be taken, even if the panel is of the opinion that a Form 7 should have been included.
14.26. The responsibility whether a Form 7 should be filled out or not lies with the person making the application (Form 5). The panel has no responsibility or authority to fill out a Form 7. The panel, or trust in general, cannot refer a case to the Attorney General if there is no Form 7 included. The panel, or trust, cannot make a Form 7 after the application has been made.

14.27. When considering whether to grant or refuse an application only the criteria for detention can be considered. Inclusion of Form 7 is not a criteria for detention. The lack of Form 7 is therefore not a ground to refuse an authorisation.

14.28. The lack of a Form 7, even if the panel members want to see one, cannot allow the making of an interim authorisation. Interim authorisations can only be provided if it is not possible, based on the information provided, to determine if the criteria for authorisation are met, but that there is a good prospect they may be.

14.29. The inclusion or not of Form 7 does not change the ability to consider the criteria for authorisation (as the consideration of Form 7 can only take place after granting an authorisation). The lack of a Form 7 can therefore not change the outcome of the panel. There is no legal foundation for such decision making.

14.30. In this case, the absence of a Form 7 may be an accountability issue for the professional making the application and should be dealt with using such appropriate mechanisms.
Chapter 15. THE REVIEW TRIBUNAL

Introduction

15.1. Where an authorisation has been granted an application can be made to the Review Tribunal (“the Tribunal”) in respect of the authorisation. This provides a review of the decision to ensure that it has been made in accordance with the law and that the criteria for the authorisation have been met.

What can the Tribunal consider?

15.2. The Review Tribunal can only consider the care arrangements amounting to a deprivation of liberty. A decision to authorise a deprivation of liberty relates only to the care arrangements in the place where the person who lacks capacity is. It does not include where the person should live, the treatment the person should receive or any other aspects of the care or treatment that is not directly relating to a deprivation of liberty. An application, or referral, to the Tribunal can therefore not relate to those aspects of the person’s care and treatment.

15.3. Other aspects of the care and treatment may be of great importance to the person, or to the nominated person. However, during the first phase of commencement of the Mental Capacity Act only aspects relating to deprivation of liberty are included. These other aspects of the care and treatment are not within the remit of the Mental Capacity Act and therefore not within the jurisdiction of the Tribunal.
There are, of course, other methods for the person, and others, to challenge decisions, including seeking declaratory orders from the High Court.

15.4. It is expected that the Tribunal in its consideration utilises those individuals who have made the reports on which the authorisation rests. It is not expected that the trust panel members would have any involvement with the Tribunal or that trust panel members should be called to give evidence. As the trust panel does not have to provide a reason for their decision, involving the panel would only have limited value.

**When can applications be made to the Tribunal?**

15.5. An authorisation in the form of a trust panel authorisation, interim authorisation, trust panel extension authorisation, short-term detention authorisation or an extension authorisation can be taken to the Tribunal for consideration. An application can be made to the Tribunal throughout the full period of the authorisation. If an authorisation has lapsed or been revoked an application cannot be made to the Tribunal.

**Who can make an application to the Tribunal?**

15.6. The person to whom the authorisation relates (“P”) and the nominated person can make an application to the Tribunal. If P has capacity as to whether an application should be made the nominated person can only do so with P’s consent.

15.7. Throughout the period of authorisation the Attorney General, the Department of Health and the Master
(Care and Protection) acting on the direction of the court may refer a case to the Tribunal for consideration.

15.8. If an authorisation has been in force for two years, or one year if P is under 18, and the Tribunal has not considered the case the HSC Trust in which the intervention is taking place must refer the case to the Tribunal for consideration as to whether the authorisation is appropriate.

**Tribunal decisions**

15.9. Upon reaching a decision the Tribunal must either revoke the authorisation or decide to take no action in respect of the authorisation. If it does not revoke the authorisation, it may make recommendations in relation to P.

15.10. A decision by the Tribunal can be appealed on a point of law to the Court of Appeal. Also, as with all decisions by public bodies leave for judicial review can be sought in the High Court.
Chapter 16. CHILDREN AND YOUNG PEOPLE

Introduction

16.1. Whilst the Act applies to 16 and 17 year olds, in some circumstances different rules apply. This chapter sets out where the Act applies to children under 16 and the special rules regarding 16 and 17 year olds. The chapter also provides for when an act is proposed to be done in respect of a person after that person has reached the age of 16 but at the time the act is proposed the person is under 16.

16.2. 16 and 17 year olds are children and are as such afforded special protection under international agreements, including the United Nations Convention of the Rights of the Child.

Age appropriate environment

16.3. If a child who is under 18 is an in-patient in hospital for the purpose of assessment or treatment of a mental disorder the hospital must ensure that the person’s environment in the hospital is suitable to the person’s age. The hospital must consider all relevant factors when determining what environment is suitable. This may include, but is not limited to:

   a. the wishes of the person;
   
   b. the wishes of parents or guardians;
c. the other persons in the environment where the person is;

d. where the person can receive the best care and treatment; and

e. if there is age specific accommodation available.

16.4. The hospital must consult a person who has the knowledge or expertise to help determine if the environment is appropriate for the person’s age. This person may be a parent or relative or it may be a professional, such a social worker.

16.5. The requirement to ensure that the environment is suitable for the person’s needs does not mean that they have to be placed on a dedicated children’s ward. Rather, it requires that all relevant circumstances must be considered when deciding where to place the child; the environment must be suitable to the individual’s needs.

16.6. In most cases this means that the child will be placed on a children’s ward. However, a children’s ward may not always be suitable. Examples of this can be where the available children’s ward is far away and it is more beneficial for child to be closer to family and friends or if a particular, required, expertise is not available on the children’s ward.

Acts proposed before the 16th birthday

16.7. There may be circumstances where a DoL is proposed to be done on behalf of a person after that person has reached the age of 16 but at the time the DoL is proposed the person is under 16. This can be a DoL which will happen immediately after the person’s 16th
birthday, for example it is considered that a 15 year old who is about to turn 16 needs deprived of liberty.

16.8. Immediately on a person’s 16th birthday the Act applies and all safeguards must be in place for DoL to be lawful. To ensure a practical transition for those that are 15 into the Act, the safeguards required for protection of liability can be done in the month before the person’s 16th birthday. This includes:

a. formal assessment of capacity;

b. the requirement to put in place a nominated person; and

c. application to a trust panel for trust panel authorisation.

16.9. It is important to note that protection from liability for a DoL done on behalf of a person who lacks capacity can only be relied upon if the person is 16 or over when the DoL is carried out regardless whether some of the safeguards may have been put in place before the person is 16.

16.10. Although the process for ensuring the safeguards are in place can be started up to a month before the person’s 16th birthday it is important to remember that while a person may lack capacity a month before their 16th birthday, they may have capacity to make the decision when he or she turns 16. Just because it is permissible to put the safeguards in place up to a month before a person’s 16th birthday does not mean it is always appropriate to do so; the individual circumstances must always be considered.
Chapter 17. OFFENCES

Introduction

17.1. The Act creates a number of new criminal offences, which are set out in Part 13. This Chapter provides more detail on what these new offences are and when they will apply.

Ill-treatment or neglect

17.2. Section 267 makes it an offence for a person to ill-treat or wilfully neglect another person where:

a. he or she is caring for the other person and know or believe that the person lacks capacity in relation to matters concerning their care;

b. he or she is an attorney appointed by the person under an enduring power of attorney.

17.3. This offence applies in respect of persons of all ages. For those aged 16 or over, capacity is assessed as set out in the Act. For those under the age of 16, capacity is assessed as per common law and the direction of the Courts. Conviction can result in a fine, prison term or both.

17.4. This offence has two elements, which are separate from each other; ill-treatment and wilful neglect. Ill-treatment occurs when a person deliberately ill-treats another person, or is reckless in a manner that results in ill-treatment of the person. It does not matter whether the behaviour was likely to cause, or actually caused, harm or damage to the victim. Neglect is
defined as conduct that falls below the standards of behaviour for the protection of others against unreasonable risk of harm. The circumstances around cases of wilful neglect will vary, but it will commonly involve a situation where the person has deliberately failed to do something that they knew they had a duty to do.

**Forgery, false statements**

17.5. **Section 268** makes it an offence for anyone to make a false entry or statement in certain documents and makes it an offence to use a false entry or statement in such document with the intent to deceive. Conviction can result in a fine, prison term or both.

17.6. The documents include:

a. a statement of incapacity in a formal assessment of capacity;

b. an extension report; and

c. any documents in relation to trust panel authorisations, short-term detentions or trust panel extensions.

**Unlawful detention of persons lacking capacity**

17.7. **Section 269** makes it an offence for a person to knowingly detain another person (“P”) who is over 16 and lacks capacity, in circumstances amounting to a deprivation of liberty when there is no statutory authority to do so. This means that it is impossible to detain a person who lacks capacity relying on common law or non-statutory procedures.
17.8. A further offence covers the situation where P continues to be detained after the statutory authority has ceased.

17.9. Conviction can result in a fine, prison term or both. No offence under this section is committed where P is under 18 and the detention gives effect to a decision made by a parent or guardian of the person. Nor does this new offence replace or in any way interfere with the common law offence of false imprisonment or any statutory provision allowing for lawful detention of an individual, for example, if P has been arrested.

17.10. The offence of unlawful detention is not commenced with the rest of the provisions on 2 December 2019 but are commenced on 2 December 2020.

Assisting persons to absent themselves without permission

17.11. **Section 270** provides offences relating to assisting someone to absent themselves without permission from a place in which they are liable to be detained in circumstances amounting to a deprivation of liberty under the Act. The three distinct offences cover the following actions:

a. induce or assist P to leave a place where a deprivation of liberty takes place;

b. allow P to stay at his or her place when subject to a deprivation of liberty or prevent P’s return to a place where P will be deprived of liberty (or assist in making this difficult); and

c. help P escape when being transported to a place where P will be deprived of liberty.
17.12. A person can only be guilty of an offence under this section if they know that P is liable to be detained under the Act. Conviction can result in a fine, prison term or both.

17.13. It should be noted that in the above circumstances P is not committing an offence.

**Obstruction**

17.14. In certain circumstances a person may be authorised by the Act to visit, interview or examine a person affected by the provisions of the Act and access records about that person.

17.15. **Section 272** makes it an offence to refuse or obstruct that access, or to refuse to produce related records when requested by the authorised person. The section also makes it an offence for any third person to insist on being present after having been requested to withdraw by the authorised person.

17.16. Conviction can result in a fine, prison term or both.

**Offences by bodies corporate**

17.17. Where an offence has been committed under the Act by a body corporate, e.g. bank, building society, private healthcare company or HSC trust, **section 273** sets out that any director, manager, secretary, or other similar officer of that body is also guilty of the offence if it was done with their consent, they connived in the offence or the offence can be attributed to neglect on their part.
Chapter 18. WARRANTS

Introduction and overview

18.1. Part 15 of the Act provides powers to apply for a warrant to gain access to premises where a person (“P”) who is liable to be detained under the Act in circumstances amounting to a deprivation of liberty (“DoL”) is residing.

18.2. A person who meets the test for DoL and meets the criteria for detention amounting to DoL (see Chapter 2) is liable to be detained. Even if P is currently not detained because he or she is in a place other than where care or treatment is available (for example, this could be a private residence), but would be detained if he or she was in a place where care or treatment is available, P is liable to be detained. Similarly if P meets the criteria for detention amounting to DoL, and there is no authorisation but he or she meets the criteria for emergency (see Chapter 10), P is liable to be detained.

18.3. An application for a warrant can be made to a Magistrates Court by an officer of a HSC Trust or a constable where P is found on any premises to which admission has been refused or refusal of such admission is anticipated. When a warrant has been issued it authorises a constable accompanied by a medical practitioner, and, if appropriate, an approved social worker, to enter the premises and to remove P.

18.4. There must be at all times a reasonable belief that P lacks capacity and that his or her removal would be in P’s best interests. Where P is known this may be clearly evident and possibly previously established. However,
it may be the case that there is adequate evidence to suggest that an unknown person is liable to be detained and it would be in the best interests of that person for authorities to intervene.

**When is a warrant required?**

18.5. A warrant may be required under a number of different circumstances. However, it should be noted that it will always be preferable to gain consent to enter the premises without the use of a warrant. Professionals or others may be able to facilitate discussion and mediation resulting in access being granted without the use of a warrant. In particular, persons with knowledge or previous contact with any individuals involved may aid de-escalation of the situation. This approach should always be considered in the first instance.

**Who applies for the warrant?**

18.6. Where it is clear that access is unlikely to be granted, or has clearly been refused, application for the issuing of a warrant to a lay magistrate is appropriate.

18.7. A constable or an officer of the relevant HSC trust must apply to a court to issue the warrant. It is the responsibility of the constable to execute the warrant. The constable **must** be accompanied by a medical practitioner, and **may** be accompanied by an approved social worker if appropriate.
Details to be included in the application

18.8. The application for the warrant must include as much detail as possible, and in particular specify the reasoning behind the assumption that P is in the premises.

18.9. It may be the case that the name of P is not known, but that there is a justifiable argument to be made that a person who would be liable to be detained is within the premises. This is why a warrant does not necessarily require P to be named. However, where the name of P is known, it must be included in the application.

Actions after warrant issued

18.10. When a warrant has been issued, the constable may take steps to gain access to the premises. The constable and the medical professional, and the approved social worker if appropriate, may enter and make contact with P. An initial assessment of P’s capacity and what would be in his or her best interests should be conducted.

18.11. At this point, it may be possible to ascertain that P does not need to be removed from the premises. However, if appropriate, P may be removed and taken to a place where they are liable to be detained in circumstances amounting to a DoL. Further assessment and treatment can then be provided as appropriate.

Emergencies

18.12. It may be clear that, in some circumstances, to wait for a warrant to be issued would create a risk of harm to
those inside the premises, possibly from violence or injury. In these circumstances the police should be contacted and they may deem it appropriate to gain access to the property under Article 19 Police and Criminal Evidence (NI) Order 1989, or, for example, to prevent a breach of the peace under common law.
## ANNEX A – FORMS

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<td>Form 22</td>
<td>Appointment, revocation, making of a declaration or revoking a declaration in relation to nominated person</td>
</tr>
<tr>
<td>Trust panel proforma</td>
<td>Trust panel proforma</td>
</tr>
</tbody>
</table>
Forms 1 – 2 and 4 – 16 are statutory forms which have been prescribed in the Mental Capacity (Deprivation of Liberty) (No. 2) Regulations (Northern Ireland) 2019. When these forms are referenced they must be used.

Forms 17 – 21 contain statutory information with the contents prescribed in the Mental Health (Deprivation of Liberty) (No. 2) Regulations (Northern Ireland) 2019. The forms do not have to be used but the contents in the forms must be provided to the relevant people at the relevant time.

Forms 3, 22 and the trust panel proforma are provided for guidance, help and support.
Form 1 – Statement of incapacity

A statement of incapacity can only be carried out by a medical practitioner, a nurse, a midwife, a social worker, a dentist, an occupational therapist, a speech and language therapist or a practitioner psychologist who has received specific training in the 36 months prior to making the statement and has 2 years’ experience in working with persons who lack capacity.

The decision maker must ensure that the reasons for making a statement of incapacity are recorded on this form. The supporting evidence can be provided in the person’s care plan or notes in line with professional or agency requirement. It is not necessary to duplicate the supporting evidence on this form but a note should be made of where it can be found.

1. **The person’s details (a label can also be affixed here)**
   
   Name:
   Address:
   Date of Birth:
   HSC number (if known):

2. **The assessors details**
   
   Name:
   Work address:
   Phone number:
   Job title, team and staff number:

3. **Date of formal assessment of capacity**
   
   Date the assessment was carried out:

4. **Support to the person**
   
   Before deciding that someone lacks capacity, all practical help and support must be provided to enable the person to make a decision by themselves. This includes considering the environment and timing of the decision, ensuring that appropriate communication support is provided to the person and involving all relevant people who might help the person make the decision.
Has the environment for the decision been considered? (delete as appropriate)  Yes / No

Has the timing for the decision been considered?  Yes / No

Has all practical help and support, including communication support, been given?  Yes / No

Have all relevant people who may help the person make a capacitous decision been included?  Yes / No

Has the information relevant to the decision been provided and/or explained in a way which is appropriate? For example, in simple language?  Yes / No

Provide details.

Further sheets can be added if required.

5. Three Elements Test of Mental Capacity

Functional test

In relation to the detention amounting to deprivation of liberty, the person in section 1 is unable to understand the information relevant to the care arrangements amounting to a deprivation of liberty. retain that information long enough to make the a decision accepting or refusing the care arrangements deprivation of liberty. appreciate and use and weigh that information. communicate his/her decision (whether by talking or any other means).

Provide details on how the person is unable to do the above and how this has been determined.

Further sheets can be added if required.
Impairment or disturbance test
There is no need for a formal diagnosis, it is sufficient to have reasonable belief that there is an impairment of, or disturbance in the functioning of, the mind or brain.

Provide details on the impairment of, or disturbance in the functioning of, the mind or brain.

Further sheets can be added if required.

Causal link
For a statement of incapacity to be provided there must be a causal link between the inability to make a decision in relation to the detention amounting to a deprivation of liberty and the impairment of, or the disturbance in the functioning of, the mind or brain. If there is no causal link the person does not lack capacity in the meaning of the Mental Capacity Act.

Provide details on the causal link.

Further sheets can be added if required.

6. Decision
If a person is unable to make a decision because they have an impairment of, or disturbance in the function of, the mind or brain a statement of incapacity can be made.

Statement of Incapacity
I certify that __________________________ (name) lacks capacity within the meaning of the Mental Capacity Act (Northern Ireland) 2016 in relation to the care arrangements which amount to a deprivation of his/her liberty and that I am suitably qualified to make a statement of incapacity.

Signature:

Date:
Form 2 – Best interests determination statement

A decision to deprive a person of liberty must be made in the person’s best interests.

The decision maker should ensure that the reasons for this determination are recorded on this form. The supporting evidence can be provided in the person’s care plan or notes in line with professional or agency requirements. It is not necessary to duplicate the supporting evidence on this form but a note should be made of where it can be found.

1. The person’s details (a label can also be affixed here)

   Name:
   Address:
   Date of Birth:
   HSC number (if available):

2. The assessors details

   Name:
   Work address:
   Phone number:
   Job title, team and staff number:
   Professional relationship to person:

3. Checklist

   Have you ensured you have not made assumptions based on the person’s age, appearance, condition or behaviour?
   Yes ☐ No ☐

   Have you considered all the relevant circumstances?
   Yes ☐ No ☐
Have you tried whatever is reasonable and practicable to permit and encourage the person to take part, or to improve their ability to take part, in determining what is the best interests?

Yes ☐ No ☐

**You must have special regard to past and present wishes and feelings and beliefs and values.**

Have you had *special regard* to the person's past and present wishes and feelings (expressed verbally, in writing or through behaviour or habits)?

Yes ☐ No ☐

Have you had *special regard* to any beliefs and values (religious, cultural or moral) and any other factors which would be likely to influence the decision?

Yes ☐ No ☐

Have you considered the human rights of the person?

Yes ☐ No ☐

Have you considered other options that may be less restrictive of the person’s rights?

Yes ☐ No ☐

Have you consulted all relevant people as far as it is practical and appropriate to do so, including any person named by the person, anyone engaged in caring for the person or interested in the person’s welfare?

Yes ☐ No ☐

Have you consulted any nominated person?

Yes ☐ No ☐

Have you considered the risk of harm to others which may result in harm to the person?

Yes ☐ No ☐
4. **Nominated person**
The nominated person’s details:
Name:
Address:
Phone number:
The nominated person has been appointed by the person / selected from the default list / been appointed by the Tribunal. (Delete as appropriate).

The nominated person must be consulted with during the best interests determination, if it is practicable and appropriate to do so. If it is not practicable and appropriate provide details.

Provide details of the consultation with the nominated person, including how the consultation took place and the views of the nominated person on P’s wishes, feelings, beliefs and values. If Form 3 has been used to provide details of the consultation with the nominated person, note that below and attach Form 3 to the best interests statement.

5. **Consideration**
Outline factors which suggest that deprivation of liberty may not be in the person’s best interests.

Outline whether it is likely that the person will have capacity at some point, and if so, whether or not is it appropriate to delay the deprivation of liberty until the person can make a decision.

Outline the reasoning why the deprivation of liberty is in the best interests of the person. This should include what other options have been considered, who has been involved in the decision and how the person’s past and present wishes, feelings, beliefs, values and any other factors that the person would have included if he or she had capacity have been considered. It must also include consideration of harm, including how the prevention of serious harm condition is met.

*Further sheets can be added if required.*
6. **Statement**

Best interests should be determined on the grounds of reasonable belief and must include special regard to the person’s past and present wishes, feelings, beliefs, values and any other factors the person would have considered if he or she had capacity.

**Best interests determination statement**

It is my opinion that it is in the best interests of _________________________(name) to be deprived of his/her liberty.

Signature:

Date:
Form 3 – Consultation with nominated person

Form 3 is not a statutory Form and there are no requirements to use the Form. It can be used as an attachment to Form 2 or Form 6 and can be used to note consultation with nominated person outside the statutory Forms.

1. **The person’s details (a label can also be affixed here)**

   Name:
   Address:

   Date of Birth:
   HSC number (if known):

2. **The nominated person’s details**

   Name:
   Address:

   Phone number:
   The nominated person has been appointed by the person / selected from the default list / appointed by the Tribunal. (Delete as appropriate.)

3. **Views of the nominated person**

   Provide details of the consultation with the nominated person, including how the nominated person has been consulted, the views of the nominated person what P would have wanted and how any disagreements have been dealt with.

   *Further sheets can be added if required.*
Form 4 – Care plan

1. **The person’s details (a label can also be affixed here)**
   
   Name:
   
   Address:
   
   Date of Birth:
   
   HSC number (if known):

2. **Treatment during deprivation of liberty**

   Outline the treatment P is receiving during the deprivation of liberty, if P is receiving treatment.

3. **Actions to be taken to ensure the deprivation of liberty can be ended as soon as possible**

   Outline actions that are to be taken to end the deprivation of liberty as soon as possible.

4. **Care and / or treatment during deprivation of liberty**

   Provide details on the care and / or treatment amounting to, and relevant to, deprivation of liberty and how it is being managed.

<table>
<thead>
<tr>
<th>Care and/or treatment</th>
<th>Objectives</th>
<th>Action needed to meet objective</th>
<th>Who is responsible</th>
<th>Time of action (hourly / daily / etc)</th>
</tr>
</thead>
</table>

*Further sheets can be added if required.*
Form 5 – Application for trust panel authorisation

If more space is required additional sheets or information may be attached to this form. Information may also be copied from other sources, such as medical notes, and reference may be made to them without such document’s inclusion.

1. The person’s details (a label can also be affixed here)
   
   Name: 
   Address: 
   
   Date of Birth: 
   HSC number (if known): 

2. Person who is making the application
   
   Name: 
   Work address: 
   
   Phone number: 
   Job title, team and staff number: 
   Professional relationship to person: 

3. Person or body in charge of P’s care or treatment (if same as applicant, leave blank)
   
   Name: 
   Work address: 
   
   Phone number: 
   Job title, team and staff number: 
   Professional relationship to person:
4. **Details about the deprivation of liberty**

What is the place or places of the deprivation of liberty, including address and which trust it is in?

*A deprivation of liberty authorisation must specify the place of the deprivation*. The authorisation can cover deprivation of liberty in more than one place, for example in the place of residence of the person and in the day care centre, or the ordinary place of residence of the person and in a named place of respite.

*Further sheets can be added if required.*

5. **Capacity whether to apply to the Review Tribunal**

In your opinion, if the intervention was to be authorised, does the person lack (or probably lack) capacity to decide whether an application to the Review Tribunal should be made? **Yes / No** (delete as appropriate)

A person does not need to have the ability to make an application to the Review Tribunal. The determination of capacity only relates to the decision on whether an application should be made or not.

The distinction is important. This assessment relates to the capacity to decide whether an application should be made or not. Even if the person does not have ability to understand what the Tribunal process is or how an application should be made or be able to make an application, the person may still have capacity to decide whether or not an application should be made for an independent check on care arrangements that amount to a deprivation of liberty.

If the person is able to understand

a. *that the care arrangements mean that someone will always be checking on him or her;*

b. *that he or she cannot leave when he or she wishes to leave;* and
c. that a meeting can take place to decide whether or not that
   should be allowed
then it is likely that the person has the capacity whether to apply to
the Review Tribunal.

If yes a Form 7 has to be included in the application.
If no a Form 7 does not have to be included in the application.

6. **Annexes that must be attached to the Application**

The annexes form part of the application and must be included (if
required).

Annex A – statement of incapacity on **Form 1**.
Annex B – best interests determination statement on **Form 2**.
Annex C – care plan on **Form 4**.
Annex D – medical report on **Form 6**.
Annex E – statement on capacity whether to apply to the Review
Tribunal on **Form 7** (if required).

*It is the responsibility of the person signing the declaration to
determine if Form 7 should be included in the application.*

7. **Declaration**

---

**Declaration**

I confirm I am eligible to make this application.
To the best of my knowledge all information in this application is
correct and all required information is included.

Signature:

Date:
Form 6 – Medical report

A medical report must be attached to a Form 5, application for trust panel authorisation, Form 8, short-term detention authorisation and Form 16, application for trust panel extension authorisation.

The medical report must be done by a medical practitioner who is suitably qualified and who is unconnected to the person.

1. The person’s details (a label can also be affixed here)

   Name:
   Address:

   Date of Birth:
   HSC number (if known):

2. Medical practitioner who is making the report

   Name:
   Work address:

   Phone number:
   Job title, team and staff number:
   Professional relationship to person:

3. Criteria for authorisation – care and treatment

   Is care and treatment available in the place where the person will be deprived of liberty?
   Yes / No (delete as appropriate)

   Provide details on the care and treatment.

   Further sheets can be added if required.
4. **Criteria for authorisation – lack of capacity**
Have you personally completed a Form 1 – statement of incapacity?  
**Yes / No** (delete as appropriate)  
*If yes, continue to section 5.*  
*If no, fill out the rest of section 4.*

Provide details of how the person lacks capacity to make the decision, including how the statement of incapacity has been considered.  
*References can be made to Form 1 – formal assessment of capacity.*

*Further sheets can be added if required.*

5. **Criteria for authorisation – best interests**
Have you personally completed a Form 2 – best interests determination statement?  
**Yes / No** (delete as appropriate)  
*If yes, continue to section 6.*  
*If no, fill out the rest of section 5.*

The nominated person must be consulted with during the best interests determination, *if it is practicable and appropriate to do so.* If it is not practicable and appropriate provide details.

The nominated person’s details:  
Name:  
Address:  
Phone number:  
The nominated person has been appointed by the person / selected from the default list / been appointed by the Tribunal. (Delete as appropriate).

Provide details of how the intervention is in the person’s best interests, including how the best interests determination statement has been considered.  
*References can be made to Form 2 – best interests statement.*

*Further sheets can be added if required.*
6. **Criteria for authorisation - prevention of serious harm condition**

Would failing to detain the person in circumstances amounting to a deprivation of liberty create a risk of serious harm to the person or of serious physical harm to other persons? Yes / No (delete as appropriate)

Is the detention proportionate to the likelihood of harm concerned? Yes / No (delete as appropriate)

Is the detention proportionate to the seriousness of the harm concerned? Yes / No (delete as appropriate)

*If no to any of the questions the prevention of serious harm condition is not met.*

Provide details of how the prevention of serious harm condition is met.

*Further sheets can be added if required*

7. **(Only for short-term detention) criteria for authorisation – illness / suspected illness**

Does the person have an illness or a suspected illness? Yes / No (delete as appropriate)

*If there is no illness or suspected illness a short-term detention authorisation cannot be made.*

Provide details of the illness or suspected illness.

*Further sheets can be added if required*
8. **Statement**

**Statement**

I am unconnected with the person in section 1 and I am suitably qualified to make a medical report under the Mental Capacity Act (Northern Ireland) 2019.

In my opinion the criteria for authorisation are met and I have examined the person in section 1 no more than two days before the date on which this report was signed.

Signature:

Date:
Form 7 – Statement that the person lacks capacity whether an application should be made to the Review Tribunal

Is the referral safeguard necessary for this person?

If the person lacks or probably lacks the capacity to decide whether or not to apply to the Review Tribunal (if the deprivation of liberty is authorised) then the referral safeguard applies.

The level of decision making ability required in relation to a Tribunal application is in most cases likely to be less than that needed to make a decision about the care arrangements which are being authorised.

A person does not need to have the ability to make an application to the Review Tribunal. The determination of capacity only relates to the decision on whether an application should be made or not.

The distinction is important. This assessment relates to the capacity to decide whether an application should be made or not. Even if the person does not have ability to understand what the Tribunal process is or how an application should be made or be able to make an application, the person may still have capacity to decide whether or not an application should be made for an independent check on care arrangements that amount to a deprivation of liberty.

If the person is able to understand
  a. that the care arrangements mean that someone will always be checking on him or her;
  b. that he or she cannot leave when he or she wishes to leave; and
  c. that a meeting can take place to decide whether or not that should be allowed
then it is likely that the person has the capacity whether to apply to the Review Tribunal.
1. **The person’s details (a label can also be affixed here)**

Name:
Date of Birth:
HSC number (if known): 

2. **Details of capacity assessment**

Provide details on the capacity assessment and why the person lacks (or probably lacks) capacity whether an application should be made to the Review Tribunal if the intervention is authorised.

Further sheets can be added if required.

3. **Views of the person**

Are you aware of the person expressing any wishes or feelings, in the past or present, on whether an application should be made to the Review Tribunal? **Yes / No** (delete as appropriate)

If yes, provide details:

Further sheets can be added if required
4. **Statement**

**Statement**

In my opinion the person in section 1 lacks (or probably lacks) capacity to decide whether an application to the Review Tribunal in relation to a trust panel authorisation or extension by extension report or trust panel extension authorisation should be made.

**Signature:**

**Date:**

The completed Form 7, together with all other forms completed for the application for trust panel authorisation, authorisation for short-term detention, extension authorisation or application for trust panel extension authorisation must be sent to the Attorney General:

- by the trust immediately after the trust panel has provided an authorisation as a result of an application for trust panel authorisation or trust panel extension authorisation; or
- by the person completing an extension report immediately after signing that report.
Form 8 – Short-term detention authorisation for examination or examination followed by treatment or care

1. The person’s details (a label can also be affixed here)

Name:
Address:

Date of Birth:
HSC number (if known):

2. Person who is making the authorisation report

It is intended that where possible an ASW should make the report authorising the short term detention.

Name:
Work address:

Phone number:
Job title, team and staff number:

Professional role (delete as appropriate):
   Approved Social Worker
   Healthcare Professional (designated by the hospital to make authorisation reports)

3. Responsible medical practitioner (if same as person making the authorisation, leave blank)

Name:
Work address:

Phone number:
Job title, team and staff number:
Professional relationship to person:
4. **Hospital of detention**

In what hospital, including ward and address, is the person being detained?

5. **Examination or examination followed by treatment**

Provide details of the examination, and if followed by treatment, details of the treatment (if known):

*Further sheets can be added if required.*

6. **Capacity whether to apply to the Review Tribunal**

In your opinion, does the person lack (or probably lack) capacity to decide whether an application to the Review Tribunal should be made? **Yes / No** (delete as appropriate)

*A person does not need to have the ability to make an application to the Review Tribunal. The determination of capacity only relates to the decision on whether an application should be made or not.*

*The distinction is important. This assessment relates to the capacity to decide whether an application should be made or not. Even if the person does not have ability to understand what the Tribunal process is or how an application should be made or be able to make an application, the person may still have capacity to decide whether or not an application should be made for an independent check on care arrangements that amount to a deprivation of liberty.*

*If the person is able to understand*

- that the care arrangements mean that someone will always be checking on him or her;
- that he or she cannot leave when he or she wishes to leave; and
c. *that a meeting can take place to decide whether or not that should be allowed*
then it is likely that the person has the capacity whether to apply to the Review Tribunal.

*If yes a Form 7 has to be attached to the authorisation.*

7. **Objection from the nominated person**

Is the nominated person providing a reasonable objection to the short-term detention for examination or examination followed by treatment or care? **Yes / No** (delete as appropriate)

*If yes a Form 9 has to be attached to the authorisation.*

8. **Annexes that must be attached to the authorisation**
The annexes form part of the authorisation and must be included (if required).

Annex A – statement of incapacity on **Form 1**.
Annex B – best interests determination statement on **Form 2**.
Annex C – medical report on **Form 6**.
Annex D – statement on capacity to apply to the Review Tribunal on **Form 7** (if required).
Annex E – approved social worker report on **Form 9** (if required).

9. **Further information / comments**

Further information or comments by the authoriser. This can include other evidence or observations not captured anywhere else in the authorisation. There are no requirements to add any further information.
10. **Declaration**

**Declaration**

I have seen the person in section 1 personally no more than two days before the date below and in my opinion, based on the content of this authorisation and attachments, the criteria for detention are met.

This report authorises the detention in circumstances amounting to a deprivation of liberty in the hospital noted at section 4 for the purpose of examination or examination followed by treatment or care as outlined in section 5.

Signature:

Date:

11. **Decision not to proceed with authorisation**

If the authoriser decided not to authorise the short-term detention this can be recorded below. The declaration above should not be signed if the authorisation is not proceeded with. There are no requirements to use this form if an authorisation is not proceeded with.
Form 9 – Consultation with approved social worker

Form 9 is only required if the nominated person provides a reasonable objection to the short-term detention for examination or examination followed by treatment or care.

1. **The person’s details (a label can also be affixed here)**

   Name:
   Address:
   Date of Birth:
   HSC number (if known):

2. **Approved social worker consulted with**

   Name:
   Work address:
   Phone number:
   Job title, team and staff number:
   Professional relationship to person:

3. **Person completing Form 9 (if same as person completing Form 8, leave blank)**

   Name:
   Work address:
   Phone number:
   Job title, team and staff number:
   Professional relationship to person:
4. **Consultation with approved social worker**

Provide details on how an approved social worker has been consulted in relation to the short-term detention for examination or examination followed by treatment or care, including the views of the approved social worker and the approved social worker’s opinion on whether the short-term detention is in the person’s best interests. Also provide details on the reasonable objection from of the nominated person and the views of the approved social worker on the objection.

*Further sheets can be added if required.*
Form 10 – Short-term detention admission exception certificate

If the person is not admitted to hospital within 2 days of the completion of a medical report a new medical report and a new short-term detention authorisation report have to be made unless an exception certificate has been completed.

By signing the short-term detention admission exception certificate the admission to hospital can be delayed by up to 12 days to the 14th day after the completion of the medical report. If the person is not admitted within the period certified on the exception certificate a new medical report and a new short-term detention authorisation report have to be made.

1. The person’s details (a label can also be affixed here)

   Name: 
   Address:

   Date of Birth: 
   HSC number (if known):

2. Person who is making the certificate

   Name: 
   Work address:

   Phone number: 
   Job title, team and staff number:

   Professional role (delete as appropriate): 
   responsible medical practitioner 
   alternative medical practitioner
3. **Responsible medical practitioner (if same as person making the certificate, leave blank)**

Name:
Work address:

Phone number:
Job title, team and staff number:

4. **Length of delay**
When was the medical report completed?

How long can the admission to hospital be delayed? (the delay can be no longer than 14 days beginning with the day the medical report was completed)

5. **Reason for delay**
What are the exceptional circumstances for the delay and why is it necessary to delay the admission?

*Further sheets can be added if required.*

6. **Declaration**

**Certification**

I am certifying that it is necessary because of exceptional circumstances to delay the admission for the period noted in step 4.

Signature:

Date:
Form 11 – Short-term detention admission report

If more space is required additional sheets or information may be attached to this form.

1. **The person’s details (a label can also be affixed here)**

   Name:
   Address:

   Date of Birth:
   HSC number (if known):

2. **Person who is making the report**

   Name:
   Work address:

   Phone number:
   Job title, team and staff number:

   Professional role (delete as appropriate):
   - responsible medical practitioner
   - alternative medical practitioner
   - medical practitioner (member of staff)

3. **Responsible medical practitioner (if same as person making the report, leave blank)**

   Name:
   Work address:

   Phone number:
   Job title, team and staff number:
4. **Examination or care**

What examination or care will be provided to the person?

*Further sheets can be added if required.*

5. **Harm**

How would failure to detain the person, for the purposes of examination or care as outlined in section 4, create a risk of serious harm to the person or risk of serious physical harm to others?

*Further sheets can be added if required.*

6. **Proportionality**

Explain the likelihood of harm to the person or physical harm to others, the seriousness of the harm and how the detention is proportionate to the harm.

*Further sheets can be added if required.*

7. **Capacity**

Does the person lack capacity in relation to the short-term detention?  
**Yes / No** (delete as appropriate)  
Explain how the person lacks capacity and which part of the functional test the person is unable to do.

*Further sheets can be added if required.*
8. **Best interests**
Is the short-term detention in person’s best interests? **Yes / No** (delete as appropriate)

Explain the best interests determination.

*Further sheets can be added if required.*

9. **Nominated person**
Has the nominated person been consulted? **Yes / No** (delete as appropriate)

*The nominated person must be consulted with if practical and appropriate.*

Has the nominated person provided any further/new information since the creation of the short-term detention authorisation report? **Yes / No** (delete as appropriate)

*If yes, provide details:*

10. **Declaration**

<table>
<thead>
<tr>
<th>Declaration</th>
</tr>
</thead>
<tbody>
<tr>
<td>In my opinion (delete as appropriate):</td>
</tr>
<tr>
<td>a) the conditions for detention are not met and the authorisation is terminated.</td>
</tr>
<tr>
<td>b) the conditions for detention are met and the authorisation can continue.</td>
</tr>
</tbody>
</table>

    Signature:  

    Date:  

*If the person signing the declaration is not a responsible medical practitioner or another medical practitioner a further admission report must be made within 48 hours of this report being signed.*
Form 12 – Short-term detention further admission report

If more space is required additional sheets or information may be attached to this form.

1. **The person’s details (a label can also be affixed here)**

   Name:
   Address:
   Date of Birth:
   HSC number (if known):

2. **Person who is making the report**

   Name:
   Work address:
   Phone number:
   Job title, team and staff number:
   Professional role (delete as appropriate):
   responsible medical practitioner
   alternative medical practitioner

3. **Responsible medical practitioner (if same as person making the report, leave blank)**

   Name:
   Work address:
   Phone number:
   Job title, team and staff number:
4. **Examination or care**

What examination or care will be provided to the person?

*Further sheets can be added if required.*

5. **Harm**

How would failure to detain the person, for the purposes of examination or care as outlined in section 4, create a risk of serious harm to the person or risk of serious physical harm to others?

*Further sheets can be added if required.*

6. **Proportionality**

Explain the likelihood of harm to the person or physical harm to others, the seriousness of the harm and how the detention is proportionate to the harm.

*Further sheets can be added if required.*

7. **Capacity**

Does the person lack capacity in relation to the short-term detention? Yes / No (delete as appropriate)

Explain how the person lacks capacity and which part of the functional test the person is unable to do.

*Further sheets can be added if required.*
8. **Best interests**

Is the short-term detention in person’s best interests? **Yes / No** (delete as appropriate)

Explain the best interests determination.

*Further sheets can be added if required.*

9. **Nominated person**

Has the nominated person been consulted? **Yes / No** (delete as appropriate)

*The nominated person must be consulted with if practical and appropriate.*

Has the nominated person provided any further/new information since the creation of the short-term detention authorisation report? **Yes / No** (delete as appropriate)

*If yes, provide details:*

10. **Declaration**

<table>
<thead>
<tr>
<th>Declaration</th>
</tr>
</thead>
<tbody>
<tr>
<td>In my opinion (delete as appropriate):</td>
</tr>
<tr>
<td>a) the conditions for detention are not met and the authorisation is terminated.</td>
</tr>
<tr>
<td>b) the conditions for detention are met and the authorisation can continue.</td>
</tr>
</tbody>
</table>

  
<table>
<thead>
<tr>
<th>Signature:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
</tr>
</tbody>
</table>
Form 13 – Short-term detention further report

If more space is required additional sheets or information may be attached to this form.

1. The person’s details (a label can also be affixed here)

   Name:
   Address:
   Date of Birth:
   HSC number (if known):

2. Person who is making the report

   Name:
   Work address:
   Phone number:
   Job title, team and staff number:

   Professional role (delete as appropriate):
   responsible medical practitioner
   alternative medical practitioner

3. Responsible medical practitioner (if same as person making the report, leave blank)

   Name:
   Work address:
   Phone number:
   Job title, team and staff number:
4. **Examination or care**

What examination or care will be provided to the person?

*Further sheets can be added if required.*

5. **Harm**

How would failure to detain the person, for the purposes of examination or care as outlined in section 4, create a risk of serious harm to the person or risk of serious physical harm to others?

*Further sheets can be added if required.*

6. **Proportionality**

Explain the likelihood of harm to the person or physical harm to others, the seriousness of the harm and how the detention is proportionate to the harm.

*Further sheets can be added if required.*

7. **Capacity**

Does the person lack capacity in relation to the short-term detention? **Yes / No** (delete as appropriate)

Explain how the person lacks capacity and which part of the functional test the person is unable to do.

*Further sheets can be added if required.*
8. **Best interests**

Is the short-term detention in person’s best interests? **Yes / No** (delete as appropriate)

Explain the best interests determination.

*Further sheets can be added if required.*

9. **Nominated person**

Has the nominated person been consulted? **Yes / No** (delete as appropriate)

*The nominated person must be consulted with if practical and appropriate.*

Has the nominated person provided any further/new information since the creation of the short-term detention authorisation report? **Yes / No** (delete as appropriate)

*If yes, provide details:*

10. **Declaration**

**Declaration**

In my opinion (delete as appropriate):

a) the conditions for detention are not met and the authorisation is terminated.

b) the conditions for detention are met and the authorisation can continue.

Signature:

Date:
Form 14 – Extension authorisation (extension by report)

If more space is required additional sheets or information may be attached to this form. Information may also be copied from other sources, such as medical notes, and reference may be made to them without such document’s inclusion.

1. The person’s details (a label can also be affixed here)

Name:
Address:

Date of Birth:
HSC number (if known):

2. Medical practitioner who is making the authorisation

Name:
Work address:

Phone number:
Job title, team and staff number:
When was the person examined?

3. Person or body in charge of the person’s care (if same as person making the extension authorisation, leave blank)

Name:
Work address:

Phone number:
Job title, team and staff number:
4. **Extension being authorised**

Is the report a first or subsequent extension? **First / Subsequent** (delete as appropriate)

How long is the extension for? (delete as appropriate)
- 6 months (maximum for first extension)
- 12 months (maximum for subsequent extension)

5. **Details about the deprivation of liberty**

What is the place or places of the deprivation of liberty, including address and which trust it is in?

A deprivation of liberty authorisation must specify the place of the deprivation. The authorisation can cover deprivation of liberty in more than one place, for example in the place of residence of the person and in the day care centre, or the ordinary place of residence of the person and in a named place of respite.

*Further sheets can be added if required.*

6. **Criteria for continuation – care and treatment**

Is care and treatment available in the place where the person will be deprived of liberty? **Yes / No** (delete as appropriate)

Provide details on the care and treatment.

*Further sheets can be added if required.*
7. **Criteria for continuation – lack of capacity**

Have you personally completed a Form 1 – statement of incapacity?  
**Yes / No** (delete as appropriate)  
*If yes, continue to section 8.  
If no, fill out the rest of section 7.*

Provide details of how the person lacks capacity to make the decision, including how the statement of incapacity has been considered.

*Further sheets can be added if required.*

8. **Criteria for continuation – best interests**

Have you personally completed a Form 2 – best interests determination statement?  
**Yes / No** (delete as appropriate)  
*If yes, continue to section 9.  
If no, fill out the rest of section 8.*

*The nominated person must be consulted with during the best interests determination, if it is practicable and appropriate to do so. If it is not practicable and appropriate provide details.*

The nominated person’s details:  
Name:  
Address:  
Phone number:  
The nominated person has been **appointed by the person / selected from the default list / been appointed by the Tribunal**.  
(Delete as appropriate).

Provide details of how the intervention is in the person’s best interests, including how the best interests determination statement has been considered.  
*References can be made to Form 2 – best interests statement.*

*Further sheets can be added if required.*
9. **Criteria for continuation - prevention of serious harm condition**

Would failing to detain the person in circumstances amounting to a deprivation of liberty create a risk of serious harm to the person or of serious physical harm to other persons? **Yes / No** (delete as appropriate)

Is the detention proportionate to the likelihood of harm concerned? **Yes / No** (delete as appropriate)

Is the detention proportionate to the seriousness of the harm concerned? **Yes / No** (delete as appropriate)

*If no to any of the questions the prevention of serious harm condition is not met.*

Provide details of how the prevention of serious harm condition is met.

*Further sheets can be added if required*

10. **Opinion of the responsible person**

Has the responsible person provided a statement on Form 15 that in his or her opinion the criteria for continuation are met for each of the interventions in section 4? **Yes / No** (delete as appropriate)

*If yes, Form 15 must be attached to the report.*

*If no, the authorisation cannot be extended by the making of a report. An application has to be made to the trust panel on Form 16.*
11. **Capacity whether to apply to the Review Tribunal**

In your opinion, does the person lack (or probably lack) capacity to decide whether an application to the Review Tribunal should be made? **Yes / No** (delete as appropriate)

A person does not need to have the ability to make an application to the Review Tribunal. The determination of capacity only relates to the decision on whether an application should be made or not.

The distinction is important. This assessment relates to the capacity to decide whether an application should be made or not. Even if the person does not have ability to understand what the Tribunal process is or how an application should be made or be able to make an application, the person may still have capacity to decide whether or not an application should be made for an independent check on care arrangements that amount to a deprivation of liberty.

If the person is able to understand
a. that the care arrangements mean that someone will always be checking on him or her;
b. that he or she cannot leave when he or she wishes to leave; and
c. that a meeting can take place to decide whether or not that should be allowed

then it is likely that the person has the capacity whether to apply to the Review Tribunal.

*If yes a Form 7 has to be included in the application.*
*If no a Form 7 does not have to be included in the application.*
12. **Annexes that must be attached to the authorisation**
The annexes are part of the extension and must be included (if required).

Annex A – statement of incapacity on **Form 1**.

Annex B – best interests determination statement on **Form 2**.

Annex C – care plan on **Form 4**.

Annex D – statement on capacity to apply to the Review Tribunal on **Form 7** (if required).

Annex E – responsible person statement on **Form 15**.

13. **Declaration**

```
Declaration

I confirm I am eligible to make this extension report.

In my opinion the criteria for continuation are met in respect of the deprivation of liberty and the authorisation is extended for the period mentioned in section 4.

Signature:

Date:
```
Form 15 – Responsible person statement

If more space is required additional sheets or information may be attached to this form.

1. **The person’s details (a label can also be affixed here)**
   - Name: 
   - Address: 
   - Date of Birth: 
   - HSC number (if known): 

2. **The responsible person**
   - Name: 
   - Work address: 
   - Phone number: 
   - Job title, team and staff number (if applicable): 

3. **The responsible person criteria**
   - Have you completed the statement of incapacity? **Yes / No** (delete as appropriate)

   If yes, you cannot complete the responsible person statement as the person making the report and the person who completes the statement of incapacity must be different.

   Are you unconnected with the person in section 1? **Yes / No** (delete as appropriate)

   If no, you cannot complete the responsible person statement as the person making the report must be unconnected with the person.

   Role that qualifies as a responsible person (delete as appropriate):
   - an approved social worker who is involved in relevant care or treatment of the person.
   - a person designated by the managing authority in the hospital or care home where the person is an in-patient or resident.
4. **Criteria for continuation – care and treatment**
Is care and treatment available in the place where the person will be deprived of liberty? **Yes / No** (delete as appropriate)

Provide details on the care and treatment.

_Further sheets can be added if required._

5. **Criteria for authorisation – lack of capacity**
Have you personally completed a Form 1 – statement of incapacity? **Yes / No** (delete as appropriate)
*If yes, continue to section 6.*
*If no, fill out the rest of section 5.*

Provide details of how the person lacks capacity to make the decision, including how the statement of incapacity has been considered.

Reference can be made to Form 1 – formal assessment of capacity.

_Further sheets can be added if required._

6. **Criteria for authorisation – best interests**
Have you personally completed a Form 2 – best interests determination statement? **Yes / No** (delete as appropriate)
*If yes, continue to section 7.*
*If no, fill out the rest of section 6.*

Provide details of how the intervention is in the person’s best interests, including how the best interests determination statement has been considered.

Reference can be made to Form 2 – best interests statement.

_Further sheets can be added if required._
7. **Criteria for authorisation - prevention of serious harm condition**

Would failing to detain the person in circumstances amounting to a deprivation of liberty create a risk of serious harm to the person or of serious physical harm to other persons? **Yes / No** (delete as appropriate)

Is the detention proportionate to the likelihood of harm concerned? **Yes / No** (delete as appropriate)

Is the detention proportionate to the seriousness of the harm concerned? **Yes / No** (delete as appropriate)

*If no to any of the questions the prevention of serious harm condition is not met.*

Provide details of how the prevention of serious harm condition is met.

*Further sheets can be added if required*

8. **Statement**

<table>
<thead>
<tr>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>In my opinion the criteria for continuation for deprivation of liberty are (delete as appropriate):</td>
</tr>
<tr>
<td>a) met.</td>
</tr>
<tr>
<td>b) not met.</td>
</tr>
</tbody>
</table>

*If you do not believe the criteria has been met the deprivation of liberty cannot be extended using an extension authorisation (extension report)!*

Signature:

Date:
Form 16 – Application for trust panel extension authorisation

If more space is required additional sheets or information may be attached to this form. Information may also be copied from other sources, such as medical notes, and reference may be made to them without such document’s inclusion. More than one intervention can be applied for in one application. If required more than one form can be used for one application.

1. **The person’s details (a label can also be affixed here)**

Name:
Address:
Date of Birth:
HSC number (if known):

2. **Person who is making the application**

Name:
Work address:
Phone number:
Job title, team and staff number:
Professional relationship to person:

3. **Person on body in charge of P’s care or treatment (if same as applicant, leave blank)**

Name:
Work address:
Phone number:
Job title, team and staff number:
Professional relationship to person:
4. **Extension(s) being applied for and length of authorisation**

Is the report a first or subsequent extension? **First / Subsequent** (delete as appropriate)

How long is the extension for? (delete as appropriate)
- 6 months (maximum for first extension)
- 12 months (maximum for subsequent extension)

5. **Details about the deprivation of liberty**

What is the place or places of the deprivation of liberty, including address and which trust it is in? A deprivation of liberty authorisation must specify the place of the deprivation. The authorisation can cover deprivation of liberty in more than one place, for example in the place of residence of the person and in the day care centre, or the ordinary place of residence of the person and in a named place of respite.

6. **Capacity whether to apply to the Review Tribunal**

In your opinion, if the extension was to be authorised, does the person lack (or probably lack) capacity to decide whether an application to the Review Tribunal should be made? **Yes / No** (delete as appropriate)

A person does not need to have the ability to make an application to the Review Tribunal. The determination of capacity only relates to the decision on whether an application should be made or not.

The distinction is important. This assessment relates to the capacity to decide whether an application should be made or not. Even if the person does not have ability to understand what the Tribunal process is or how an application should be made or be able to make an application, the person may still have capacity to decide whether or not an application should be made for an independent check on care arrangements that amount to a deprivation of liberty.
If the person is able to understand
  a. that the care arrangements mean that someone will always be checking on him or her;
  b. that he or she cannot leave when he or she wishes to leave; and
  c. that a meeting can take place to decide whether or not that should be allowed
then it is likely that the person has the capacity whether to apply to the Review Tribunal.

If yes a Form 7 has to be included in the application.
If no a Form 7 does not have to be included in the application.

7. **Annexes that must be attached to the Application**
The annexes form part of the application and must be included (if required).
Annex A – statement of incapacity on Form 1.
Annex C – care plan on Form 4.
Annex E – statement on capacity to apply to the Review Tribunal on Form 7 (if required).
It is the responsibility of the person making the application to determine if a Form 7 should be included in the application.
Annex F – responsible person statement on Form 15.

8. **Declaration**

**Declaration**

I confirm I am eligible to make this application.

To the best of my knowledge all information in this application is correct and all required information is included.

Signature:

Date:
Form 17 – Notification of application for trust panel authorisation and trust panel extension authorisation

To:
Name:
Address:

This is to notify you that the ________________________ (trust name) has on ____________ (date) received an application under the Mental Capacity Act (Northern Ireland) 2016 in respect of
Name:
Address:

for a trust panel to (delete as appropriate):

- authorise a deprivation of liberty.
- extend an authorisation for a deprivation of liberty.

The trust has constituted a panel to consider the application. The panel has 7 working days to make a decision from when the trust received application. The panel can authorise the intervention, refuse to grant an authorisation or provide an interim authorisation for a maximum of 28 days.

If you like more information about the reasons for the application you can contact the trust directly.

Enclosed with this letter is a leaflet providing information on the trust panel and a person’s rights under the Mental Capacity Act.

Trust details
Trust:
Address:

Reference number:
Contact person:
Phone number:
Email:
Form 18 – Notification of trust panel decision

To:
Name:
Address:

This is to notify you that a trust panel constituted under the Mental Capacity Act (Northern Ireland) 2016 in the ___________ (trust name) has on ____________ (date) made a decision respect of

Name:
Address:

The trust panel has granted / extended / refused / granted an interim (delete as appropriate) authorisation for a deprivation of liberty.

The purpose or purposes of the deprivation of liberty is/are:

The place or places where the deprivation of liberty will take place:

(the authorisation may authorise a deprivation of liberty in one place for one purpose and another place for another purpose)

If you like more information about the reasons for the decision you can contact the trust directly.

A decision by the trust panel to grant, extend or grant an interim authorisation can be considered by the Review Tribunal.

Enclosed with this letter is a leaflet providing information on the trust panel, the Review Tribunal and a person’s rights under the Mental Capacity Act.

Trust details
Trust:
Address:
Reference number:
Contact person:
Phone number:
Email:
Form 19 – Notification of short-term detention

To:
Name:
Address:

This is to notify you that a short-term detention for examination or examination followed by treatment or care under the Mental Capacity Act (Northern Ireland) 2016 at __________________________ (name of hospital) in the __________________________ (trust name) has on ____________ (date) been authorised in respect of
Name:
Address:

If you like more information about the reasons for the decision you can contact the trust directly.

The decision to authorise a short-term detention for examination or examination followed by treatment or care can be considered by the Review Tribunal.

Enclosed with this letter is a leaflet providing information on short-term detentions, the Review Tribunal and a person’s rights under the Mental Capacity Act.

Trust details

Trust:
Address:

Reference number:
Contact person:
Phone number:
Email:

200
Form 20 – Notification of an extension

To:
Name:
Address:

This is to notify you that an authorisation under the Mental Capacity Act (Northern Ireland) 2016 in the ___________________________ (trust name) has on ____________ (date) been extended in respect of
Name:
Address:

The extension relates to an authorisation for a deprivation of liberty.

The purpose or purposes of the deprivation of liberty is/are:

The place or places where the deprivation of liberty will take place:
(the authorisation may authorise a deprivation of liberty in one place for one purpose and another place for another purpose)

If you like more information about the reasons for the decision to extend the authorisation you can contact the trust directly.

The decision to extend the authorisation can be considered by the Review Tribunal.

Enclosed with this letter is a leaflet providing information on the extension process, the Review Tribunal and a person’s rights under the Mental Capacity Act.

Trust details
Trust:
Address:
Reference number:
Contact person:
Phone number:
Email:
Form 21 – Discharge from detention
When a person is discharged from detention under the Mental Capacity Act (Northern Ireland) 2016 the information in this Form must be provided to the person being discharged and to any other person the person being discharged has asked to be notified.

To:
Name:
Address:

This is to notify you that:
Name:
Address:

has on ____________ (date) been discharged from detention amounting to deprivation of liberty by virtue of the Mental Capacity Act (Northern Ireland) 2016.

The effect of the discharge from detention is that a previous authorisation (authorising the detention amounting to a deprivation of liberty by virtue of a short-term detention in hospital, trust panel authorisation, trust panel extension authorisation or an extension report) under the Mental Capacity Act (Northern Ireland) 2016 is revoked. That authorisation cannot be used again as an additional safeguard and if a new detention amounting to a deprivation of liberty is necessary a new authorisation is required.

Enclosed with this letter is a leaflet providing information on deprivations of liberty under the Mental Capacity Act and the effect of the discharge from detention.

Trust details
Trust:
Address:
Reference number:
Contact person:
Phone number:
Email:

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Form 22 – Appointment, revocation, making of a declaration or revoking a declaration in relation to nominated person

A person who has capacity can at any time appoint a nominated person, revoke such appointment, declare that certain persons, or persons of a certain description, should not be a nominated person and revoke such a declaration.

All section reference refer to the Mental Capacity Act (Northern Ireland) 2016.

This form is not required for making an appointment, revocation, making of a declaration or revoking a declaration but may be helpful as it contains all the information required.

1. The person’s details

Name:
Address:

Date of Birth:
HSC number (if known and available):

2. Decision

This is (delete as appropriate)
- an appointment of a nominated person under section 70
- a revocation of an appointment under section 71(1)
- the making of a declaration under section 77(1)
- the revocation of a declaration under section 77(5)

If the decision is an appointment or revocation of a nominated person go to section 3.
If the decision is the making of a declaration go to section 4.
If the decision is the revocation of a declaration go to section 5.
3. **Appointment or revocation of appointment**

Person that should be appointed nominated person / revoked as the nominated person (delete as appropriate).

Name:
Address:

Date of Birth:
HSC number (if known and available):

4. **Declaration**

The person, persons or persons of the described description should not be the nominated person.

Provide details:

*Further sheets can be added if required.*

5. **Revocation of previous declaration**

A previous declaration made is revoked and the person, persons or persons of the described description can now be the nominated person.

Provide details:

*Further sheets can be added if required.*
6. **Witness**

The witness must be ordinarily resident in Northern Ireland, be unconnected with the person and not be the person’s nominated person.

Provide details of the witness.
Name:
Address:

Date of Birth:
HSC number (if known and available):

**Certification by witness**

I meet the criteria to be a witness.

In my opinion the person in section 1 understands the effect of the appointment, revocation, declaration or revocation of a declaration and the person has not been subjected to any undue pressure in relation to the appointment, revocation, declaration or revocation of a declaration.

If the decision is an appointment of a nominated person, in my opinion the person in section 1 understands that the appointment may result in information about the person (including sensitive personal information) being disclosed to the nominated person.

Signature:

Date:
7. **Signature by person**

**Signature by person**

I am the person in section 1 and the appointment, revocation, declaration or revocation of a declaration is my capacitous decision.

Signature:

Date:
8. **Addition sheet**

If the person in section 1 is physically unable to sign the declaration in section 7 this sheet may be inserted in place of section 7. The addition sheet must be signed by a person on behalf of the person in section 1. That person must be unconnected with the person in section 1. The addition sheet must also be witnessed by an additional witness.

Provide details of the person signing on behalf of the person in section 1.
Name:
Address:

Date of Birth:

**Statement**

In my opinion the person in section 1 is physically unable to sign section 7 and I am therefore signing on behalf of the person in section 1.

In my opinion the person in section 1 understands the effect of the appointment, revocation, declaration or revocation of a declaration and the person has not been subjected to any undue pressure in relation to the decision.

If the decision is an appointment of a nominated person, in my opinion the person in section 1 understands that the appointment may result in information about the person (including sensitive personal information) being disclosed to the nominated person.

Signature:

Date:
The witness must have known the person in section 1 personally for at least two years and is not a relative of the person in section 1. The witness cannot be the same person as in section 6.

Provide details of the additional witness.
Name:
Address:

Date of Birth:

Certification by additional witness

In my opinion the person in section 1 understands the effect of the appointment, revocation, declaration or revocation of a declaration and the person has not been subjected to any undue pressure in relation to the decision.

If the decision is an appointment of a nominated person, in my opinion the person in section 1 understands that the appointment may result in information about the person (including sensitive personal information) being disclosed to the nominated person.

Signature:

Date:
## Trust Panel Authorisation Proforma
Developed by the Northern HSC Trust.

### 1. Patient, Panel and Application Details

<table>
<thead>
<tr>
<th>Patient Details</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s name</td>
<td>DoB</td>
</tr>
</tbody>
</table>

Is this person under an emergency DoL arrangement? | Yes / No |

<table>
<thead>
<tr>
<th>Trust Panel Details</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Panel</td>
<td></td>
</tr>
<tr>
<td>Panel Member 1 (Medical Practitioner)</td>
<td></td>
</tr>
<tr>
<td>Panel Member 2 (ASW)</td>
<td></td>
</tr>
<tr>
<td>Panel Member 3 (Nurse / AHP / other)</td>
<td></td>
</tr>
</tbody>
</table>

(please note “Chair” beside Chair of Panel)

<table>
<thead>
<tr>
<th>Application Details</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Application type (tick one)</td>
<td>New application (Form 5)</td>
</tr>
<tr>
<td>Application for extension (Form 16)</td>
<td></td>
</tr>
<tr>
<td>Date Application made</td>
<td></td>
</tr>
<tr>
<td>Name of Applicant</td>
<td></td>
</tr>
<tr>
<td>Date Application received by Trust</td>
<td></td>
</tr>
<tr>
<td>Form 17 - date of issue</td>
<td></td>
</tr>
<tr>
<td>Form 17 - recipients (must include Person, Nominated Person and/or others)</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Evidence of Incapacity (Form 1 / Form 6)</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Evidence of Best Interests (including consultation with NP) (Form 2 / Form 6)</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Application Details continued</td>
<td></td>
</tr>
<tr>
<td>Medical Report (Form 6)</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Date Medical Report completed</td>
<td></td>
</tr>
<tr>
<td>Was Medical Report completed by someone other than the Applicant?</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Has the Care Plan been included?</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Is there any evidence in the application that the principles(^1) have not been followed? (If Yes, provide details)</td>
<td>Yes / No</td>
</tr>
</tbody>
</table>

\(^1\) The Five Principles are:
1. No-one should be treated as lacking capacity unless established that they do
2. No assumptions can be made
3. Help and support must be provided
4. No assumptions can be made because of unwise decisions
5. Any act done on behalf of a person who lacks capacity must be in his or her best interests

---

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2. Criteria for Authorisation
The Trust Panel’s purpose is to provide a further opinion on the facts surrounding the deprivation of liberty to ensure that the criteria for authorisation are met.

### Criteria for Authorisation

<table>
<thead>
<tr>
<th>Criteria (tick one for each of the criteria)</th>
<th>Satisfied</th>
<th>Not satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is care and treatment in the place where the DoL will take place</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P lacks capacity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The DoL is in P’s best interests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Prevention of Serious Harm (PoSH) condition is met</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Things to consider

**Care and treatment in the place where the DoL will take place**
- Does the care plan / best interest statement / medical report detail what will happen to the person during the DoL?

**P lacks capacity**
- Has the person been provided with all practicable help and support to allow him or her to make his or her own decision?
- Have the functional element, impairment/disturbance element and causal link been adequately demonstrated?
DoL is in P’s best interests

- Would waiting for a time in the future when the person might regain capacity be in the person’s best interests?
- Has the person been encouraged and supported to participate in the best interests determination?
- Have the relevant people, including the nominated person, been consulted, in so far as practicable, and their views been taken into account?
- Has special regard been given to the person’s past and present wishes, feelings, beliefs and values? Special regard means giving top priority to the wishes, feelings, beliefs, values and any other factors that the person would have considered relevant. It is the primary factor when determining what is in the person’s best interests.

PoSH condition is met

- Would a lack of a deprivation of liberty cause a risk of serious harm to the person or serious physical harm to others?
- Is the likelihood of the harm and the seriousness of the harm proportionate to the detention?
## 3. Trust Panel Decision

<table>
<thead>
<tr>
<th>Trust Panel Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Decision</strong> (tick one)</td>
</tr>
<tr>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trust Panel Follow-Up Actions (excluding Interim Authorisation actions)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Does the Panel require any follow-up actions?</strong> Yes / No</td>
</tr>
<tr>
<td>N.B. this does not include follow up actions for Interim Authorisations which are recorded in Annex A</td>
</tr>
<tr>
<td>(If Yes, provide details)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Panel Members Signatures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Panel Member 1</strong> (Medical Practitioner)</td>
</tr>
<tr>
<td><strong>Panel Member 2</strong> (ASW)</td>
</tr>
<tr>
<td><strong>Panel Member 3</strong> (Nurse / AHP / other)</td>
</tr>
</tbody>
</table>
4. Further Actions

<table>
<thead>
<tr>
<th>Review Arrangements / end point</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review arrangements (tick one)</td>
</tr>
<tr>
<td>Within 28 days (Interim Authorisation – Annex A to be completed on Trust Panel final consideration)</td>
</tr>
<tr>
<td>6 Months if Authorisation Approved or Extended (within 1st year)</td>
</tr>
<tr>
<td>1 Year if Authorisation extended (after 1st year)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attorney General</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was a Form 7 (statement that person lacks capacity whether an application should be made to the Review Tribunal) included in application?</td>
</tr>
<tr>
<td>Yes / No</td>
</tr>
<tr>
<td>If Yes, date application was sent to Attorney General²</td>
</tr>
</tbody>
</table>

² The completed Form 7, together with all other forms completed for the application for trust panel authorisation, authorisation for short-term detention, extension authorisation or application for trust panel extension authorisation must be sent to the Attorney General: by the trust immediately after the trust panel has provided an authorisation as a result of an application for trust panel authorisation or trust panel extension authorisation; or by the person completing an extension report immediately after signing that report.
<table>
<thead>
<tr>
<th>Other Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If Panel requested follow-up actions (see section 3), provide details on action taken</td>
</tr>
<tr>
<td>Form 18 - date of issue</td>
</tr>
<tr>
<td>Form 18 - recipients (must be issued to everyone who received the Form 17 notification – see P1)</td>
</tr>
<tr>
<td>Proforma copied to</td>
</tr>
<tr>
<td>Date entered onto DoLS system</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Admin Team Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin Team member name</td>
</tr>
<tr>
<td>Signature</td>
</tr>
</tbody>
</table>
## Annex A – Interim Authorisation Actions

### Trust Panel Final Consideration

<table>
<thead>
<tr>
<th>Date of Panel Final Consideration&lt;sup&gt;3&lt;/sup&gt;</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide summary of the reason why the Interim Authorisation was granted (rather than a full Authorisation)</td>
<td></td>
</tr>
<tr>
<td>Provide details explaining whether or not the Panel is content that the issues noted in the Interim Authorisations table in section 3 have been suitably addressed to ensure that the criteria for authorisation have now been met and to authorise the DoL</td>
<td></td>
</tr>
</tbody>
</table>

### Trust Panel Final Decision

<table>
<thead>
<tr>
<th>Decision (tick one)</th>
<th>Authorisation granted</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorisation refused</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Panel Members Signatures

<table>
<thead>
<tr>
<th>Panel Member 1 (Medical Practitioner)</th>
<th></th>
</tr>
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<tbody>
<tr>
<td>Panel Member 2 (ASW)</td>
<td></td>
</tr>
<tr>
<td>Panel Member 3 (Nurse / AHP / other)</td>
<td></td>
</tr>
</tbody>
</table>

---

<sup>3</sup> Date of Trust Panel final consideration must be no longer than 28 days after Interim Authorisation was granted.
ANNEX B – DEPRIVATION OF LIBERTY
SAFEGUARDS SCENARIOS

Mental Capacity Act (Northern Ireland) 2016

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Deprivation of liberty – general scenarios

Deprivation of liberty in nursing home

A person who moves to a nursing home from the family home and will be prevented from leaving at the nursing home is deprived of liberty and the safeguards and additional safeguards of the Mental Capacity Act are required.

Bob is a 78 year old man with dementia living in East Belfast. He has been living in his family home with his wife as his main carer. Due to the dementia Bob has very limited understanding about most things and needs help with all aspects of life.

Bob is prone to wandering, however, he has previously not put himself in immediate danger and the wandering has been managed successfully. As Bob’s dementia has deteriorated he is showing an increasing lack in understanding of dangers and has very recently, on a number of occasions, walked out in the road without awareness of cars and other vehicles. Bob’s wife and others around Bob have become increasingly worried that he may get hurt as he does not appear to understand normal dangers any more.

Bob’s wife’s health has now deteriorated to a point where she cannot care for Bob. Bob’s health has also deteriorated lately and an assessment of Bob’s functionality and health has identified that he would be best suited for a nursing home. A nursing home is identified in Newtownards, which is liked by Bob’s wife and their children. It is also considered that as Bob is no longer aware of dangers it would be best for him to be deprived of liberty.
The district nurse who has been involved in Bob’s care over the last number of years, and knows Bob and his wife well through this engagement, carries out a capacity assessment in relation to the care arrangements that would amount to a deprivation of liberty. It is quickly determined that Bob lacks capacity in relation to the care arrangements.

The district nurse speaks to Bob’s wife, as his nominated person, and Bob’s children. She also involves other health and social care workers that have been involved in Bob’s care. The district nurse concludes that Bob has made no previous comments on deprivations of liberty and that he is in general happy to receive care and treatment as appropriate. The district nurse therefore considers that care arrangements that would amount to a deprivation of liberty is in Bob’s best interests.

During the best interests consideration the district nurse also considers the prevention of serious harm condition. As Bob lacks awareness of normal dangers, such as vehicles, and is prone to wander (and may therefore walk out in front of cars when he is wandering) there is a risk of serious harm to Bob. The district nurse also considers that a detention amounting to a deprivation of liberty in the nursing home is proportionate to the seriousness and likelihood of the harm.

The district nurse contacts the Belfast Trust’s single point of contact for deprivation of liberty to ensure a medical examination and report is done, as Bob currently resides in Belfast Trust. Belfast Trust arranges for one of the doctors that have been assigned as a doctor who can carry out medical
reports to visit Bob and examine him. The doctor reads the statement of incapacity and best interests statement and after speaking to Bob and Bob’s wife considers that he is satisfied that they are correct and that the criteria for authorisation are met. The doctor therefore fills out the medical report and signs it.

The district nurse then completes an application for trust panel authorisation including all annexes. When completing the Form she considers whether Bob has capacity to decide whether an application should be made to the Review Tribunal in respect of an authorisation that may be granted by the trust panel. The district nurse considers this to be a different capacity threshold than capacity in relation to the care arrangement that amounts to a deprivation of liberty. The district nurse considers if Bob is able to understand:

- that the care arrangements mean that someone will always be checking on him;
- that he cannot leave when he wishes to leave; and
- that a meeting can take place to decide whether or not that should be allowed.

The district nurse considers that Bob can understand this and therefore does not include Form 7 in the application to the trust for trust panel authorisation. The district nurse then sends the application, and all annexes, by email to the single point of contact in the South Eastern Trust as this is the trust where the nursing home where the deprivation of liberty will occur is located.

Whilst waiting for a trust panel authorisation arrangements are made for Bob to move. Bob is moved before the
authorisation has been received and the care arrangements that amount to a deprivation of liberty are put in place by using the emergency provisions of the Mental Capacity Act (as it is determined to be an unacceptable risk of harm to Bob to wait with the deprivation of liberty whilst the application for authorisation is considered).

Four working days after the application is received by the South Eastern Trust, the trust panel has made a decision to grant the authorisation. Bob, Bob’s wife as the nominated person and the managing authority of the nursing home are notified of the trust panel decision on Form 18. The Form is put in Bob’s care plan.
Short-term detention in hospital for examination or examination followed by treatment or care

*If a person is deprived of liberty in a hospital and there is no prior trust panel authorisation a short-term detention authorisation is required.*

Victoria is a 69 year old lady who lives in a residential care home. There are normally no concerns about her mental capacity but she requires some help with normal day to day activities due to physical limitations.

Staff in the home have found Victoria in a very confused state. The GP responsible for her normal care has visited the home and diagnosed a urinary tract infection which has caused delirium. It is the GP’s opinion that Victoria needs IV antibiotics and should therefore be taken to the Emergency Department (ED) at the local hospital.

The residential care home staff accompany Victoria to ED. Other staff are trying to contact Victoria’s relatives, but are unsuccessful.

When arriving at the hospital Victoria is even more confused and tries to leave. ED staff are very concerned over her health and agree with the GP diagnosis and the need for IV antibiotics. They are of the opinion that with IV antibiotics Victoria will recover fairly quickly but without the medication she is at risk of serious harm due to the untreated illness. Staff consider that the criteria for short-term detention in hospital for examination or examination followed by treatment or care are met:
• Victoria suffers from an illness and requires treatment or care in hospital;
• Victoria is unable to understand information due to the delirium which means she lacks mental capacity in relation to the deprivation of liberty;
• It is in Victoria’s best interests to be deprived of liberty as this will allow her to receive treatment and regain capacity. If she is not deprived of liberty, she will not receive treatment and may therefore decline further; and
• If Victoria is not deprived, and therefore does not receive treatment and is allowed to leave, there is serious risk that she will come to serious harm, both due to her confusion and lack of awareness and due to a deterioration in the illness. The deprivation of liberty therefore meets the prevention of serious harm condition threshold.

Staff are of the opinion that she needs to be deprived of liberty immediately and this takes place without any of the additional safeguards that can be delayed in the case of an emergency. Victoria is quickly moved to a ward and IV antibiotics are started.

The ward sister is aware of the requirements for a short-term authorisation and it is agreed that the treating doctor will carry out a formal assessment of capacity, best interests statement and the medical report. The doctor does this on the relevant Forms.

The ward sister then tries to contact an approved social worker (ASW) as it is intended that where possible an ASW should make the report authorising the short term detention. No ASW is available at the time and may not be available until
the next day. The ward sister, who is suitably qualified and designated by the hospital to make authorisation reports, then makes the short-term detention authorisation on Form 8. As Victoria lacks capacity whether to make an application to the Review Tribunal a Form 7 is completed and the relevant information is sent to the Attorney General’s office.

Two days later Victoria’s condition has improved and she has regained capacity in relation to the care arrangements. As she no longer meets the criteria for detention amounting to a deprivation of liberty she is discharged from detention and agrees to stay as a voluntary patient to receive further treatment. A Form 21 is provided to Victoria noting the discharge from detention.

As Victoria is no longer deprived of liberty the Attorney General takes no further action.
Detention in hospital when detained in the normal place of residence

*If a person is deprived of liberty in a hospital and there is a prior trust panel authorisation a short-term detention authorisation is not required the first seven days.*

Victoria is a 69 year old lady who lives in a residential care home. Her mental capacity is limited and she is subject to a deprivation of liberty in the care home.

Staff in the home have found Victoria in a very confused state. The GP responsible for her normal care has visited the home and diagnosed a urinary tract infection which has cause delirium. It is the GP’s opinion that Victoria needs IV antibiotics and should therefore be taken to the Emergency Department (ED) at the local hospital.

The residential care home staff accompany Victoria to ED. Other staff are trying to contact Victoria’s relatives, but are unsuccessful. When arriving at the hospital Victoria is even more confused and tries to leave. ED staff are very concerned over her health and agree with the GP diagnosis and the need for IV antibiotics. They are of the opinion that with IV antibiotics Victoria will recover fairly quickly but without the medication she is at risk of serious harm due to the untreated illness. Staff considers that the criteria for short-term detention in hospital for examination or examination followed by treatment or care are met:

- Victoria suffers from an illness and requires treatment or care in hospital;
Victoria is unable to understand information due to the delirium which means she lacks mental capacity in relation to the deprivation of liberty;

It is in Victoria’s best interests to be deprived of liberty as this will allow her to receive treatment and regain capacity. If she is not deprived of liberty, she will not receive treatment and may therefore decline further; and

If Victoria is not deprived, and therefore does not receive treatment and is allowed to leave, there is serious risk that she will come to serious harm, both due to her confusion and lack of awareness and due to a deterioration in the illness. The deprivation of liberty therefore meets the prevention of serious harm condition threshold.

Staff are of the opinion that she needs to be deprived of liberty immediately. As Victoria is deprived of liberty in the residential care home where she normally resides staff understand that the trust panel authorisation for that deprivation of liberty allows deprivation of liberty in a place other than specified in the authorisation for the first seven days. This is noted on Victoria’s care plan and no further action in relation to authorisation is made.

Two days later Victoria’s condition has improved and she is ready to be discharged. She is discharged back to the residential care home where she continues to reside as before.
Short-term detention in hospital for examination or examination followed by treatment or care

If a person is deprived of liberty in a hospital and there is a prior trust panel authorisation a short-term detention authorisation is not required the first seven days. If the deprivation continues after seven days a short-term detention authorisation is required.

Victoria is a 69 year old lady who lives in a residential care home. Her mental capacity is limited and she is subject to a deprivation of liberty in the care home.

Staff in the home have found Victoria in a very confused state. The GP responsible for her normal care has visited the home and diagnosed a urinary tract infection which has cause delirium. It is the GP’s opinion that Victoria needs IV antibiotics and should therefore be taken to the Emergency Department (ED) at the local hospital.

The residential care home staff accompany Victoria to ED. Other staff are trying to contact Victoria’s relatives, but are unsuccessful.

When arriving at the hospital Victoria is even more confused and tries to leave. ED staff are very concerned over her health and agree with the GP diagnosis and the need for IV antibiotics. They are of the opinion that with IV antibiotics Victoria will recover fairly quickly but without the medication she is at risk of serious harm due to the untreated illness. Staff considers that the criteria for short-term detention in hospital
for examination or examination followed by treatment or care are met:

- Victoria suffers from an illness and requires treatment or care in hospital;
- Victoria is unable to understand information due to the delirium which means she lacks mental capacity in relation to the deprivation of liberty;
- It is in Victoria’s best interests to be deprived of liberty as this will allow her to receive treatment and regain capacity. If she is not deprived of liberty, she will not receive treatment and may therefore decline further; and
- If Victoria is not deprived, and therefore does not receive treatment and is allowed to leave, there is serious risk that she will come to serious harm, both due to her confusion and lack of awareness and due to a deterioration in the illness. The deprivation of liberty therefore meets the prevention of serious harm condition threshold.

Staff are of the opinion that she needs to be deprived of liberty immediately. As Victoria is deprived of liberty in the residential care home where she normally resides staff understand that the trust panel authorisation for that deprivation of liberty allows deprivation of liberty in a place other than specified in the authorisation for the first seven days. This is noted on Victoria’s care plan and no further action in relation to authorisation are made.

Victoria is quickly moved to a ward and IV antibiotics are started and it is expected that her treatment will be finished quickly. However, after six days it becomes apparent that Victoria will need further treatment and will remain an in-
patient for longer than seven days. As the trust panel authorisation will no longer be valid after the seven days a short-term authorisation is required.

The ward sister is aware of the requirements for a short-term authorisation and it is agreed that the treating doctor will carry out a formal assessment of capacity, best interests statement and the medical report. The doctor does this on the relevant Forms.

The ward sister then tries to contact an approved social worker (ASW) as it is intended that where possible an ASW should make the report authorising the short term detention. An ASW is available, comes and makes the appropriate examinations and then makes the short-term detention authorisation on Form 8. When considering if Victoria lacks capacity whether an application should be made to the Review Tribunal the ASW is of the opinion that he has capacity in relation to this and Form 7 is not completed.

Nine days later Victoria’s condition has improved and is ready for discharge back to the care home. A Form 21, discharge from detention, is provided to Victoria as she is no longer subject to a short-term detention authorisation.

As Victoria’s trust panel authorisation was never revoked and as the conditions for detention have been met continuously the trust panel authorisation which authorised the deprivation of liberty in the residential care home is still valid and in force. No further work in relation to authorisations are therefore needed when she is discharged from the hospital back to the home.
Deprivation of liberty in hospital with extension and later trust panel authorisation

A person can be deprived of liberty in hospital using the short-term authorisation report for up to 28 days. When the person is being moved from the hospital a trust panel authorisation is required.

Norman was diagnosed with dementia a number of years ago. He lives alone, with carer support four times every day. Today his daughter finds him much more confused than usual with visual hallucinations. She calls the GP who advises hospital admission.

Norman is diagnosed with delirium, but without any underlying cause, and admission to hospital is discussed. Staff believe that Norman currently lacks the capacity to make the decision about his hospital admission and the requirement to stay in hospital for treatment because of his delirium. A bed in an acute medical admissions ward is available. It is considered to be in Norman’s best interests to be admitted and deprived of liberty using a short-term detention authorisation for examination followed by treatment. Norman’s daughter, as nominated person, does not object to her father being admitted to hospital for examination and treatment even though this would mean a deprivation of liberty.

A short-term authorisation report requires a number of annexed forms, including a medical report. However, to delay admission until all of the required safeguards are in place would create an unacceptable risk of harm to Norman as it is determined that he needs admitted immediately. The
emergency provisions of the Mental Capacity Act are used to admit Norman to hospital.

Norman is admitted to the hospital ward and a medical report and short term detention authorisation are completed later that day. The medical practitioner and the approved social worker believe that Norman lacks the capacity to make the decision about staying in hospital for examination and treatment, has an illness that requires hospital admission for examination and treatment, that the prevention of serious harm condition is met, and that hospital admission for examination and treatment is in Norman’s best interests.

The short term detention authorisation authorises detention in hospital for an initial 14 day period. Norman is examined on admission and an admission report is completed by the responsible medical practitioner. The admission report confirms that:

- Failure to detain Norman in hospital would create a risk of serious harm to Norman (as his delirium would remain un-investigated and untreated, potentially leading to his death);
- The detention for examination and treatment is a proportionate response to the likelihood and seriousness of that potential harm;
- Norman lacks capacity to make the decision to be admitted and stay in hospital for examination and treatment; and
- It is in Norman’s best interests to be detained for examination and treatment for his delirium.

Norman still requires to stay in hospital after the initial 14 day period, as his delirium has not resolved and he stills lacks
capacity to make decisions about his hospital admission. A further report is required. Norman’s daughter is consulted as nominated person and does not have an objection to the extension of the short-term detention. A further report is completed by the alternative medical practitioner. This report confirms that:

- Failure to detain Norman in hospital would create a risk of serious harm to Norman (as his delirium still requires treatment, and failure to treat could potentially lead to his death);
- The detention for treatment is a proportionate response to the likelihood and seriousness of that potential harm;
- Norman lacks capacity to make the decision to stay in hospital for treatment; and
- It is in Norman’s best interests to be detained for treatment for his delirium.

The short term detention is authorised for a further 14 days.

When Norman has been in hospital for 21 days, the medical team agree that soon he will no longer need to be treated in an acute hospital ward, but will require on-going treatment after his discharge from hospital. It is agreed that due to Norman’s ongoing confusion caused by his delirium, this care and treatment should be delivered by nursing staff in a nursing home. Staff maintain their reasonable belief that Norman lacks capacity to make the decision about where his care and treatment should be provided. Staff are aware that the short term detention authorisation will expire in seven days and that it will not be valid outside the hospital. Staff
therefore start the process of authorisation for deprivation of liberty in a nursing home.

A registered nurse with the required training undertakes a formal assessment of capacity. This assessment concludes that Norman lacks the capacity to make the decision about how his care and treatment should be delivered to allow him to recover as fully as possible from his delirium. Norman is unable to understand or retain the information to allow him to make a decision, despite his daughter being involved in helping to provide the information to her father. The registered nurse notes that this is most likely due to the diagnosis of delirium (rather than dementia in this case). A formal statement of incapacity is made.

Norman’s daughter has been involved in all of the discussions around what care and treatment is to be provided in her father’s best interests. She is hesitant about her father going to a nursing home, anxious that he may never be able to return to his own home. She is reassured however that when her father regains capacity to make decisions on this matter independently, the deprivation of liberty authorisation must be removed. Norman’s daughter therefore raises no objection to the planned deprivation of liberty.

The required application form and annexed forms are completed and forwarded to the trust panel based in the Trust area where the care home is situated. The panel consider the application and authorise deprivation of liberty for Norman in a named nursing home for continuing treatment for his
delirium for a period of six months. At that point the authorisation for deprivation of liberty must be reviewed.

Norman moves to a nursing home where he is deprived of his liberty. He is subject to continuous supervision by staff, and the exit doors of the care home are locked, preventing him from leaving.

Norman receives continuing care and treatment for his delirium. He progresses over the course of the next three months and his daughter believes that he has regained the capacity to make decisions about where he should live and how he should receive any care and treatment.

An assessment of capacity is undertaken by a registered nurse with the relevant training. Norman is able to understand and retain the information provided to him about staying in the nursing home to receive appropriate care and treatment. He therefore is considered to have the capacity to make the decision independently. The condition of a lack of capacity for authorisation of a deprivation of liberty no longer exists. Norman can no longer be required to stay in the nursing home or be prevented from leaving the nursing home and is discharged from detention.

Norman agrees to stay in the nursing home as a voluntary patient for another two weeks to complete his planned treatment and to ensure that appropriate home care arrangements are in place to facilitate his return home. Norman is not prevented from leaving the nursing home when he wishes to do so in that two week period.
Care planning, deprivation of liberty and restraint

Care planning that includes restraint, deprivation of liberty and seclusion to protect the safety of the person.

Steve is a 35 year old man with severe learning disability. He is non-verbal and does not respond to speech. He is unable to indicate any understanding to questions and cannot express emotions which causes him to be physically aggressive. His aggression has caused himself serious physical harm as he has thrown himself against walls, banged his head against hard objects and put his fists through windows on a number of occasions. His aggression has also caused serious physical harm to others when he has hit his carers.

Steve has recently been assessed by the Behaviour Support Service who have developed a Behaviour Support Plan. The plan includes environmental changes, such as reducing unpredictable noises and using daily schedules, teaching him new skills to help him cope with his emotions and de-escalation strategies for the purpose of risk management.

The support plan is being incorporated in a new care plan which includes Steve being taken to a bedroom or quiet space if he shows signs of heightened agitation, physical restraint as a method to get him to his room and seclusion in the form of having the door closed on the bedroom if he becomes more agitated to protect both him and the staff, with staff standing outside the door monitoring Steve at all time. The care plan also includes provisions for day care facility with locked front doors as Steve has no concept of danger, high locks on rooms.
within the centre to limit movement and 2 to 1 care at all times to manage any incidents that may occur.

Steve’s mental capacity is assessed and it is determined that he lacks capacity in relation to the care plan and the care arrangements that amount to a deprivation of liberty that is contained in the care plan. A best interests meeting is convened where his treating consultant, behaviour support team representative, staff from his residential care home and day care centre and nominated person are present. It is agreed that the care plan (and the arrangements that amount to a deprivation of liberty) is in Steve’s best interests and that the plan includes a deprivation of liberty, as it includes locked facilities, seclusion and planned restraint. Considering the circumstances it is agreed that the prevention of serious harm condition is met.

A nurse from the residential care home where he resides completes Form 5 – application for trust panel authorisation. In the application she includes:

- a statement of incapacity on Form 1;
- a best interests determination statement on Form 2;
- a care plan on Form 4;
- a medical report on Form 6; and
- Form 7; the nurse completing the application form considers if Steve has capacity whether an application should be made about the Tribunal if the panel authorises the detention. As Steve is unable to communicate and is not responding to interaction the nurse considers that he lacks capacity whether an application should be made to the Tribunal and therefore fills in Form 7 and signs the statement.
The nurse signs the application and sends it to the trust in which Steve lives. As the panel has seven working days to make a decision the multi-disciplinary team decides that waiting for the authorisation before the care plan is effectuated would cause an unacceptable risk of harm to Steve so the deprivation of liberty is commenced using the emergency provisions of the Mental Capacity Act.

Six working days later the panel has made a decision and authorises the deprivation of liberty. The authorisation is added to the care plan to ensure that all staff who are working with Steve are aware of it.
Deprivation of liberty in an acute hospital

A person who is deprived of liberty in hospital for a physical ill should be detained using short-term detention authorisation

Colin was admitted to an acute medical ward having sustained a head injury caused by a fall. Colin also developed orthostatic hypotension and subsequently had a number of falls in the ward, causing further injuries.

The registered nurse considers Colin to lack the capacity to understand that he needs to stay in bed until his blood pressure stabilises to avoid further injury, including additional head injuries and that he lacks the capacity whether he should leave.

In an immediate attempt to prevent further collapses and potential injuries one to one nursing is introduced and a care plan outlining that Colin should be prevented from leaving if he tries to do so. This includes monitoring Colin’s movements and ensuring that he stays in his bed or chair. If he tries to leave the bed or chair the care plan notes that he should be prevented from leaving. The registered nurse believes that this intervention may need to continue until Colin has regained the capacity to understand the significance of the potential harm he could sustain because of the problems with his blood pressure.

The registered nurse considers that the conditions for a deprivation of liberty are met as Colin is not free to leave and is under continuous control and supervision. As Colin is deprived of liberty a short-term authorisation is sought.
Colin is monitored continuously and the care arrangements are regularly reviewed. After a few days Colin is much better and it is considered that he has regained capacity and that one to one nursing is no longer needed and Colin is discharged from detention. A few days later Colin is discharged home.
Capacity to make decisions, even if unwise, and times when decision cannot be made even if the person lacks capacity

No act can be made on behalf of a person who has capacity to make a decision (unless the person consents to the act). A person must be allowed to make capacitous unwise decisions even if this is against the wishes of others, including family and professionals. Family members cannot demand action and cannot veto actions by others.

Eileen is a 55 year old woman who has a severe learning disability and autism. She went to “Special School” and lived with her family until she was 16. At this point Eileen’s behaviour became more challenging and the family found it increasingly hard to cope. Eileen presented a risk to herself and others, including her siblings and as a result was admitted to Muckamore Abbey Hospital under the powers of detention in the Mental Health (Northern Ireland) Order 1986.

Eileen spent 10 years in hospital moving from acute admissions to the children’s ward and then the long-stay ward. She settled fairly well in hospital and responded well to the routine and her treatment. She also engaged positively in activities and the social scene in the hospital. She was often detained for long periods in hospital under the Mental Health Order. She was described as “Special Care”.

After many years Eileen moved into the community and increased the range of community based activities she attended, including going to an “integrated club” where clients from mental health services also attended. She starts to talk a lot about her friends at the club and is keen to spend
more time with them and to opt out of other activities she previously enjoyed. Issues that arose which resulted in a series of case discussions and reviews, included:

- Eileen talking about one of the group being her boyfriend. She openly says she loves Jim and he loves her. Jim lives in the local mental health group home and has an extensive forensic history, including acts of physical and sexual violence. The views of Eileen’s family and the engaged professionals are that this relationship is not in her best interests given her vulnerability and his history.
- Eileen’s compliance with her care plan and engagement with staff reduces significantly. She stays out very late, sometimes overnight and says that she wants to move in with Jim and marry him.
- Eileen subsequently becomes pregnant and gives birth to a daughter. There are pre-birth child protection meetings and her daughter is made the subject of a Care Order. Eileen only has limited contact and her daughter is placed for adoption.
- Eileen becomes pregnant again and is physically assaulted by Jim who is arrested and subsequently jailed for 18 months. This baby, is also taken into care. There is more contact with grandparents and kinship arrangements are considered for the baby.
- Eileen remains friendly with a group of friends from club. She reports to staff that she has no money. When asked further she eventually says that she always buys the other group attendees drinks and cigarettes, as she wants them to be her friends.
- Eileen is assaulted again by Jim when he is released from prison and this time she agrees to seek legal redress and a Non-Molestation Order is issued.
• Following this Eileen’s mental health deteriorates and she ends up detained under the Mental Health Order in hospital again. When she leaves hospital, a similar pattern continues.

Eileen’s family are very critical of the professionals and agencies involved and for failing to protect Eileen at all stages since she started going to the “integrated club” and met Jim. They insist that Eileen should have been deprived of liberty claiming that:

• they should have stopped her going out to see him and his friends;
• they should have intervened when it was obvious they were having a sexual relationship;
• they should have made other arrangements to protect her from Jim on his release from prison; and
• they failed to prevent her getting financially exploited by her “friends”.

The multi-disciplinary team now has a meeting with the family where the family’s concerns are discussed. At first the principles of the Mental Capacity Act are explained; that no assumptions can be made in relation to a person’s capacity, that the person must be allowed to make unwise decisions, that no assumptions can be made due to age or condition, that support must be provided and that any decision on behalf of the person must be in the person’s best interests. The team then go through the four individual complaints.

Firstly they talk about Eileen going seeing Jim and his friends. The team explains that in general no decision can be made on Eileen’s behalf if she is competent to make the decision, even if it is unwise. And as she has capacity in relation to care
arrangements that amount to a deprivation of liberty she should not be detained. The team also explains that Eileen has been provided support to help her keep safe. However, ultimately Eileen must be allowed to make decisions, even if they are risky and may appear unwise, as she has capacity to do so.

Secondly they talk about the sexual relationship. The team explains that a capacity assessment under common law was done in relation to sexual consent and that it was determined that Eileen did not have capacity to consent to sexual acts. The team also explains that even though she lacks capacity in relation to this there is not much that can be done to prevent it happening without depriving her of liberty. Various options were considered and it was determined that the only two ways of preventing sex was to either ensure that Eileen did not meet Jim, which could not be done as Eileen has capacity in relation to the care arrangements that would amount to a deprivation of liberty. Eileen does not appear to suffer any harm from the sexual activity, and while she does not have capacity in relation to the act, she expresses wishes and feelings that she wants to have sex with Jim. The prevention of serious harm condition is therefore not met and a deprivation of liberty can therefore not be done, even if she lacked capacity. The team also explains that help and support is provided to Eileen to help her understand sex (so she can become capacitous) and to help her understand what is happening when she is meeting Jim.

Thirdly they discuss the protection of Eileen when Jim was released from prison. The team explains as Eileen has capacity
to decide whether to see Jim therefore no acts can be done to stop it happening. This is even though seeing Jim may be considered unwise. Help and support is provided to Eileen with the effect that when she is assaulted again she agrees to stop seeing Jim and a Non-Molestation Order is put in place.

Fourthly they discuss the financial exploitation by her friends. Again the team explains that as Eileen has capacity in relation to care arrangements that would amount to a deprivation of liberty and nothing can be done to prevent her seeing her friends as the only mechanisms to do so would be a deprivation of liberty.
Deprivation of liberty and the Mental Health Order

If the Mental Health Order can be used it must be used.

Wendy is 16 and has an eating disorder. Wendy has had a year of community based treatment with limited response. She is underweight and not eating. She has recently lost a further 3kgs in weight and purges daily. Her blood potassium levels are dangerously low which could cause cardiac arrest. The GP and the approved social worker believe that Wendy requires to be hospitalised. They believe that she lacks the capacity to make a decision about eating a healthy diet, has an illness that requires hospital admission for treatment, that hospital is required to prevent serious harm, and that hospital admission for treatment is in Wendy’s best interests.

As Wendy meets the requirements of the Mental Health (Northern Ireland) Order 1986 she is detained for admission for assessment, in line with normal procedures. The Mental Capacity Act cannot be used.
Capacity in relation to the deprivation of liberty

Determining capacity

Applying the functional test.

Roberta is an 84 year old lady with early onset dementia. She lives by herself and has done so since her husband died 20 years ago. Her children live far away and while they have regular phone contact they do not often visit Roberta’s house.

Roberta has recently had a fall and has been hospitalised for the last week. During the hospital stay the hospital staff became concerned that Roberta was not eating properly at home and that she was very dirty. Her children also expressed surprise at the state Roberta was in as she appeared to have lost a lot of weight since the last time they saw her.

Roberta’s medical treatment is now finished and she is due to be discharged from hospital. The hospital staff are querying if she is able to cope at home and want her to move to a residential care home, rather than returning home. Roberta does not want to move to a care home and wants to return to her own home. She also expresses very strong views against anyone coming into her home to help her cope. It is considered that if Roberta is moved to a care home she would be deprived of liberty as she would most likely try to leave and return home.

A multi-disciplinary team meeting is called in the hospital where Roberta’s case is discussed. It is agreed at the meeting that Roberta’s ability to do normal day-to-day activities is severely reduced and that she is unable to provide food for
herself or to keep her personal hygiene at safe levels. All participants at the meeting are of the opinion that it would be best for Roberta to move to a residential care home and that if she doesn’t move to a care home she is at risk of serious physical harm to herself. It is agreed that a capacity assessment should be carried out to determine if Roberta has mental capacity to decide about the care arrangements amounting to a deprivation of liberty that will be put in place at the home.

It is agreed that a social worker, who has had previous interactions with Roberta, should carry out the capacity assessment.

The social worker speaks to Roberta at length in the hospital. Roberta expresses a clear wish to return home and to return to an independent life. She does not want to move to a residential care home. She also does not want to be “robbed” of her independence by being unable to leave.

The social worker tests if Roberta is unable to make a decision. Firstly he checks if Roberta can understand what they are discussing and if she can remember the information long enough to make a decision. Roberta is able to repeat what is being said and is demonstrating an understanding of the information.

Secondly the social worker asks Roberta about the consequences of her decision to see if she can appreciate and use and weigh the information. Roberta explains that she understands that poor hygiene and a lack of food may make her unwell and that this can cause her harm and even death.
She also understands what the effect of the care arrangements in the home would be in relation to these issues and that these arrangements would amount to a deprivation of liberty; that she would not be free to leave. She says that the risks identified are risks she is willing to take as she has lived a long and happy life which has always been independent, especially as the option is to lose the independence she has always had. The social worker is of the opinion that Roberta can appreciate and use and weigh the information and that she can communicate the decision.

The social worker therefore concludes that as Roberta is able to do the four aspects of the functional test she does not lack capacity in relation to the care arrangements amounting to a deprivation of liberty.

The social worker asks Roberta if she wants to move to a residential care home or receive help to cope in her home. Roberta confirms that all she wants is to go home without any help. As Roberta has capacity and as her medical treatment in hospital is complete she is discharged into her own home without further help imposed on her.
Appreciation and vulnerable adults

Appreciation in long term situations and deprivation of liberty. The requirement to meet the prevention of serious harm condition before a deprivation of liberty can be imposed.

Mary is a 23 year old woman with brain injury who lives in a supported living facility. The facility is staffed 24 hours a day and provides the residents with regular care. A number of months ago staff at the facility became concerned that Mary has had several incidents where she has become severely distressed that short-term relationships, including one night stands after visiting a local nightclub, have not developed into long term relationships. The staff recognised that Mary is vulnerable and were concerned about what actions should be taken to protect Mary. The staff considers locking the door and preventing Mary leaving to control who she is seeing.

A clinical psychologist was asked to determine Mary’s capacity in relation care arrangements amounting to a deprivation of liberty to prevent her visiting nightclubs with the ultimate aim to prevent the one night stands. During the assessment Mary demonstrated that she can describe the risks and benefits of going to nightclubs. She showed clear understanding that she becomes upset when there is no long term relationship as a result of the one night stands originating in the night club. Mary clearly retains the information well and can communicate her thoughts and her decision that she wants to continue going to the nightclub, but that she will resist one night stands as she knows this will only lead to distress.
The psychologist is of the opinion that Mary has capacity to make decisions around the care arrangements that would amount to a deprivation of liberty. As these arrangements are a direct impact on the nightclub visits and the one night stands this forms a substantial part of the discussion, in particular around harm. Ultimately, however, it is the capacity in relation to the arrangements that amount to a deprivation of liberty that is assessed.

The psychologist recommends that Mary should be supported to prevent disappointment when short term relationships, and one night stands, does not develop into long term relationships.

It is now six months later and there have been a further 13 incidents where Mary has become distressed following one night stands originating in the local night club. This affects Mary’s emotional and psychological wellbeing, however, Mary is not at immediate risk of serious harm.

The clinical psychologist has returned and is assessing Mary’s capacity again. Mary again clearly demonstrates that she understands the effect of care arrangements amounting to a deprivation of liberty by discussing the benefits and risks of going to the nightclub. She also expresses a clear understanding that one night stands will not lead to long term relationships and that this will cause her significant distress. Mary is insisting that she can go to the nightclub without a resulting one night stand.

The clinical psychologist considers that Mary can clearly understand the information, retain it long enough to make a
decision and communicate the decision. The psychologist is also considering that Mary can present a reasoned understanding of the effects of the decision. However, taking into account the evidence of her actions, which is contrary to what she is saying, the psychologist considers that Mary is unable to appreciate that going to the nightclub will lead to one night stands which in turn leads to distress. This means that she cannot appreciate that the care arrangements amounting to a deprivation of liberty may have positive effects on Mary. The psychologist therefore determines that Mary is unable to make a decision about the care arrangements amounting to a deprivation of liberty because of her brain injury; Mary therefore lacks capacity in relation to deprivation of liberty to prevent her going to nightclubs.

Before considering if a deprivation of liberty would be in Mary’s best interests the prevention of serious harm condition is considered; that failure to detain Mary would create a risk of serious harm to her or serious physical harm to others and the likelihood of harm and the seriousness of the harm is proportionate to the detention. The psychologist weighs up the arguments, including that the detention would be short-term and temporary although regular (as it would only prevent her to leave to go to the night club, in general on Friday and Saturday nights), that detention is a very serious infringement on a person’s human rights and the harm it would cause Mary to let her continue going to the night club.

The psychologist considers that, at present, the non-existence of long term relationships after one night stands causes Mary distress. However, the distress abates fairly quickly, within a
few days, and is not preventing Mary attending her place of work (day centre placement) or other regular events in the supported living facility. The psychologist therefore considers that while detaining Mary would prevent harm to her, the detention would not prevent serious harm and the detention would not be proportionate to the seriousness of the harm. As the prevention of serious harm condition is therefore not met the psychologist does not consider if a deprivation of liberty is in Mary’s best interests.

The psychologist informs the supported living facility that Mary cannot be prevented from leaving. However, to help Mary cope with break ups and to make decisions she is happy with the psychologist suggestion of regular meetings with a counsellor to help Mary. Mary accepts this help and the supported living staff help organise the meetings.
Unwise decisions

Making unwise decisions

A person is allowed to make decisions that to others appear unwise. Unwise decisions cannot be used as evidence of lack of capacity.

Mary is a 19 year old lady with a mild learning disability and attachment disorder. She lives in privately rented accommodation and has a social worker that helps her manage her money. Mary and the social worker has a good relationship and Mary is often keen on speaking to the social worker about her private life.

Mary has told her social worker that she is having casual sex with her landlord. Her social worker is concerned that the landlord is sexually exploiting Mary and using his position as her landlord to have sex with her. Mary is also very active online and regularly meets men she has met online for casual sex.

The social worker is concerned that Mary’s actions are putting her at risk and wants Mary to move to a 24 hour staffed supported living facility where she would be deprived of liberty as she would otherwise try to leave, in particular to have sex. However, Mary states that she is fine and that she is fully aware of the dangers of the lifestyle she is living, including the risk of getting killed and sexually assaulted. She also repeatedly refuses the request to move into a supported living facility and is very upset at the concept of being deprived of liberty.
The social worker is still concerned and reports the landlord’s behaviour to the police and wants it assessed if Mary has common law capacity to consent to sex (as the landlord may otherwise commit sexual offences) and mental capacity in accordance with the Mental Capacity Act in relation to the care arrangements that would amount to a deprivation of liberty at the supported living facility. The social worker discusses this in the multi-disciplinary team involved in Mary’s long term care and it is decided that the consultant psychiatrist on the team will assess Mary’s mental capacity.

The psychiatrist speaks with Mary, who is very open about her sex life and clearly expresses an understanding of the dangers of casual sex and meeting men online. Mary also expresses a clear understanding on all aspects of sex, including pregnancy, sexually transmitted diseases and contraception. In the discussion about supported living Mary is clear that she wants to reside at her own home and that she understands the risks of having casual sex with her landlord. She refutes that the landlord is exploiting her and states that she has sex with him because she wants to, not because he forces her.

Using the common law assessment of capacity the psychiatrists considers that Mary has an understanding about sex and residence. In the psychiatrists opinion Mary can consent to sex and has mental capacity in relation to care arrangements that would amount to a deprivation of liberty. No actions can therefore be taken to prevent Mary having sex and she cannot be forced to move away from her current residence.
Mary consents that the psychiatrists report is shared with the police. After the police receive the report they stop the investigation of sexual exploitation as the sex was consensual.

*It is important to note that although the Mental Capacity Act can never be used if the person has mental capacity there may be other protocols and procedures, such as vulnerable adult protocols, that it may be appropriate to follow.*
Deprivation of liberty and unwise decisions

A capacitous person cannot be deprived of liberty and must be free to leave, even if doing so is considered unwise by others.

Deprivation of liberty was authorised for Muriel in a care home for respite care 13 weeks ago to allow her to be treated for a delirium.

Muriel has regained capacity to independently make the decision about her care arrangements. This condition for an authorisation of deprivation of liberty is no longer met and Muriel can therefore no longer be deprived of her liberty.

Muriel wishes to return to her own home. She has limited family support and as yet not all of the required domiciliary care calls have been sourced. Muriel’s nearest relative, her nephew who lives in England, wants Muriel to stay in the care home. He believes the risk to Muriel’s safety, falling for example, are too much for her to manage living alone.

Muriel wants to return home immediately, regardless of whether the domiciliary care package is in place or not.

The risks are discussed with Muriel, who accepts that they exist. Staff in the care home and Muriel’s nephew believe that Muriel is making an unwise decision but, as Muriel has capacity, to prevent her from leaving the care home would be unlawful.

Muriel returns home without all of the required support package in place.
Best interests and prevention of serious harm condition

Best interests

*Special regard must be had to wishes, feelings, beliefs and values.*

*This case does not relate to deprivation of liberty. However, it provides a real life example of special regard to wishes, feelings, beliefs and values even if this is contrary to the clinically best decision.*

Ben is a 73 year old man. He is diabetic and has been a long-term sufferer of a form of bipolar disorder and a long-standing mental illness that has deprived him of the capacity to make most decisions for himself.

Ben is now suffering from peripheral neuropathy, a complication of diabetes resulting in reduced sensation in the feet. This can lead to the patient being unaware that they have damaged their foot, leading to ulceration and subsequent infection. Ben’s leg has now become severely infected. Ben’s doctor, Dr Shaw is considering whether to amputate the leg or not. If the leg is amputated Ben might live for a few years, if it is not, it is likely that he would die, quite possibly within a few days.

When examining Ben’s records Dr Shaw finds that Ben has a particular type of mental illness that causes him to have religious delusions. He has previously described hearing angelic voices that told him whether or not to take his
medication. Dr Shaw also finds that Ben has always put a lot of importance to his religious views.

Dr Shaw assesses Ben’s mental capacity and finds that he lacks capacity as he cannot appreciate and use and weigh the information to make an informed decision. Dr Shaw also determines that the medically best option would be to have surgery to amputate the leg.

Dr Shaw then considers the best interests of Ben, including consulting with all relevant people and having special regard to his wishes, feelings, beliefs and values. Although Ben lacks capacity Dr Shaw starts by speaking to him to involve him as much as possible in the decision. They discuss Ben’s preferred option and what his wishes, feeling, beliefs and values are. During this discussion Mr B says:

I don’t want an operation.

I’m not afraid of dying, I know where I’m going. The angels have told me I am going to heaven. I have no regrets. It would be a better life than this.

I don’t want to go into a nursing home, my wife died there.

I don’t want my leg tampered with. I know the seriousness, I just want them to continue what they’re doing.

I don’t want it. I’m not afraid of death. I don’t want interference. Even if I’m going to die, I don’t want the operation.
Dr Shaw then speaks to others, including Ben’s nominated person. In these discussions it becomes evident that Ben’s religious views are strong and persistent. It also becomes evident that Ben’s future life quality would be significantly limited if he has to live in a residential care or nursing home as he has strong negative connotations with them after his wife passed away in one.

Dr Shaw considers that Ben’s expressed wishes, whilst not capacitous, did not appear to be showing florid psychiatric symptoms or to be unduly affected by toxic infection; rather they appeared to reflect his religious views. Even if the operation to amputate the foot was a success, the loss the foot would be a continual reminder that his wishes, feelings, beliefs and values had not been respected. Further to that, Ben’s religious sentiments will undoubtedly continue and he will believe that the amputation was carried out against the Lord’s wishes.

Dr Shaw also considered Ben’s life after a successful operation, where he would not be able to return to any sort of independent life. At this point Ben has already been in hospital for 15 months and, given his multiple physical and mental difficulties, a discharge date could not be predicted. Dr Shaw considers that the best that could be hoped for was a discharged to a residential care home or, more likely, a nursing home.

To determine Ben’s best interests, Dr Shaw combines all the known factors and after having special regard to wishes, feelings, beliefs and values finds that it would not be in Ben’s
best interests to take away the little independence and dignity he has in order to replace it with a future for which he does not want and which would be against his strongly held religious beliefs.

Dr Shaw therefore finds that the best interests of Ben is not to have surgery to amputate the leg and that he should be allowed to die in accordance with his religious views.

This is an adaptation of the Court of Protection case of Wye Valley NHS Trust v Mr B [2015] EWCOP 60.
Least restrictive option and alternatives to deprivation of liberty

Less restrictive practices and finding alternatives to deprivation of liberty

A person who is not deprived of liberty must be free to leave when he or she wishes.

Minnie is 84 years of age. Her physical health is in decline. She needs assistance with personal care tasks and walks with a Zimmer frame. A distant niece has recently arranged for admission to a local nursing home, but has little other involvement in Minnie’s life. Minnie has a diagnosis of dementia but this is not the main reason for admission to the care home. She was able to participate in the decision making around moving to the care home.

The nursing home staff note that Minnie becomes distressed when she cannot get outside for a walk during the day. Staff believe that although Minnie has fluctuating levels of confusion, nevertheless she could go outside for walk and return safely back to the care home. The exit doors of the nursing home can only be opened by keying number code into a keypad. Minnie has been given the exit code but she cannot remember the numbers. Staff have written the code on a piece of paper for Minnie. However, her dementia makes it difficult for her to understand what to do with the information. If Minnie wants to go outside for a walk she needs a member of staff to permit her access in and out of the home.
The home manager considers that Minnie is being deprived of her liberty, although that is not the intention of the staff. The home manager is concerned that staff are acting unlawfully because there is no legal basis to deprive Minnie of her liberty, although in reality this is what is happening; staff are in control of when Minnie can exit the home. The home manager considers that Minnie is able to make decisions about her safety when outside the home. Deprivation of liberty is not appropriate or in Minnie’s best interests.

The home manager arranges for a key operated lock on the front door, which will work in tandem with the electronic keypad. Minnie is given a door key. She is able to exit and re-enter the building when she wishes to do so.
Less restrictive practices and finding alternatives to deprivation of liberty

Restrictive practices may be a suitable alternative to deprivation of liberty.

Ivan is an 82 year old man who has lived with his wife in a care home for around five years. He was diagnosed with dementia a number of years ago. Physically he is well. As a younger man he regularly ran marathons, running until he was 70 years old. When he was no longer fit enough to run, Ivan walked around five miles every day. He really enjoys being outside.

When he and his wife moved to the care home, Ivan maintained his daily walking routine. He always informed the staff in the care home when he was leaving the home, and gave an approximate return time.

Recently staff have noted a deterioration in Ivan’s memory. He has become confused about the time of day, regularly thinking evening time is morning time. He often forgets that he has already been for his daily walk. He has started leaving the care home much more frequently and has stopped informing staff when he leaves. He is walking further away from the care home than he used to. He has gotten lost on a number of occasions recently, and has been returned to the home by the police.

An assessment of capacity indicates that Ivan is unable to independently make decisions about his safety when outside of the care home. The nursing home manager and her team meet with Ivan’s family to discuss their concerns. Ivan’s eldest
son was appointed nominated person when Ivan was first diagnosed with dementia. Ivan is leaving the care home more often than he did before, increasing the risk of harm to himself. Together the staff and Ivan’s son discuss how to keep Ivan safe. Three options are discussed:

- Authorised deprivation of liberty, which would allow staff to keep the exit door locked and Ivan in the building;
- A GPS tracking system; and
- 30 minute checks by staff of Ivan’s whereabouts.

Option A is not considered to be in Ivan’s best interests. Special regard is given to the fact that Ivan has always been an “outdoors” person and to not allow him the option of an independent daily walk would be detrimental to his physical, mental and emotional health.

Option C is not suitable either, as Ivan could leave the building in the time between checks.

Option B appears to be the most suitable, least restrictive option. Ivan’s son agrees that a GPS tracking system with a pre-determined perimeter would be appropriate. The system would alert staff and family when Ivan moves outside of the perimeter, allowing someone to monitor Ivan and direct him back home if he appears lost. This will allow Ivan to continue his daily walking routine, whilst providing some reassurances about his safety. There is some discussion around the ethical use of a tracking device. Ivan’s son confirms that he believes his father would not object to the use of the tracking device if it allows him to continue to have the freedom to walk safely around the neighbourhood.
Ivan now wears a keyring on his belt that incorporates a GPS tracker that alerts Ivan’s son when he walks outside of the agreed perimeter, allowing his son to quickly locate him or alert the care home of Ivan’s whereabouts.
Restraint and exceptions

Restraint in an acute hospital ward

A person can be restrained to prevent harm without it amounting to a deprivation of liberty

Colin was admitted to an acute medical ward, having sustained a head injury caused by a fall. Colin also developed orthostatic hypotension and subsequently had a number of falls in the ward, causing further injuries. The registered nurse considers Colin to lack the capacity to understand that he needs to stay in bed until his blood pressure stabilises to avoid further injury, including additional head injuries. However, the circumstances of the care does not meet the test for deprivation of liberty as he would be free to leave to ward if he so wished.

In an immediate attempt to prevent further collapses and potential injuries one to one nursing is introduced. This includes monitoring Colin’s movements and encouraging him to stay on his bed or chair. If he tries to leave the bed or chair the nurse will support him to ensure he doesn’t fall and hurt himself. This may include restraining Colin by holding him to prevent immediate harm. The registered nurse believes that this intervention may need to continue until Colin has regained the capacity to understand the significance of the potential harm he could sustain because of the problems with his blood pressure. A number of days later Colin is much better and the one to one care can stop. Colin is later discharged home.
Example Forms

Short-term detention in hospital – scenario with forms

Admission into ED by patient with diabetic ketoacidosis who required detention in hospital to receive treatment for diabetes and associated illness. Without treatment and detention in hospital it was considered that the patient’s life would be at risk.

Mr Brown was admitted from the Emergency Department (ED) to the Acute Medical Unit (AMU) with diabetic ketoacidosis (DKA). Mr Brown has subsequently developed alcohol withdrawal becoming agitated, sweating and hallucinating. He has been attempting to leave the ward. Alcohol withdrawal treatment is required with the sedative chlordiazepoxide.

Mr Brown’s blood sugars are not under control. Mr Brown continues to be confused. The suspicion is of an underlying alcohol related brain injury (ARBI). Treatment with intravenous vitamins is commenced.

Mr Brown is under continuous supervision and control on the medical ward. He is not free to leave because his medical condition may deteriorate to become life threatening. There is a reasonable belief he does not have capacity to decide to stay in hospital which is based on his presentation with confusion and hallucinations.
Medical background:

**Diabetic ketoacidosis (DKA)** is a life threatening condition where blood sugars become dangerously high. In someone who does not take insulin properly or eat regularly after DKA blood sugar control may be problematic even if the person is in hospital.

**Alcohol withdrawal** is a physical condition with confusion, sweating, tremor hallucinations. Alcohol withdrawal happens 24-48 hours after a person, who has been drinking a large amount of alcohol daily for weeks or months, stops alcohol intake suddenly. It is a serious condition where seizures and unconsciousness may develop. If untreated 5% of patients may die. The treatment is with a sedative drug.

**Alcohol related brain injury (ARBI)** is a condition where chronic alcohol use and nutritional depletion of a vitamin called thiamine interferes with the function of the brain. A person presents as confused and often confabulates - that is on questioning- makes up answers that sound plausible but are in fact untrue. The treatment is with an intravenous vitamin preparation. ARBI may or may not be reversible with this treatment.
Form 1 – Statement of incapacity

A statement of incapacity can only be carried out by a medical practitioner, a nurse, a midwife, a social worker, a dentist, an occupational therapist, a speech and language therapist or a practitioner psychologist who has received specific training in the 36 months prior to making the statement and has 2 years’ experience in the last 10 in working with persons who lack capacity.

The decision maker must ensure that the reasons for making a statement of incapacity are recorded on this form. The supporting evidence can be provided in the person’s care plan or notes in line with professional or agency requirement. It is not necessary to duplicate the supporting evidence on this form but a note should be made of where it can be found.

1. The person’s details (a label can also be affixed here)

Name: Mr Brown

2. The assessors details

Name: A ward nurse manager

3. Date of formal assessment of capacity

Date the assessment was carried out: 02/12/2019

4. Support to the person

Before deciding that someone lacks capacity, all practical help and support must be provided to enable the person to make a decision by themselves. This includes considering the environment and timing of the decision, ensuring that appropriate communication support is provided to the person and involving all relevant people who might help the person make the decision.

(delete as appropriate)

Has the environment for the decision been considered? Yes
Has the timing for the decision been considered? Yes
Has all practical help and support, including communication support, been given? Yes
Have all relevant people who may help the person make a capacitous decision been included? Yes
Has the information relevant to the decision been provided and/or explained in a way which is appropriate? For example, in simple language?

Provide details.

Mr Brown was assessed privately in the ward office. He was assessed after lunch when his blood sugars were stable. Mr Brown had had chlordiazepoxide prior to assessment which controlled his symptoms of alcohol withdrawal. He was alert and cooperative and not made drowsy by the medication. No requirement for any additional communication support was identified. Mr Brown’s wife attended the assessment with him which had a calming effect. The discussion with Mr Brown used simple language and non-medical terms for example ‘very high blood sugars that were life threatening’ instead of ‘diabetic ketoacidosis’. Easy read information with regard to both diabetic ketoacidosis and alcohol withdrawal were provided although Mr Brown had difficulty focusing to read these information leaflets.

5. Three Elements Test of Mental Capacity

Functional test

In relation to the detention amounting to deprivation of liberty, the person in section 1 is unable to (delete as appropriate)

understand the information relevant to the care arrangements amounting to a deprivation of liberty.

Provide details on how the person is unable to do the above and how this has been determined.

Mr Brown was unable to understand the risk of his diabetes becoming unstable again (as it was prior to his admission). He was unable to understand the requirement for regular insulin or what dose of insulin he may need to administer. He was unable to explain what he would need to do in terms of delivering an increased dose of insulin should his sugars become elevated. He was unable to understand that he needed to stay in hospital for care and treatment in order to prevent a further episode of life threatening diabetic ketoacidosis.
Impairment or disturbance test

There is no need for a formal diagnosis, it is sufficient to have reasonable belief that there is an impairment of, or disturbance in the functioning of, the mind or brain.

Provide details on the impairment of, or disturbance in the functioning of, the mind or brain.

Mr Brown presents in a state of acute alcohol withdrawal with a likely additional alcohol related brain injury both resulting in significant impairment in the functioning of his brain.

Causal link

For a statement of incapacity to be provided there must be a causal link between the inability to make a decision in relation to the detention amounting to a deprivation of liberty and the impairment of, or the disturbance in the functioning of, the mind or brain. If there is no causal link the person does not lack capacity in the meaning of the Mental Capacity Act.

Provide details on the causal link.

I believe that Mr Brown’s inability to understand the risk of his high blood sugars and his subsequent need to stay in hospital for management of the high blood sugars is because of the above disturbance in the functioning of the mind or brain.

6. Decision

If a person is unable to make a decision because they have an impairment of, or disturbance in the function of, the mind or brain a statement of incapacity can be made.
Statement of Incapacity

I certify that Mr Brown (name) lacks capacity within the meaning of the Mental Capacity Act (Northern Ireland) 2016 in relation to the care arrangements which amount to a deprivation of his liberty and that I am suitably qualified to make a statement of incapacity.

Signature: need to sign

Date: 02/12/2019
Form 2 – Best interests determination statement

A decision to deprive a person of liberty must be made in the person’s best interests.

The decision maker should ensure that the reasons for this determination are recorded on this form. The supporting evidence can be provided in the person’s care plan or notes in line with professional or agency requirements. It is not necessary to duplicate the supporting evidence on this form but a note should be made of where it can be found.

1. The person’s details (a label can also be affixed here)

   Name: Mr Brown

2. The assessors details

   Name: Dr

3. Checklist

   Have you ensured you have not made assumptions based on the person's age, appearance, condition or behaviour?

   Yes √  No □

   Have you considered all the relevant circumstances?

   Have you tried whatever is reasonable and practicable to permit and encourage the person to take part, or to improve their ability to take part, in determining what is the best interests?

   Yes √  No □

   You must have special regard to past and present wishes and feelings and beliefs and values.

   Have you had special regard to the person’s past and present wishes and feelings (expressed verbally, in writing or through behaviour or habits)?

   Yes √  No □
Have you had **special regard** to any beliefs and values (religious, cultural or moral) and any other factors which would be likely to influence the decision?

Yes √  No □

Have you considered the human rights of the person?

Yes √  No □

Have you considered other options that may be less restrictive of the person’s rights?

Yes √  No □

Have you consulted all relevant people as far as it is practical and appropriate to do so, including any person named by the person, anyone engaged in caring for the person or interested in the person’s welfare?

Yes √  No □

Have you consulted any nominated person?

Yes √  No □

Have you considered the risk of harm to others which may result in harm to the person?

Yes √  No □

4. **Nominated person**
The nominated person’s details:
Name: Mrs Relative Brown

The nominated person has been **selected from the default list**

The nominated person must be consulted with during the best interests determination, if it is practicable and appropriate to do so. If it is not practicable and appropriate provide details.

Provide details of the consultation with the nominated person, including how the consultation took place and the views of the nominated person on P’s wishes, feelings, beliefs and values. If Form 3 has been used to provide details of the consultation with the nominated person, note that below and attach Form 3 to the best interests statement.

Mrs Brown feels that Mr Brown has had difficulty with his diabetes and has been happy to remain in hospital on past
occasions for the treatment and control of his blood sugar. She feels that the withdrawal and effects of alcohol are affecting his judgement on this occasion. Mrs Brown would like to take Mr Brown home but is aware of the care and treatment he is receiving in hospital. The same level of care and treatment would not be available at home and Mrs Brown and feels that it is in the best interests of Mr Brown to remain in hospital for now.

5. **Consideration**

Outline factors which suggest that deprivation of liberty may *not* be in the person’s best interests.

No factors identified

Outline whether it is likely that the person will have capacity at some point, and if so, whether or not is it appropriate to delay the deprivation of liberty until the person can make a decision.

It is hoped that Mr Brown will regain capacity in the coming days or weeks as the features of the acute alcohol withdrawal subside. The alcohol related brain injury (ARBI) is being treated however the impact of this condition upon Mr Brown’s capacity in the longer term (months to years) is not predictable at this time. It is not appropriate to delay the DOL because Mr Brown needs immediate care and treatment in hospital to reduce the risk of a life threatening diabetic ketoacidosis developing.

Outline the reasoning why the deprivation of liberty is in the best interests of the person. This should include what other options have been considered, who has been involved in the decision and how the person’s past and present wishes, feelings, beliefs, values and any other factors that the person would have included if he or she had capacity have been considered. It must also include consideration of harm, including how the prevention of serious harm condition is met.

The DOL is in Mr Brown’s best interests. Mr Brown’s detention in hospital will enable care and treatment to continue to be provided thereby reducing the risk of a life threatening diabetic ketoacidosis developing again. Diabetic ketoacidosis was the condition Mr Brown was admitted to hospital and could recur without proper blood sugar control. The prevention of serious harm condition is therefore met. The option of Mr Brown going home with supervision from his wife, the community diabetic nurse and the district nursing team was explored as a less restrictive option. Mrs Brown did not feel she could provide the same level of
support that the hospital staff could provide and was concerned that Mr Brown would leave the home and consume alcohol thus further destabilising his blood sugars. The district nurse could attend the home but only for around 15 minutes twice a day to administer the insulin, not to provide ongoing care and treatment.

Mr Brown has had several previous admissions to hospital in Jan 2018, June 2018 and August 2019. During these admissions there was no belief Mr Brown lacked capacity. He stayed in hospital voluntarily on these occasions until his sugars were stable.

It is believed that if Mr Brown was free to leave he would be leaving and would be consuming alcohol. This would cause immediate risk of serious harm and if he left it would prevent the medical treatment he urgently requires.

This best interests determination with regard to the DOL of Mr Brown has been considered by the nursing manager, the diabetic nurse, the medical consultant and Mr Brown’s nominated person his wife.

6. Statement

Best interests should be determined on the grounds of reasonable belief and must include special regard to the person’s past and present wishes, feelings, beliefs, values and any other factors the person would have considered if he or she had capacity.

Best interests determination statement

It is my opinion that it is in the best interests of _______Mr Brown____________________(name) to be deprived of his liberty.

Signature: to be signed

Date:02/12/2019
Form 6 – Medical report

A medical report must be attached to a Form 5, application for trust panel authorisation, Form 8, short-term detention authorisation and Form 16, application for trust panel extension authorisation.

The medical report must be done by a medical practitioner who is suitably qualified and who is unconnected to the person.

1. The person's details (a label can also be affixed here)

Name: Mr Brown

2. Medical practitioner who is making the report

Name: Dr

3. Criteria for authorisation – care and treatment

Is care and treatment available in the place where the person will be deprived of liberty?
Yes

Provide details on the care and treatment.

Care and treatment includes three to four times daily monitoring of blood sugars. Adjustment of insulin will be done at each mealtime to stabilise Mr Brown’s diabetes. Mr Brown will also receive treatment for alcohol withdrawal with clor Diazepam. He will also receive multivitamins called pabrinex to reduce damage caused from alcohol related brain injury.

4. Criteria for authorisation – lack of capacity

Have you personally completed a Form 1 – statement of incapacity?
No

If yes, continue to section 5.
If no, fill out the rest of section 4.

Provide details of how the person lacks capacity to make the decision, including how the statement of incapacity has been considered.

References can be made to Form 1 – formal assessment of capacity.

A capacity assessment was performed by my colleague nurse manager 02/12/2019. Please see Form 1. The manager found
that Mr Brown was unable to meet the requirements of the functional test. He did not understand the information relevant to the risk of uncontrolled diabetes nor that the risks would result in significant harm should he not be detained in hospital. Relevant support was given during the capacity assessment.

5. **Criteria for authorisation – best interests**

Have you personally completed a Form 2 – best interests determination statement? **No**

*If yes, continue to section 6.*

*If no, fill out the rest of section 5.*

The nominated person must be consulted with during the best interests determination, **if it is practicable and appropriate to do so. If it is not practicable and appropriate provide details.**

The nominated person’s details:
Name: Mrs Brown
The nominated person has been **selected from the default list**

Provide details of how the intervention is in the person’s best interests, including how the best interests determination statement has been considered.

*References can be made to Form 2 – best interests statement.*

The NP was consulted during the best interests determination (see Form 2). It is not appropriate to discuss the case again with the NP to avoid unnecessary stress to NP.

6. **Criteria for authorisation - prevention of serious harm condition**

Would failing to detain the person in circumstances amounting to a deprivation of liberty create a risk of serious harm to the person or of serious physical harm to other persons? **Yes**

Is the detention proportionate to the likelihood of harm concerned? **Yes**

Is the detention proportionate to the seriousness of the harm concerned? **Yes**

*If no to any of the questions the prevention of serious harm condition is not met.*

Provide details of how the prevention of serious harm condition is met.
If Mr Brown were to leave hospital there is a significant risk of his condition deteriorating to become life threatening. He was admitted with life threatening diabetic ketoacidosis and it is probable without the correct care and treatment that this would recur. If Mr Brown was not deprived of liberty he would leave. The detention in hospital is proportionate to the risk of harm which is significant and serious.

7. **(Only for short-term detention) criteria for authorisation – illness / suspected illness**

Does the person have an illness or a suspected illness? **Yes**

*If there is no illness or suspected illness a short-term detention authorisation cannot be made.*

Provide details of the illness or suspected illness.

Mr Brown is suffering from the effects of uncontrolled diabetes, alcohol withdrawal and alcohol related brain injury.

8. **Statement**

**Statement**

I am unconnected with the person in section 1 and I am suitably qualified to make a medical report under the Mental Capacity Act (Northern Ireland) 2019.

In my opinion the criteria for authorisation are met and I have examined the person in section 1 no more than two days before the date on which this report was signed.

Signature: to be signed

Date: 03/12/2019
Form 8 – Short-term detention authorisation for examination or examination followed by treatment or care

1. **The person’s details (a label can also be affixed here)**

   Name: Mr Brown

2. **Person who is making the authorisation report**

   *It is intended that where possible an ASW should make the report authorising the short term detention.*

   Name: ASW in the hospital
   Professional role (delete as appropriate):
   Approved Social Worker

3. **Responsible medical practitioner (if same as person making the authorisation, leave blank)**

   Name: Dr

4. **Hospital of detention**

   In what hospital, including ward and address, is the person being detained?
   Ward. Hospital.

5. **Examination or examination followed by treatment**

   Provide details of the examination, and if followed by treatment, details of the treatment (if known):
   Mr Brown is receiving care and treatment on the Acute Medical Unit. Blood sugars are being monitored and insulin prescribed and administered. In addition Mr Brown is receiving treatment for alcohol withdrawal with chlordiazepoxide and alcohol related brain injury with intravenous vitamin preparation.

6. **Capacity whether to apply to the Review Tribunal**

   In your opinion, does the person lack (or probably lack) capacity to decide whether an application to the Review Tribunal should be made? **No** (delete as appropriate)
A person does not need to have the ability to make an application to the Review Tribunal. The determination of capacity only relates to the decision on whether an application should be made or not.

The distinction is important. This assessment relates to the capacity to decide whether an application should be made or not. Even if the person does not have ability to understand what the Tribunal process is or how an application should be made or be able to make an application, the person may still have capacity to decide whether or not an application should be made for an independent check on care arrangements that amount to a deprivation of liberty.

If the person is able to understand
  d. that the care arrangements mean that someone will always be checking on him or her;
  e. that he or she cannot leave when he or she wishes to leave; and
  f. that a meeting can take place to decide whether or not that should be allowed
then it is likely that the person has the capacity whether to apply to the Review Tribunal.

If yes a Form 7 has to be attached to the authorisation.

7. **Objection from the nominated person**

Is the nominated person providing a reasonable objection to the short-term detention for examination or examination followed by treatment or care? **No**

If yes a Form 9 has to be attached to the authorisation.

8. **Annexes that must be attached to the authorisation**

The annexes form part of the authorisation and must be included (if required).

Annex A – statement of incapacity on Form 1.
Annex D – statement on capacity to apply to the Review Tribunal on Form 7 (if required).
Annex E – approved social worker report on Form 9 (if required).
9. **Further information / comments**

Further information or comments by the authoriser. This can include other evidence or observations not captured anywhere else in the authorisation. There are no requirements to add any further information.

No further comments

10. **Declaration**

**Declaration**

I have seen the person in section 1 personally no more than two days before the date below and in my opinion, based on the content of this authorisation and attachments, the criteria for detention are met.

This report authorises the detention in circumstances amounting to a deprivation of liberty in the hospital noted at section 4 for the purpose of examination or examination followed by treatment or care as outlined in section 5.

Signature: to be signed

Date: 03/12/2019

11. **Decision not to proceed with authorisation**

If the authoriser decided not to authorise the short-term detention this can be recorded below. The declaration above should not be signed if the authorisation is not proceeded with. There are no requirements to use this form if an authorisation is not proceeded with.

Not applicable
Form 11 – Short-term detention admission report

If more space is required additional sheets or information may be attached to this form.

1. The person’s details (a label can also be affixed here)

Name: Mr Brown

2. Person who is making the report

Name: Dr (RMP)

3. Responsible medical practitioner (if same as person making the report, leave blank)

Name:

4. Examination or care

What examination or care will be provided to the person?

Mr Brown is receiving care and treatment on the Acute Medical Unit. Blood sugars are being monitored and insulin prescribed and administered. In addition Mr Brown is receiving treatment for alcohol withdrawal with chlordiazepoxide and alcohol related brain injury with intravenous vitamins.

5. Harm

How would failure to detain the person, for the purposes of examination or care as outlined in section 4, create a risk of serious harm to the person or risk of serious physical harm to others?

The serious risk is of a life threatening diabetic emergency, significant effects from alcohol withdrawal or of permanent alcohol related brain injury. If Mr Brown was not detained he would leave and would therefore not receive treatment.

6. Proportionality

Explain the likelihood of harm to the person or physical harm to others, the seriousness of the harm and how the detention is proportionate to the harm.
The risks are significant and proportional to detaining Mr Brown on a medical ward in hospital. Failure to detain him carries a real risk to his life.

7. **Capacity**

Does the person lack capacity in relation to the short-term detention? **Yes**

Explain how the person lacks capacity and which part of the functional test the person is unable to do.

Mr Brown is unable to meet the functional test because he does not understand the life threatening risks associated with improper management of his diabetes or alcohol related conditions. He has a disturbance of his cognitive function secondary to acute alcohol withdrawal and/or alcohol related brain injury. The former is caused by the latter.

8. **Best interests**

Is the short-term detention in person’s best interests? **Yes**

Explain the best interests determination.

It is in Mr Brown’s best interests to receive care and treatment in hospital in order to prevent the development of a life threatening diabetic condition and also to reduce the effects of alcohol withdrawal and/or any subsequent alcohol related brain injury.

If Mr Brown was free to leave he would leave and would therefore not receive the treatment. Mr Brown has in the past not expressed any wishes and feelings about detention, but has expressed a wish during our discussions to receive treatment.

9. **Nominated person**

Has the nominated person been consulted? **Yes**

*The nominated person must be consulted with if practical and appropriate.*

Has the nominated person provided any further/new information since the creation of the short-term detention authorisation report? **No**

*If yes, provide details:*
10. **Declaration**

**Declaration**

In my opinion (delete as appropriate):

b) the conditions for detention are met and the authorisation can continue.

Signature: to be signed

Date: 04/12/2019

*If the person signing the declaration is not a responsible medical practitioner or another medical practitioner a further admission report must be made within 48 hours of this report being signed.*
Form 13 – Short-term detention further report

If more space is required additional sheets or information may be attached to this form.

1. **The person’s details (a label can also be affixed here)**

   Name: Mr Brown

2. **Person who is making the report**

   Name: Dr (RMP)

3. **Examination or care**

   What examination or care will be provided to the person?
   Mr Brown will be provided with ongoing management of his insulin dosing in order to optimise his blood sugar control. He continues to receive education about his diabetes management in hospital. Mr Brown remains cognitively impaired most likely due to a possible alcohol related brain injury. He continues to need support and prompting to carry out tasks related to personal care. His gait is unsteady. He is having ongoing input from the occupational and physiotherapists to optimise his functional ability.

4. **Harm**

   How would failure to detain the person, for the purposes of examination or care as outlined in section 4, create a risk of serious harm to the person or risk of serious physical harm to others?
   Failure to detain Mr Brown would result in the risk of his diabetes becoming uncontrolled which may deteriorate into a life threatening situation. There is risk of Mr Brown falling at home and sustaining an injury particularly when his wife is not there. Due to his diabetes the risks associated with falling are significant. Mr Brown is at risk of not attending to his personal care and hygiene which would leave him at increased risk of infection particularly given his diabetes.
5. **Proportionality**

Explain the likelihood of harm to the person or physical harm to others, the seriousness of the harm and how the detention is proportionate to the harm.

It is more likely than not that Mr Brown would come to serious harm as outlined above should he leave hospital at this time. The detention on a general hospital ward is proportionate. Mr Brown is accompanied off the ward when he wishes although this can only be whenever ward staffing allows.

6. **Capacity**

Does the person lack capacity in relation to the short-term detention? **Yes**

Explain how the person lacks capacity and which part of the functional test the person is unable to do.

Mr Brown continues to fail to understand the significance of the risk associated with improper management of his diabetes. He has a disturbance of his cognitive function secondary to a probable diagnosis of alcohol related brain injury. The former is caused by the latter.

7. **Best interests**

Is the short-term detention in person’s best interests? **Yes**

Explain the best interests determination.

Mr Brown is unable to manage his diabetes independently. It is in his best interests to remain in hospital until the diabetic nurse in the community and the district nursing team can be available to administer his insulin. Prior to this admission Mr Brown had been engaging with diabetic clinic which had demonstrated his wish to have his diabetes managed. Mr Brown has shown some improvement in cognitive function during his time in hospital. With further rehabilitation input from the multidisciplinary team and with the provision of a care package in the community it is hoped that Mr Brown can be discharged home safely. Mr Brown is engaging with the multidisciplinary team and is not displaying distress or making attempts to leave the ward at present.

At this point allowing Mr Brown to be free to leave would mean a likely risk of Mr Brown leaving. This would cause a
risk to his life. As Mr Brown has expressed wishes to engage regarding his diabetes it is believed that Mr Brown wants the treatment. It is therefore determined that Mr Brown’s best interests are to be detained in hospital until he has improved sufficiently to manage his condition independently.

8. **Nominated person**

Has the nominated person been consulted? **Yes**

The nominated person must be consulted with *if practical and appropriate.*

Has the nominated person provided any further/new information since the creation of the short-term detention authorisation report? **No**

*If yes, provide details:*

9. **Declaration**

```
Declaration

In my opinion (delete as appropriate):

b) the conditions for detention are met and the authorisation can continue.

Signature: to be signed

Date: 13/12/2019
```
Trust panel authorisation – scenario with Forms
Discharge from hospital into nursing home with a trust panel authorisation in the nursing home.

Mrs Dale was admitted to hospital 3 weeks ago from the Emergency Department (ED). A concerned neighbour had phoned the police when he found Mrs Dale wandering in the street and she was transported to the hospital.

In ED Mrs Dale was very confused and agitated. She was subsequently admitted to the Acute Medical Unit (AMU). The diagnosis was of a urinary tract infection secondary delirium.

Her hospitalisation amounted to a DoL. A short-term detention authorisation (STDA) was granted for the first 14 days of the hospitalisation. Review of the STDA was undertaken on Day 14 by the responsible medical practitioner, who extended the DOL STDA for a further 14 days.

Initially Mrs Dale had required 1:1 supervision by a Health Care Assistant. Whilst this level of supervision is no longer required Mrs Dale remains very confused. Multidisciplinary team (MDT) assessment identifies Mrs Dale needs assistance of one for washing and dressing and that she has no safety awareness in the kitchen. At night Mrs Dale becomes particularly confused and agitated tending to wander around the ward. At night time she requires supervision and reassurance from nursing staff.

The recommendation from the MDT is that the care needs identified would be most likely to be met by temporary placement in a nursing home.

It is now day 18 and a nursing home place has been identified. The home will provide ongoing care and treatment. During her stay in the home Mrs Dale will be under constant supervision and control and she will not be free to leave, as she has no
awareness of her surroundings. The care home placement will therefore amount to a DoL.

The home can accept Mrs Dale into their care on day 22 of her hospital admission. The hospital MDT must now put in place appropriate safeguards for the proposed ongoing DoL in the care home including an application for trust panel authorisation.

An application for trust panel authorisation on day 20. On day 22 (the day of the discharge from hospital into the home) the trust panel has not made a decision. Mrs Dale is discharged to the home and deprived of liberty in the home using the emergency provisions. As it would cause Mrs Dale an unacceptable risk of harm not to be deprived of liberty in the home whilst the trust panel making their decision the emergency provisions are satisfied.

**Medical background:**

**Urinary Tract Infection (UTI):** A urinary tract infection is an infection of the bladder or kidneys.

**Delirium:** A delirium is a disturbance in the functioning of the brain. A person with delirium generally appears more confused than normal, may see people or things that are not there and may behave in a way that is not usual for them. Older people are at particular risk of a delirium especially if they develop another medical condition like an infection or dehydration. There are many different medical conditions that might result in a person developing a delirium.
Form 1 – Statement of incapacity

A statement of incapacity can only be carried out by a medical practitioner, a nurse, a midwife, a social worker, a dentist, an occupational therapist, a speech and language therapist or a practitioner psychologist who has received specific training in the 36 months prior to making the statement and has 2 years’ experience in the last 10 in working with persons who lack capacity.

The decision maker must ensure that the reasons for making a statement of incapacity are recorded on this form. The supporting evidence can be provided in the person’s care plan or notes in line with professional or agency requirement. It is not necessary to duplicate the supporting evidence on this form but a note should be made of where it can be found.

1. The person’s details (a label can also be affixed here)

Name: Mrs Dale

2. The assessors details

Name: Acute medical consultant

3. Date of formal assessment of capacity

Date the assessment was carried out: 02.12.19

4. Support to the person

Before deciding that someone lacks capacity, all practical help and support must be provided to enable the person to make a decision by themselves. This includes considering the environment and timing of the decision, ensuring that appropriate communication support is provided to the person and involving all relevant people who might help the person make the decision.

(delete as appropriate)

Has the environment for the decision been considered? Yes
Has the timing for the decision been considered? Yes
Has all practical help and support, including communication support, been given? Yes
Have all relevant people who may help the person make a capacitous decision been included? Yes
Has the information relevant to the decision been provided and/or explained in a way which is appropriate? For example, in simple language?  

Yes

Provide details.

Mrs Dale was assessed away from the busy ward in our interview room. The assessment was carried out in the morning after Mrs Dale had had her morning tea. The morning was the optimal time to undertake the formal assessment because this lady tends to be more confused in the afternoon. Mrs Dale required a hearing aid – she was wearing this during the interview.

Please see attached further information.

5. **Three Elements Test of Mental Capacity**

   **Functional test**

   In relation to the detention amounting to deprivation of liberty, the person in section 1 is unable to

   (delete as appropriate)

   understand

   appreciate and use and weigh that information.

   Provide details on how the person is unable to do the above and how this has been determined.

   Mrs Dale did not feel that she would have any difficulty managing at home. It was her view that she would be able to wash and dress herself despite needing assistance of one and prompting in hospital.

   Mrs Dale did not appreciate the risks highlighted by the kitchen assessment. She was unaware of the fact she left the hob on after making a cup of tea.

   Mrs Dale says she sleeps very well but is awake, confused and agitated each night.

   See further information which contains a transcript of the relevant questions and answers during the assessment.

   **Impairment or disturbance test**

   *There is no need for a formal diagnosis, it is sufficient to have reasonable belief that there is an impairment of, or disturbance in the functioning of, the mind or brain.*

   Provide details on the impairment of, or disturbance in the functioning of, the mind or brain.
Throughout this hospital admission Mrs Dale has shown signs of a new delirium which has occurred as a result of a urinary tract infection. The delirium has significantly impaired the functioning of Mrs Dale’s brain she is confused and becomes upset and agitated particularly at night.

Causal link
For a statement of incapacity to be provided there must be a causal link between the inability to make a decision in relation to the detention amounting to a deprivation of liberty and the impairment of, or the disturbance in the functioning of, the mind or brain. If there is no causal link the person does not lack capacity in the meaning of the Mental Capacity Act.

Provide details on the causal link.
It is my reasonable belief that the cause of Mrs Dale’s inability to decide upon her future care provision is because of her delirium (as outlined above).

6. Decision

*If a person is unable to make a decision because they have an impairment of, or disturbance in the function of, the mind or brain a statement of incapacity can be made.*

**Statement of Incapacity**

I certify that ____Mrs Dale_____ (name) lacks capacity within the meaning of the Mental Capacity Act (Northern Ireland) 2016 in relation to the care arrangements which amount to a deprivation of his/her liberty and that I am suitably qualified to make a statement of incapacity.

Signature: to be signed

Date:02/12/2019
Form 1: Statement of Incapacity Further Information
Person’s details
Name: Mrs Dale

Assessor’s details
Name: Acute medical consultant

Date of assessment: 02/12/2019

Support to the person
Sarah, health care assistant was present during the assessment. Sarah had been providing one to one care for Mrs Dale during the admission and her presence helped Mrs Dale feel reassured. Mrs Dale was given information about her condition. It was explained that the multidisciplinary team had concerns about her safety particularly with regard to providing her own personal care and managing in the kitchen. The concern around worsening of Mrs Dale’s confusion at night was discussed. Simple language was used and the information was given slowly. Pictures of the home were provided. There was a discussion also about how a package of care might be provided in Mrs Dale’s own home and the risks that would remain with this level of care in place were discussed.

Functional test
Relevant transcript from capacity assessment
Question: What help have the nurses being providing for you in hospital?
Response: I am able to manage myself the nurses don’t need to help me. There are lots of sick people here the nurses are helping but not me.

Question: How do you manage with getting washed and dressed?
Response: I have no problem with that.

Question: What do you think about going home and taking care of yourself?
Response: Taking care of myself has never been a problem and it will be fine when I go home.

Question: How did the assessment in the kitchen go?
Response: I have been cooking for my family now for years they love my cooking.

Question: Since you have been so unwell has that changed?
Response: No I am a good cook.

Question: Was there any problem when you visited our kitchen to make a cup of tea yesterday?
Response: We had a lovely cup of tea.

Question: Do you sleep well at night?
Response: Yes I have always been a good sleeper. I’ve never needed a sleeping tablet in my life.

Question: Do you wake here in the hospital at night?
Response: Sometimes only if it’s noisy but I get right back to sleep again.

Question: We had been talking about when you leave hospital. Do you remember what we had discussed?
Response: Yes I will be going home on Saturday.

Question: What would be the worry if you were to go home?
Response: I would like to go home I am fed up in hospital.

Question: Do you recall we discussed other possible places you might stay for a while instead of home?
Response: I don’t want to go to a care home I will be fine at home.
Form 2 – Best interests determination statement

A decision to deprive a person of liberty must be made in the person’s best interests.

The decision maker should ensure that the reasons for this determination are recorded on this form. The supporting evidence can be provided in the person’s care plan or notes in line with professional or agency requirements. It is not necessary to duplicate the supporting evidence on this form but a note should be made of where it can be found.

1. The person’s details (a label can also be affixed here)
   Name: Mrs Dale

2. The assessors details
   Name: Senior social worker

3. Checklist
   Have you ensured you have not made assumptions based on the person's age, appearance, condition or behaviour? Yes
   Have you considered all the relevant circumstances? Yes
   Have you tried whatever is reasonable and practicable to permit and encourage the person to take part, or to improve their ability to take part, in determining what is the best interests? Yes

You must have special regard to past and present wishes and feelings and beliefs and values.

Have you had special regard to the person’s past and present wishes and feelings (expressed verbally, in writing or through behaviour or habits)? Yes
Have you had **special regard** to any beliefs and values (religious, cultural or moral) and any other factors which would be likely to influence the decision?

Yes

Have you considered the human rights of the person?

Yes

Have you considered other options that may be less restrictive of the person’s rights?

Yes

Have you consulted all relevant people as far as it is practical and appropriate to do so, including any person named by the person, anyone engaged in caring for the person or interested in the person’s welfare?

Yes

Have you consulted any nominated person?

Yes

Have you considered the risk of harm to others which may result in harm to the person?

Yes

4. **Nominated person**

The nominated person’s details:
Name: Mrs Johnston
The nominated person has been *selected from the default list*.

The nominated person must be consulted with during the best interests determination, if it is practicable and appropriate to do so. If it is not practicable and appropriate provide details.

Provide details of the consultation with the nominated person, including how the consultation took place and the views of the nominated person on P's wishes, feelings, beliefs and values. If Form 3 has been used to provide details of the consultation with the nominated person, note that below and attach Form 3 to the best interests statement.

Mrs Johnston is Mrs Dale’s eldest daughter. Mrs Johnston visits the ward daily to see her mother.
A face to face meeting was held between myself, Hospital Social Worker and Mrs Johnston on the afternoon of 2\textsuperscript{nd} December 2019.

Mrs Johnston stated that her mother has always been very independent and values living in her own home. She is a very private person and likes to keep herself to herself. She does not think her mother would like to stay in a care home. Mrs Johnston sees quite deterioration in her mother’s health over the last 6-8 weeks. She feels that at present it would not be feasible for her mother to return home safely. Mrs Johnston would like to be assured that as her mother’s condition will hopefully improve the option for her to return to her own home remains open.

5. **Consideration**

Outline factors which suggest that deprivation of liberty may not be in the person’s best interests.

DOL may not be in Mrs Dale’s best interests because her NP has stated Mrs Dale values her independence and her privacy.

Outline whether it is likely that the person will have capacity at some point, and if so, whether or not is it appropriate to delay the deprivation of liberty until the person can make a decision.

It is possible that Mrs Dale will regain capacity if her delirium resolves. If this is going to happen it may be within the next number of weeks to months. It is not feasible nor in Mrs Dale’s best interests to remain in hospital any longer. Remaining in hospital exposes Mrs Dale to the risk of hospital acquired infection. Hospital is not an environment conducive to resolution of delirium nor is remaining in hospital beneficial from a social or psychological perspective.

Outline the reasoning why the deprivation of liberty is in the best interests of the person. This should include what other options have been considered, who has been involved in the decision and how the person’s past and present wishes, feelings, beliefs, values and any other factors that the person would have included if he or she had capacity have been considered. It must also include consideration of harm, including how the prevention of serious harm condition is met.

The temporary move to the Home is felt to be in Mrs Dale’s best interests because Mrs Dale will have help and assistance with her activities of daily living. Her occupational
therapy assessment shows that she does require prompting for washing and needs assistance of one to manage with dressing. This will be available in the Home. Mrs Dale is unable to manage in the kitchen. She has little safety awareness and during her kitchen assessment left the hob on. Meals and beverages are provided in the Home.

Mrs Dale becomes much more confused when she wakes during the night and wanders within the ward environment. At these times she requires supervision for reassurance and safety. This supervision is available within the care home environment but could not practically be provided in her own home. If she was free to leave it is feared that she would leave during these episodes. As she is highly confused it is believed that Mrs Dale has no awareness of road dangers at such times, which could cause serious harm, including death.

The option of a package of care to include provision of frozen meals (for care workers to microwave) was considered but without any overnight direct supervision the risk of Mrs Dale becoming confused agitated and wandering outside the home would still remain. Family are unable to provide overnight assistance. It is the risk of night time increased confusion, agitation and wandering that is considered to amount to serious harm.

The multidisciplinary team, NP and Mrs Dale have all been involved in the decision making process. It has been recognised that Mrs Dale’s values of independence and privacy are not met should she remain in a care home long term. All efforts are therefore to be made to end the DoL, at which point it could be possible to move Mrs Dale back to her family home. The placement is temporary with early review by the community key worker at six weeks or sooner should care home staff perceive Mrs Dale’s condition has improved.
6. **Statement**

Best interests should be determined on the grounds of reasonable belief and must include special regard to the person’s past and present wishes, feelings, beliefs, values and any other factors the person would have considered if he or she had capacity.

<table>
<thead>
<tr>
<th>Best interests determination statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is my opinion that it is in the best interests of <em>Mrs Dale</em>____ (name) to be deprived of his/her liberty.</td>
</tr>
<tr>
<td>Signature: to be signed</td>
</tr>
<tr>
<td>Date: 23/12/2019</td>
</tr>
</tbody>
</table>
1. **The person’s details (a label can also be affixed here)**

Name: Mrs Dale

2. **Treatment during deprivation of liberty**

Outline the treatment P is receiving during the deprivation of liberty, if P is receiving treatment.

Mrs Dale is receiving treatment for her delirium in terms of reassurance and reorientation at times when she is most confused. Her delirium has a greater chance of resolving if she is cared for in a calm quiet environment which is not changing and with which she can become familiar. Should she become extremely agitated there is provision to provide a small dose of sedative medication but only if her distress is significant and other measures to calm the situation have been unsuccessful. Mrs Dale will receive treatment for her other underlying medical conditions. Care home staff will administer her blood pressure and cholesterol lowering medications. The physiotherapist and occupation therapist will continue to work with Mrs Dale during her care home stay aiming to improve her ability to mobilise and undertake activities of daily living when she hopefully is well enough to return home.

3. **Actions to be taken to ensure the deprivation of liberty can be ended as soon as possible**

Outline actions that are to be taken to end the deprivation of liberty as soon as possible.

The key worker will review Mrs Dale’s care and treatment needs after six weeks from the time of hospital discharge. These needs will be kept under review so that as soon as practicable any DoL can be ended. The care home staff are aware of the DoLS framework and can alert the key worker should any of the safeguards not be met at any time.
4. **Care and / or treatment during deprivation of liberty**

Provide details on the care and / or treatment amounting to, and relevant to, deprivation of liberty and how it is being managed.

<table>
<thead>
<tr>
<th>Care and/or treatment</th>
<th>Objectives</th>
<th>Action needed to meet objective</th>
<th>Who is responsible</th>
<th>Time of action (hourly / daily / etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locked door in care home</td>
<td>Prevent wandering outside</td>
<td>The home has a keypad with a code that Mrs Dale will not be given access to.</td>
<td>Nurse in charge on shift in care home</td>
<td>Continuous</td>
</tr>
<tr>
<td>Sedative medication for extreme agitation</td>
<td>To prevent Mrs Dale experiencing distress and anxiety.</td>
<td>Staff within the care home need to be aware of the threshold for administering any sedative and must have used other strategies to lessen distress and agitation before administering medication</td>
<td>Care home manager.</td>
<td>Continuous monitoring of Mrs Dale's distress or anxiety level.</td>
</tr>
</tbody>
</table>
**Form 6 – Medical report**

A medical report must be attached to a Form 5, application for trust panel authorisation, Form 8, short-term detention authorisation and Form 16, application for trust panel extension authorisation.

The medical report must be done by a medical practitioner who is suitably qualified and who is unconnected to the person.

1. **The person's details (a label can also be affixed here)**

   Name: Mrs Dale

2. **Medical practitioner who is making the report**

   Name: ST 6
   Professional relationship to person: Medical

3. **Criteria for authorisation – care and treatment**

   Is care and treatment available in the place where the person will be deprived of liberty?
   **Yes**

   Provide details on the care and treatment.
   Nursing care will be provided to Mrs Dale including assistance with activities of daily living, her medications will be administered and she will be provided with care and reassurance should she become distressed and more confused overnight. She will be kept safe in the care home environment and not be allowed to wander outside. Sedative medication can be administered should extreme agitation occur.
   Ongoing occupation and physiotherapy should improve function in terms of mobility and in Mrs Dale’s ability to undertake activities of daily living.

4. **Criteria for authorisation – lack of capacity**

   Have you personally completed a Form 1 – statement of incapacity? **No** (delete as appropriate)

   If yes, continue to section 5.
   If no, fill out the rest of section 4.
Provide details of how the person lacks capacity to make the decision, including how the statement of incapacity has been considered.

References can be made to Form 1 – formal assessment of capacity.

As outlined in Form 1 Mrs Dale is unable to understand, appreciate, use and weigh the information relevant to her ongoing care in The Fields Care Home (amounting to a DOL).

The functional test is not met because of an underlying delirium. This delirium has resulted in an impairment of the functioning of Mrs Dale’s brain.

5. Criteria for authorisation – best interests

Have you personally completed a Form 2 – best interests determination statement? **No** (delete as appropriate)

*If yes, continue to section 6.*

*If no, fill out the rest of section 5.*

_The nominated person must be consulted with during the best interests determination, if it is practicable and appropriate to do so. If it is not practicable and appropriate provide details._

The nominated person’s details:
Name: Mrs Johnston
The nominated person has been **selected from the default list**.

Provide details of how the intervention is in the person’s best interests, including how the best interests determination statement has been considered.

References can be made to Form 2 – best interests statement.

The best interests determination was made (see form 2) with input from the MDT and Mrs Dale’s daughter. Mrs Dale’s daughter is the NP and I have personally consulted with her regarding her mother’s ongoing care. Mrs Dale is perceived to be at serious harm should she become confused and wander outside of her home at night. Least restrictive options have been considered including a package of domiciliary care for 30 minutes four times a day provided within Mrs Dale’s own home. This is not felt to meet Mrs Dale’s care needs which included the need for overnight supervision. Special regard has been given to her preference for privacy and her wish to remain independent. However the perceived risks are currently too great to discharge
her from hospital back to her own home. An early review at six weeks in the community by the key worker was agreed.

6. **Criteria for authorisation - prevention of serious harm condition**

Would failing to detain the person in circumstances amounting to a deprivation of liberty create a risk of serious harm to the person or of serious physical harm to other persons? **Yes** (delete as appropriate)

Is the detention proportionate to the likelihood of harm concerned? **Yes** (delete as appropriate)

Is the detention proportionate to the seriousness of the harm concerned? **Yes** (delete as appropriate)

*If no to any of the questions the prevention of serious harm condition is not met.*

Provide details of how the prevention of serious harm condition is met.

It is likely that Mrs Dale will become confused, agitated and wander out of her own home at night. She will subsequently be at serious risk of injury from falling outside in the dark, being involved in a road traffic accident or becoming disorientated and unable to make her way home.

Continuing Mrs Dale’s care and treatment in the Home is proportionate to the seriousness and likelihood of the harm concerned.

7. **(Only for short-term detention) criteria for authorisation – illness / suspected illness**

Does the person have an illness or a suspected illness? **Yes / No** (delete as appropriate)

*If there is no illness or suspected illness a short-term detention authorisation cannot be made.*

Provide details of the illness or suspected illness.

*Further sheets can be added if required*
8. **Statement**

<table>
<thead>
<tr>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am unconnected with the person in section 1 and I am suitably qualified to make a medical report under the Mental Capacity Act (Northern Ireland) 2019.</td>
</tr>
<tr>
<td>In my opinion the criteria for authorisation are met and I have examined the person in section 1 no more than two days before the date on which this report was signed.</td>
</tr>
<tr>
<td>Signature: to be signed</td>
</tr>
<tr>
<td>Date: 20/12/2019</td>
</tr>
</tbody>
</table>
Form 5 – Application for trust panel authorisation

If more space is required additional sheets or information may be attached to this form. Information may also be copied from other sources, such as medical notes, and reference may be made to them without such document’s inclusion.

1. The person’s details (a label can also be affixed here)

Name: Mrs Dale

2. Person who is making the application

Name: Senior Hospital Social Worker

3. Person or body in charge of P’s care or treatment (if same as applicant, leave blank)

Name: Care Home Manager
Work address: The Home

4. Details about the deprivation of liberty

What is the place or places of the deprivation of liberty, including address and which trust it is in?
A deprivation of liberty authorisation must specify the place of the deprivation. The authorisation can cover deprivation of liberty in more than one place, for example in the place of residence of the person and in the day care centre, or the ordinary place of residence of the person and in a named place of respite.

The place of the deprivation of liberty is the Home. The care home is located within Belfast Health and Social Care Trust.

5. Capacity whether to apply to the Review Tribunal

In your opinion, if the intervention was to be authorised, does the person lack (or probably lack) capacity to decide whether an application to the Review Tribunal should be made? Yes (delete as appropriate)
A person does not need to have the ability to make an application to the Review Tribunal. The determination of capacity only relates to the decision on whether an application should be made or not.

The distinction is important. This assessment relates to the capacity to decide whether an application should be made or not. Even if the person does not have ability to understand what the Tribunal process is or how an application should be made or be able to make an application, the person may still have capacity to decide whether or not an application should be made for an independent check on care arrangements that amount to a deprivation of liberty.

If the person is able to understand
  d. that the care arrangements mean that someone will always be checking on him or her;
  e. that he or she cannot leave when he or she wishes to leave; and
  f. that a meeting can take place to decide whether or not that should be allowed
then it is likely that the person has the capacity whether to apply to the Review Tribunal.

If yes a Form 7 has to be included in the application.
If no a Form 7 does not have to be included in the application.

6. **Annexes that must be attached to the Application**
The annexes form part of the application and must be included (if required).

Annex A – statement of incapacity on Form 1.


Annex C – care plan on Form 4.


Annex E – statement on capacity whether to apply to the Review Tribunal on Form 7 (if required).
*It is the responsibility of the person signing the declaration to determine if Form 7 should be included in the application.*
7. Declaration

Declaration

I confirm I am eligible to make this application.

To the best of my knowledge all information in this application is correct and all required information is included.

Signature: to be signed

Date: 20/12/2019
Form 7 – Statement that the person lacks capacity whether an application should be made to the Review Tribunal

Is the referral safeguard necessary for this person?

If the person lacks or probably lacks the capacity to decide whether or not to apply to the Review Tribunal (if the deprivation of liberty is authorised) then the referral safeguard applies.

The level of decision making ability required in relation to a Tribunal application is in most cases likely to be less than that needed to make a decision about the care arrangements which are being authorised.

A person does not need to have the ability to make an application to the Review Tribunal. The determination of capacity only relates to the decision on whether an application should be made or not.

The distinction is important. This assessment relates to the capacity to decide whether an application should be made or not. Even if the person does not have ability to understand what the Tribunal process is or how an application should be made or be able to make an application, the person may still have capacity to decide whether or not an application should be made for an independent check on care arrangements that amount to a deprivation of liberty.

If the person is able to understand
  a. that the care arrangements mean that someone will always be checking on him or her;
  b. that he or she cannot leave when he or she wishes to leave; and
  c. that a meeting can take place to decide whether or not that should be allowed
then it is likely that the person has the capacity whether to apply to the Review Tribunal.

1. The person's details (a label can also be affixed here)

Name: Mrs Dale
2. **Details of capacity assessment**
Provide details on the capacity assessment and why the person lack (or probably lacks) capacity whether an application should be made to the Review Tribunal if the intervention is authorised.

Mrs Dale is unable to understand what care in a care home will mean for her. She is unable to understand that she will not be free to leave. Whilst in hospital Mrs Dale at times thinks she is in her own home and at other times that she is in a hotel. Mrs Dale is unlikely to raise objection to a deprivation of liberty as she has no understanding or insight into the fact that she is subject to such a deprivation.

3. **Views of the person**
Are you aware of the person expressing any wishes or feelings, in the past or present, on whether an application should be made to the Review Tribunal? **No** (delete as appropriate)

If yes, provide details:

4. **Statement**

<table>
<thead>
<tr>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>In my opinion the person in section 1 lacks (or probably lacks) capacity to decide whether an application to the Review Tribunal in relation to a trust panel authorisation or extension by extension report or trust panel extension authorisation should be made.</td>
</tr>
</tbody>
</table>

| Signature: to be signed |
| Date: 20/12/2019 |

The completed Form 7, together with all other forms completed for the application for trust panel authorisation, authorisation for short-term detention, extension authorisation or application for trust panel extension authorisation must be sent to the Attorney General:

- by the trust immediately after the trust panel has provided an authorisation as a result of an application for trust panel authorisation or trust panel extension authorisation; or
- by the person completing an extension report immediately after signing that report.