MENTAL CAPACITY ACT (MCA) 2005

AND

DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) 2009

Training booklet

(updated October 2015)

Trainers:

MCA Team

Dorset County Council
and
NHS Dorset Clinical Commissioning Group

Contents:

Mental Capacity Act 2005 and Deprivation of Liberty (DoLS) Safeguards 2009

What does the Mental Capacity Act do?

- It introduces statutory principles and creates a statutory framework for assessing capacity.

- It establishes a statutory checklist to help determine what is in the best interests of a person lacking capacity.

- It introduces statutory responsibilities for everyone who works with people 16+ who lack capacity to make a particular decision.

- It provides several ways that people can influence what happens to them if they are unable to make particular decisions in the future. These are:
  - Advance Decisions to refuse medical treatment,
  - statements of wishes and feelings, and
  - Lasting Powers of Attorney (LPA) for Personal Welfare decisions or financial / property affairs (existing Enduring Powers of Attorney will continue to be valid).

- It offers protection from liability to those professionals who make decisions on behalf of someone who lacks capacity, including the use of proportionate restraint, providing that the assessment and decision are in accordance with the MCA and the code of practice.

- It establishes a statutory obligation to consult with people who are interested in caring for the person who lacks capacity, and anyone interested in their welfare.

- It creates a new advocacy service called the Independent Mental Capacity Advocate Service (IMCA).

- It establishes new criminal offences of Deliberate Ill-Treatment or Wilful Neglect of persons lacking capacity (Section 44).

- It establishes new safeguards for undertaking research involving people who lack capacity.

- It sets up a Court of Protection and a public official post (the Public Guardian) that is supported by the Office of the Public Guardian.

Statutory Principles:

The Mental Capacity Act sets out five 'statutory principles' – the values that underpin the legal requirements in the Act. The Act is intended to be enabling and supportive of people who lack capacity, not restricting or controlling of their lives. It aims to protect people who lack capacity to make particular decisions, but also to maximise their ability to make decisions, or to participate in decision-making, as far as they are able to do so.

The five statutory principles are:

1. **A person must be assumed to have capacity unless it is proved otherwise**

   There is a requirement to prove a lack of capacity (for the relevant decision) before professionals can interfere with, or go against, a person's wishes. Snapshot capacity assessments are more likely to be inaccurate, if the assessor does not maximise the person's ability to make the decision, nor consults with people who know the person.

   The nearer to capacity a person is, the more weight must be given to their opinions.

   Can the decision wait until the person regains capacity?

2. **Everyone should be given all the help and support they need to make a decision, before anyone concludes they cannot make their own decision.**

   Consulting with the Person and their family / carers must be a meaningful exercise. 'It is simply unacceptable— and an actionable breach of Article 8 ECHR, for a local (or health) authority to decide, without reference to the person or their carers, what is to be done and then merely to tell them—to "share" with them—the decision. To have regard to the person's wishes and feelings is not merely something mandated by the 2005 Act. It is surely fundamental to treating P as a human being.' (L.J. Munby)

   Capacity assessments must be decision and time specific.

   To maximise capacity:
   - *Provide relevant information*
   - *Communicate in an appropriate way*
   - *Make the person feel at ease*
   - *Can anyone help or support the person to make choices?*

3. **People are allowed to make what might be seen as an unwise or eccentric decision – this does <u>not</u> in itself indicate a lack of capacity**

   The following is an extract from an address given by Lord Justice Munby (Senior Judge –Court of Protection):

   In decision making (where a lack of capacity for the relevant decision has been proven), "the person's best interests (paramount their wishes and feelings) and welfare should be the guiding principle. Welfare extends beyond safety and physical health. It involves looking in the widest sense, taking into account a wide range of ethical, social, moral, emotional and welfare considerations. Fundamentally we have to strive to safeguard not just the person's safety, but also, and most importantly their happiness.

   All life involves risk, and the elderly and vulnerable are exposed to additional risks and to risks they are less well equipped than others to cope with. Just as wise parents resist the temptation to keep their children metaphorically wrapped up in cotton wool, so too must we avoid the temptation always to put physical health and safety before everything else. Often it will be appropriate to do so, but not always. Physical health and safety can sometimes be bought at too high a price in happiness and emotional welfare.

   The emphasis must be on sensible risk appraisal, not striving to avoid all risk, whatever the price, but instead seeking a proper balance and being willing to tolerate manageable or acceptable risks as the price to be paid in order to achieve some other good – in particular to achieve the vital good of the elderly or vulnerable person's happiness.

   What good is it making someone safer if it merely makes them miserable?"

4. **Any actions or decisions made on behalf of someone who lacks capacity must be in their best interests.**

   The decision maker, must be law, consult with family or friends, anyone named by the person, or anyone interested in the person's welfare.

5. **Any actions or decisions should aim to be the least restrictive, in terms of the person's rights and freedom of action.**

   Less restrictive options for intervention must be reasonably excluded, before escalating the level of restrictions imposed on the person.

A way of remembering these is by memorising **<u>PLUMB</u>**:

P - Presumed capacity.
L - Least restrictive interventions.
U - Unwise decisions allowed. (If person has capacity for decision)
M - Maximising capacity.
B - Best Interests.

Accessing Capacity

The Standard Test for Capacity

- Does the person have an impairment of, or disturbance in the functioning of the mind or brain?
- Does the impairment or disturbance mean the person is unable to make a specific decision when they need to?

This doesn't have to be a clinical diagnosis, it can be:

- Permanent or temporary
- Could be a result of illness
- Drugs or alcohol
- Injury
- Condition such as Alzheimer's, brain injury or
- Learning disability

To have capacity to make a decision a person must be able to:

1. Understand the information relevant to the decision (including the reasonably foreseeable consequences of making or not making the decision) and
2. Retain that information (long enough to make the decision) and
3. Use or weigh the information (as part of the decision making process) and
2. Communicate the decision (in any recognisable way)

Who carries out Capacity Assessments?

There are no specific qualifications for assessing capacity.
It could be:

- Someone who knows the person well
- For example, a Social Worker, Doctor, Nurse, OT, Psychologist, Physiotherapist or Carer
- Where appropriate someone with specialist skills i.e. speech and language therapist
- The decision maker would need to be satisfied that the person has or has not got capacity

The Court may require a specified professional such as a Doctor, Social Worker and Psychologist to do the assessment

What do you need?

- Knowledge of recent events
- An understanding of the decision that needs to be made and the reasonably foreseeable consequences, risks and benefits of the decision
- Know something about the person and the issues
- Use effective communication skills
- Be prepared for this to take time to do it properly
- Do your homework

Capacity Assessment

Time specific: An Assessment of capacity must be time specific.
Does the person have capacity to make the decision at the time the decision needs to be made?

Decision specific: An assessment of capacity relates to a specific decision that has to be made and is not about a general ability to make decisions.

Adult and Community Services

Mental Capacity Act 2005 Sections 2 & 3

Assessment of Mental Capacity (Form A)

This form should be completed where a person's capacity to consent to or refuse health or social care intervention is in doubt.

Name of person:		Date:	
Name of assessor:		Signed:	

The **health or social care issue** that needs a **specific decision**:

I believe that the person has an **impairment** of, or a **disturbance** in the **functioning** of, the **mind or brain** which may affect their ability to make this decision. This is due to or appears to be due to:

Under each heading please select either Yes or No and record evidence to support your belief.
On the date above and in relation to the decision, the person was able to:

1. Understand the information relevant to the decision

Does the person have a general understanding of the decision they need to make and why they need to make it? (Including the reasonably foreseeable consequences of deciding one way or another, or of failing to make the decision).

Yes ☐ No ☐

2. Retain the information long enough to make a decision

(The fact that a person is able to retain the information for a short period only does not prevent them from being regarded as able to make the decision).

Yes ☐ No ☐

3. Use or weigh the information to make a decision

(Degree of awareness and insight, evidence of reasoning processes).

Yes ☐ No ☐

4. Communicate the decision

(To produce a response, not necessarily verbal that indicates choice, in any way recognised by the assessor).

Yes ☐ No ☐

Failure on any **one** point means the person lacks capacity at this time to make the decision outlined above. (If this is the case then a Best Interests decision must now be made using the statutory checklist (Section 4 MCA 2005)).

Please detail any attempts to optimise understanding and maximise capacity here:

i.e. provided relevant information to enable informed choices to be made, communicated in a appropriate way, made the person feel at ease; quiet environment, time of day, provided support etc.)

Duty to consult people who know the person

To assist in forming a balanced view, please list any people you have consulted and their relationship to the person as part of the assessment to form your view.

Name	Relationship	From

Outcome of Capacity Assessment (please select one):

On the balance of probability, (more likely than not) the person

HAS CAPACITY ☐ / LACKS CAPACITY ☐ to make the decision required of them

Best Interests

The fourth key principle of the Act is that any act done for, or any decision made on behalf of a person who lacks capacity must be done, or made, in that person's *best interests*. That is the same whether the person making the decision or acting is a family carer, a paid care worker, an attorney, a court-appointed deputy, or a healthcare professional. It is also the same whether the decision is a minor, everyday issue – like what to wear – or a major issue, like whether to provide particular healthcare.

There are exceptions to this, including circumstances where a person has made an advance decision to refuse treatment and, in specific circumstances, the involvement of a person who lacks capacity in research, but otherwise the underpinning principle of the Act is that all acts and decisions should be made in the best interests of the person without capacity.

The Act does not contain a definition of "Best Interests" and working out what is in someone else's best interests may be difficult particularly as not everyone is the same. However to assist in the determination the Act requires people to follow certain steps to help them work out whether a particular act or decision is in a person's best interests.

It is clear that in determining a person's best interests, assumptions cannot be made simply on the basis of the person's age, appearance, condition or behaviour.

The Code outlines that a person trying to work out the best interests of a person who lacks capacity to make a particular decision should:

1. **Encourage participation**

   Ensure you do whatever is possible to permit and encourage the person to take part, or to improve their ability to take part, in making the decision

2. **Identify all relevant circumstances**

   Try to identify all the things that the person who lacks capacity would take into account if they were making the decision or acting for themselves

3. **Find out the person's views**

   Try to find out the views of the person, who lacks capacity, including:

   - the person's past and present wishes and feelings – these may have been expressed verbally, in writing or through behaviour or habits.
   - any beliefs and values (e.g. religious, cultural, moral or political) that would be likely to influence the decision in question.
   - any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves.

4. **Assess whether the person might regain capacity**

Consider whether the person is likely to regain capacity (e.g. after receiving medical treatment). If so, can the decision wait until then?

5. Consult others

The Act imposes a duty to consult other people (if it is practical and appropriate to do so) for their views about the person's best interests and to see if they have any information about the person's wishes and feelings, beliefs and values. In particular, try to consult:

- anyone previously named by the person as someone to be consulted on either the decision in question or on similar issues
- anyone engaged in caring for the person
- close relatives, friends or others who take an interest in the person's welfare
- any attorney appointed under a Lasting Power of Attorney or Enduring Power of Attorney made by the person
- any deputy appointed by the Court of Protection to make decisions for the person.
- an Independent Mental Capacity Advocate (IMCA) if appropriate

6. Avoid restricting the person's rights

Consider whether there are other options that may be less restrictive of the person's rights and freedom of action

The Act and the Code emphasise that in determining best interests for a decision about life sustaining treatment the decision maker should ensure that they are not be motivated in any way by a desire to bring about the person's death. They should not make assumptions about the person's quality of life.

In order to come to a final determination of what is in a person's best interests the decision maker must weigh up all of these factors.

In some cases, there may be disagreement about what someone's best interests really are. But as long as the person who is proposing the intervention has followed the steps to establish that the person lacks capacity for the relevant decision, and has done everything they reasonably can do, to work out what someone's best interests are, and then they will to be protected from liability (see Section 5 MCA).

Best interests decision making

Guidance on good practice, when making significant best interests decisions on behalf of someone lacking capacity (for the relevant decision), recommends using a 'balance sheet' approach in weighing up the relevant factors 'for and against' any planned interventions.

This approach has been supported and advocated by senior judges sitting in the Court of Protection and further advocated by case law.

Case law *(Official Solicitor, 2006)* has provided five areas that would demonstrate that the discussion has considered all aspects of the consequences of the best interest's decision to be made. It is worth referring to these five areas when reviewing the information considered or the aspects discussed.

Medical Aspects Not just the outcome, but what will be the burden and benefit of the treatment?	**Emotional Aspects** How will this person feel or react?
Welfare Aspects How will this impact (for better or worse) on the way the person lives their life?	**Ethical Issues** Are there any specific ethical issues that require separate consideration?
Social Aspects What will this do to the person's relationships etc.?	

The MCA team has produced a 'best interests' balance sheet to help ensure that consideration is given by decision makers to all relevant factors.

Case study

Sharon is 25 and has severe learning disabilities. She lives in a care home and is close to her mother who visits regularly. Sharon really enjoys her mother's visits and looks forward to them. Sharon's sister is very ill and needs a bone marrow transplant. Sharon lacks the capacity to agree to be a bone marrow donor.

What action do you think is in Sharon's best interests? Ultimately, who decides? What should be taken into account?

This is based on an actual case where the judge decided that Sharon could donate as it was to her emotional, psychological and social benefit. At a first glance, you might think that Sharon couldn't possibly benefit from the procedure; you might be concerned that the procedure would hurt or distress her, and it would be in her sister's interests, but not Sharon's.

However, the judge's decision was based on evidence that if Sharon's sister were to die this would have an adverse impact on Sharon's mother with whom she had a very close relationship. Also, the death of her other daughter would significantly affect Sharon's mother's ability to visit Sharon, which would have a very bad effect on Sharon. Sharon also had her own good relationship with her sister and the loss of that would be detrimental. Best interests go beyond what is in a person's best interests medically. Such serious and complex cases should be decided by the Court of Protection.

Best Interests Balance Sheet

In 2006 the Official Solicitor suggested 5 areas that would demonstrate that a discussion about best interests has considered all aspects of the consequences of the best interest decision:

Medical: not just the outcome, but what will be the burden and benefit of the treatment?
Welfare: How will this impact for better or worse on the way the person lives their life?
Social: What will this do to the person's relationships etc.?
Emotional: How will this person feel or react?
Ethical: Are there any specific ethical issues that require separate consideration?

Advantages or benefits	Disadvantages or burdens
Medical	**Medical**
Welfare	**Welfare**
Social	**Social**
Emotional	**Emotional**
Ethical	**Ethical**

Adult and Community Services

Mental Capacity Act 2005 Section 4

Best Interests Assessment (Form B)

This form should be used where the person lacks capacity to consent to or refuse **significant** health or social care interventions.

Name of person: Date:

The **health or social care issue** that needs a **specific decision**:

Medical treatment decisions

Does the person have a valid advance decision to refuse treatment that relates to the above decision?

Yes ☐ No ☐

If Yes, then stop this assessment and follow the advance decision.

Is there a **lasting power of attorney, deputy** or **Court of Protection order** in relation to the decision?

Yes ☐ No ☐

If Yes, then best interest decisions will be made by these people or stated in the court order.

The statutory checklist (Section 4 MCA 2005) requires that the following issues are taken in to account, as far as reasonably ascertainable, in deciding best interests.

Please tick each box to confirm you have given due regard to and **give details** as appropriate:

As far as reasonably practical, have you encouraged and permitted the person to participate in the decision? How so? ☐

The relevant circumstances (clinical opinion, history etc.): ☐

The person regaining capacity and if so, can the decision be delayed until then: ☐

The person's past and present wishes and feelings (written or oral):	☐
The person's beliefs and values that would be likely to influence the decision:	☐
Any other factors the person would take in to account:	☐
Where practical and appropriate, you must consult with and take account of the views of anyone previously named by the person as someone to consult with:	☐
Name(s) and view(s):	
Anyone involved in caring for the person:	☐
Name(s) and view(s):	
Anyone interested in their welfare (family, close relatives or existing advocate):	☐
Name(s) and view(s):	
An attorney named in a valid and applicable Lasting Power of Attorney or Deputy appointed by the Court of Protection:	☐
Name(s) and view(s):	

An Independent Mental Capacity Advocate (IMCA). An IMCA must be appointed when serious medical treatment or a change in accommodation is at issue, and there is no-one else to support the person, other than paid staff. This is a statutory requirement subject to audit. **Dorset Advocacy** provide IMCAs and they can be contacted on **0845 3891762**.	☐
IMCA view:	
Have you considered less constrictive options that may be available in terms of the person's rights and freedom of action? (List options considered).	☐

Reasonable Belief

Section 4(9) of the MCA 2005 confirms that if someone acts or makes a decision in the reasonable belief that what they are doing is in the best interests of the person who lacks capacity, then provided they have followed the checklist (above) they will have complied with the best interests principle set out in the Act.

Guidance on good practice, when making significant best interests decisions on behalf of someone lacking capacity (for the relevant decision), recommends using a 'balance sheet' approach in weighing up the relevant factors 'for and against' any planned interventions.

Medical aspects

Not just the outcome, but what will be the burden and the benefit of the treatment?

Welfare aspects

How will this impact (for better or worse) on the way the person lives their life?

Social aspects

What will this do to the person's relationships etc.?

Emotional aspects

How will this person fee or react?

Ethical issues

Are there any specific ethical issues that require separate consideration?

Having regard to all of the above, please document below:

- How the decision about the person's best interests was reached
- Why the decision is in the person's best interests
- Who was consulted to help work out best interests

- What particular factors were taken in to account
- Note any particular conflicts or disagreements regarding the decision. If there is an ongoing dispute or disagreement with the person lacking capacity, or their family, over the best interests decision, then consideration must be given to whether the case should be referred to the Court of Protection (i.e. possible infringements of Article 8 ECHR 'Right to Privacy and family life).
- If there are less restrictive options available, give details and explain why these are not being implemented.

Summary and outcome of Best Interests Assessment

Decision maker	
Name:	
Position:	
Signed:	

Independent Mental Capacity Advocates (IMCA)

The law requires health and social care staff to involve an IMCA in some decisions when the person is unable to make the decision themselves and does not have family or friends to speak on their behalf. In this case, local authorities or health trusts making the decision on behalf of the person must instruct (the legal term for involving) an IMCA.

IMCAs must be instructed for accommodation decisions, such as possible moves to care homes longer than eight weeks or to hospital for more than four weeks. IMCAs must also be instructed if decisions are being made about medical treatment which could have serious consequences for the person and perhaps is also finely balanced as to whether to proceed or not. The only exceptions to statutory IMCA involvement are if urgent decisions have to be made, or if the treatment is covered by the Mental Health Act.

Research shows that IMCAs are often involved in the following treatment decisions:

- Do Not Attempt to Resuscitate (DNAR) orders.
- Dental treatment requiring a general anaesthetic.
- Cancer treatment.
- Surgery, including hip and knee operations.
- Providing artificial nutrition and hydration.

Safeguarding Adults

Health and Local authorities also have the legal power to instruct IMCAs where they may need to take protective measures as part of safeguarding adult procedures. For safeguarding adults, IMCAs may be involved regardless of the level of involvement of family or friends. Again there should be a local policy in this respect
There are additional IMCA roles linked to the Deprivation of Liberty Safeguards process.

Expectations of IMCAs

Where an adult has been assessed as lacking capacity, responsibility for making best-interests decisions sits with the local authority or health trust. The IMCAs role is to support and represent the person through the decision making process and ensure the person's views and wishes are heard. They have the legal right to meet the person in private and view their health and social care records. While retaining their independence, IMCAs should work in partnership with health and social care staff. This would include the IMCA passing on key information as they become aware of it, sharing tasks and minimising delays to the process. IMCAs' reports should highlight important issues that need to be considered when decisions are made and reflect the person's views or wishes.

Practitioners' messages re: IMCA involvement

- Be clear about whether clients are making their own decisions regarding their care and support or
- Decisions are being made in their best interests after an assessment proves a lack of capacity for the relevant decision
- Know when IMCAs must be instructed for accommodation or serious medical treatment decisions, and when they may be instructed as part of safeguarding adults or the care review process. Check whether you have local policies in this respect.

- Identify your local IMCA service and how referrals are made.
  (Dorset Advocacy – 0300 343 7000)

- Instruct IMCAs as soon as it is identified that a person is eligible for the service (unless an urgent decision is needed and there is no time to instruct an IMCA). This will minimise the risk of delays to decision-making.

- Work in partnership with the IMCA service and try to resolve concerns before decisions are made. The IMCA will submit a report that local authorities and health trusts must consider.

- Where serious concerns cannot be resolved or the person is objecting to the decision, the IMCA must make a **timely** application to the Court of Protection.

Advance Decisions

1. Identify whether the person has expressed an advance decision to refuse medical treatment?

2. Is the person 18 years of age or more and do they have capacity to make an advance decision to refuse medical treatment (remember the assumption of capacity in adults – principle 1)?

3. Does the advance decision state precisely what treatment is to be refused? (a statement giving a general desire not to be treated is not enough)

4. Does the advance decision set out the circumstances under which the refusal should apply (this is not mandatory, but it is helpful to include as much detail as possible)?

5. Has the person sought or been offered advice about making an advance decision? It is good practice to record any discussion about this in the person's healthcare records.

6. If an advance decision has been expressed verbally, has the person been offered the opportunity for their advance decision to be recorded in their healthcare records? Where possible, a verbal advance decision should be so recorded to prevent confusion in the future

7. If the person makes an advance decision to refuse life-sustaining treatment, is the advance decision **in writing, signed by the person making the advance decision, signed by a witness and contains the words "*even if life is at risk*"?**

8. Have you advised the person to regularly review their advance decision, to make sure it is kept up to date

Lasting Power of attorney (LPA)

Advice for anyone providing health or social care interventions -

You may be approached by someone claiming to hold a LPA in relation to someone you are providing care for.

It is good practice to ask for a copy of the LPA from the person who is stating that they are an attorney. The form should be registered with the Office of the Public Guardian (OPG) and have an official stamp on every page. Take a photocopy and place with the care notes to ensure all staff can view the attorney's exact authority. Care plans must include a reminder that the attorney's opinion will need to be sought for relevant decisions.

If the evidence is in doubt or not available, then check with the OPG (details below) that the LPA has been registered with them.
There are two types of LPA, one covering personal welfare matters and the other property and financial affairs. It's important to note that a financial LPA does not allow the Attorney to make health and welfare decisions and vice versa.
If a personal welfare LPA, then the attorney has no authority to act unless the person in care lacks capacity to make the relevant decision(s)

If a financial LPA, then the attorney could have authority to act even if the person in care still has capacity to make the decision. This will be stated in the LPA form.

Does the LPA cover the decision in question, i.e. all health care decisions including life-sustaining treatment or is it more limited in scope?

The attorney must follow the requirements of the MCA 2005 in making decisions. If the attorney does not appear to be acting in best interests, then their decisions can be challenged or overridden if necessary, pending a decision by the Court of Protection. If such concerns are unresolved at a local level then the matter should be raised with the OPG who have responsibility for supervising and monitoring LPAs. An LPA can eventually be revoked, if necessary, by the Court of Protection.

Contact Details: Office of the Public Guardian:

Address: PO Box 16185, Birmingham, B2 2WH
Tel: 0300 456 0300,
Fax: 0870 739 5780.
Email: customerservices@publicguardian.gsi.gov.uk
Web: www.publicguardian.gov.uk

Mental Capacity Act 2005 Section 6, Use of Restraint

Definition of restraint within the Mental Capacity Act 2005:
'The use or threat of using force to make a person do something they are resisting' or
'the restriction of liberty of movement whether or not the person resists'

Restraint could therefore be:

- Verbal – involving threatening someone with restraint
- Chemical – using sedative medication
- Physical / Environmental – such as holding the person, using bedsides, lap belts, reclining chairs, and locked doors

Staff **must** follow the criteria below to establish and confirm they have reasonable justification for restraining a person under the MCA 2005, and are protected in law for the actions they take in meeting identified care needs in the care plan. Repeated actions within the care plan, involving proportionate restraint in order to meet identified care needs, are permissible, once the criteria below is satisfied

NB: Restraint under the MCA 2005 cannot be used to prevent harm to other people; however, the powers of restraint under the 'common law doctrine of necessity' are still available. If the person (regardless of their capacity) is acting in a way that will cause harm to others, staff may, under common law, take proportionate and necessary action to restrain the person in order to prevent harm to others. Consideration should be given to use of the Mental Health Act 1983, as an alternative safeguard, where there is risk to others.

1. The person lacks capacity to consent to or refuse the health or social care intervention

2. It will be in the person's best interests for the act to be done

3. It is reasonable to believe that it is necessary to restrain the person to prevent harm to them

4. The restraint is a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm. (A proportionate response is also one that represents the minimum force necessary for the shortest possible time)

Document the harm that will, or is likely to occur, if proportionate restraint is not used and ensure use of proportionate restraint is documented in the care plan notes, and reviewed on a regular basis, in line with reassessment of points 1 – 4 above as appropriate.

Deprivation of Liberty Safeguards 2009

Introduction

The Deprivation of Liberty Safeguards (DoLS) were introduced into the Mental Capacity Act with effect from April 2009. They were the government's response to the 'Bournewood Case', that showed British Law was not compatible with the European Convention on Human Rights. The DoLS provide Registered Care Homes and Hospitals with a way of having the lawful authority to detain people who lack the capacity to consent to their care, treatment & accommodation without having to go to court.

Care Homes and Hospitals are the 'Managing Authorities' responsible for people being cared for in their establishments and they have a legal duty to ensure that no-one in their care is detained unlawfully.

If it is decided that a resident or patient is being deprived of their liberty and it is not possible for them to receive the care and treatment they need in a less restrictive way, the Managing Authority will need to apply to the Local Authority (the 'Supervisory Body') where the person is ordinarily resident for the legal authorisation to do so.

Identifying a Deprivation of Liberty

While there is no statutory definition of what constitutes a deprivation of liberty, the recent Supreme Court judgement in the cases of P v Cheshire West & Chester and P & Q v Surrey has clarified the test that needs to be applied when considering whether a resident or patient is deprived of their liberty. The assessment now has two elements:

- is the person under continuous supervision and control? and
- are they free to leave?

If the person is under continuous supervision and control and is not free to leave (and, of course, lacks the capacity to consent to this), they are deprived of their liberty.

What is no longer relevant?

Until now, a range of factors have needed to be considered before deciding whether or not a person is deprived of their liberty. These are no longer relevant (although might still be important when looking at whether the deprivation is in the person's Best Interests). The factors ruled as irrelevant by the court include:

- the person's compliance or happiness or lack of objection;
- the suitability or relative normality of the placement (after comparing the person's circumstances with another person of similar age and condition); or

- the reason or purpose leading to a particular placement though of course all these factors are still relevant to whether or not the situation is in the person's best interests, and should be authorised.

There is now one 'acid test' to decide whether a person is deprived of their liberty: are they under continuous supervision and control and are they free to leave?

What does 'continuous supervision and control mean?

While this is likely to be the subject of some legal argument in the coming months, it would seem reasonable to suggest that this is not limited just to situations where the person is literally observed at all times (this doesn't even happen in prisons). If someone is in a 24-hour care environment, with staff on duty to intervene at any time if necessary, it is likely that the person is effectively under continuous supervision and control.

What does 'free to leave' mean?

This, again, is not strictly defined, but needs to be seen in the context of the three cases considered in the Supreme Court judgement. All three people went out regularly (P & Q both went to college 5 days a week and had an active social life) and were not confined to their homes for long periods. It would seem that the intention of the court was to say that 'free to leave' means free to leave on their own whenever they choose. Therefore, if a person can only go out when accompanied by someone else and that person can refuse to take them at the time of the person's choosing, it is likely that they are not free to leave.

Following the Supreme Court judgement on 19 March 2014, health and social care staff, and CQC inspectors, must be aware of how they should now judge whether a person might be deprived of their liberty. It is clear that the intention of the majority of the Supreme Court was to extend the safeguard of independent scrutiny.
They said: "A gilded cage is still a cage" and that "we should err on the side of caution in deciding what constitutes a deprivation of liberty." They also highlighted that a person in supported living might also be deprived of their liberty.

It is certain that, following this judgement, many more requests for authorisations under the deprivation of liberty safeguards will be made for people in hospitals or care homes. Since the deprivation of liberty safeguards apply only in hospitals and care homes, i**t is also certain that many more applications will be made to the Court of Protection for those in domestic settings with support.**

The deprivation of liberty safeguards code of practice lists the factors which may indicate a deprivation of liberty: these are still relevant but must now be read in the light of this decision of the Supreme Court.

It may not be a deprivation of liberty, although the person is not free to leave, if the person is not supervised or monitored all the time and is able to make decisions about what to do and when, that are not subject to agreement by others.

Applying for a DOLS Authorisation:

If the managing authority believes they will need to deprive someone of their liberty, whom they will shortly receive into their care, they will need to tick “a request for standard authorisation only” on the form and complete and send to the Supervisory Body. This can be done up to 28 days before the authorisation is required. If, however, a deprivation of liberty is already occurring, the managing authority will need to tick “an urgent authorisation including a request for standard authorisation”, complete and send to the Supervisory Body. The Urgent Authorisation gives the managing authority immediate authority to detain the person for up to 7 days. The supervisory body will then begin the process of assessing the person for a standard authorisation. The form can be found on the Dorset for you website: https://www.dorsetforyou.com/411659.

Where a potential deprivation of liberty is identified, a full exploration of the alternative ways of providing the care and/ or treatment should be undertaken, in order to identify any less restrictive ways of providing that care which will avoid a deprivation of liberty.

Where the care / treatment plan for an individual lacking capacity will unavoidably result in a deprivation of liberty judged to be in that person’s best interests, this MUST be authorised.

DoLS Process:

This must be done in a person centred way. The Supervisory Body needs as much information about the individual’s circumstances as possible, as a minimum this should include:

- how long they have been with you
- what their support needs are
- how they feel about the arrangements
- an up to date capacity assessment

If a person’s care is funded by a Local Authority, send the completed forms to that Local Authority. If the person is funding their own care, send the completed forms to the Local Authority covering the area where your care home is situated.

If the person is in hospital, send the completed forms to the Local Authority that covers the area where their home address is.

For person is of no fixed abode, send completed forms to the Local Authority covering the area where your care home is situated.

The Local offices are:

Bournemouth: Email to dols@bournemouth.gov.uk or fax 01202 458931, Telephone: 01202 451657 and 01202 458823

Dorset: Email to mcateam@dorsetcc.gov.uk or fax 01305 224325, Telephone: 01305 225650

Poole: Email r.kwong@poole.gov.uk **and** deprivationofliberty@poole.gov.uk, Tel: 01202 633851

The Assessment Process

Once an application has been received, the supervisory body will arrange for a series of 6 assessments to take place to determine whether a DoLS authorisation should be given. These are:

- Age assessment – is the person 18 or older
- Mental Capacity Assessment – does the person lack the capacity to decide about their care and/or treatment and where to receive it.
- Mental Health Assessment – does the person have a mental disorder
- Eligibility Assessment – is the person already subject to the Mental Health Act; or would it be more appropriate for them to be so
- No Refusals Assessment – any existing advance decision does not prevent the person from being given the treatment that is proposed. Similarly, any valid decisions made by a donee of a lasting power of attorney or deputy do not conflict with these proposals for their accommodation, treatment or care
- Best Interests Assessment – does the person's situation amount to a Deprivation of Liberty and, if so, is it in their Best Interests.

If all these assessments find that the person is eligible to be detained, an authorisation will be granted for a period not exceeding 12 months.

The assessments must be completed within 21 days of a Standard Authorisation request being made – or within 7 days of an Urgent Authorisation being made, although it is possible to extend the urgent authorisation for a further 7 days in exceptional circumstances.

An IMCA will be appointed by the supervisory body for those people who have no family or friends to consult as part of the DoLS assessment.

DoLS Person's Representative

A person's representative is appointed for the length of the authorisation. Wherever possible, this will be a family member or friend. If necessary, a paid representative (professional advocate) can be appointed.

The representative must:

- act in the person's best interest
- represent and support the person
- maintain face to face contact with the person
- ask for a review, or appeal the DoLS Authorisation if appropriate, to the Court of Protection.
- Following a recent case, AJ v A Local Authority (Feb 2015) the person being deprived of their liberty has an absolute right of appeal and the representatives role is to ensure that this right is upheld. For this reason it can often be extremely difficult for family members to take on this role and therefore more paid representatives are being taken on for this reason.

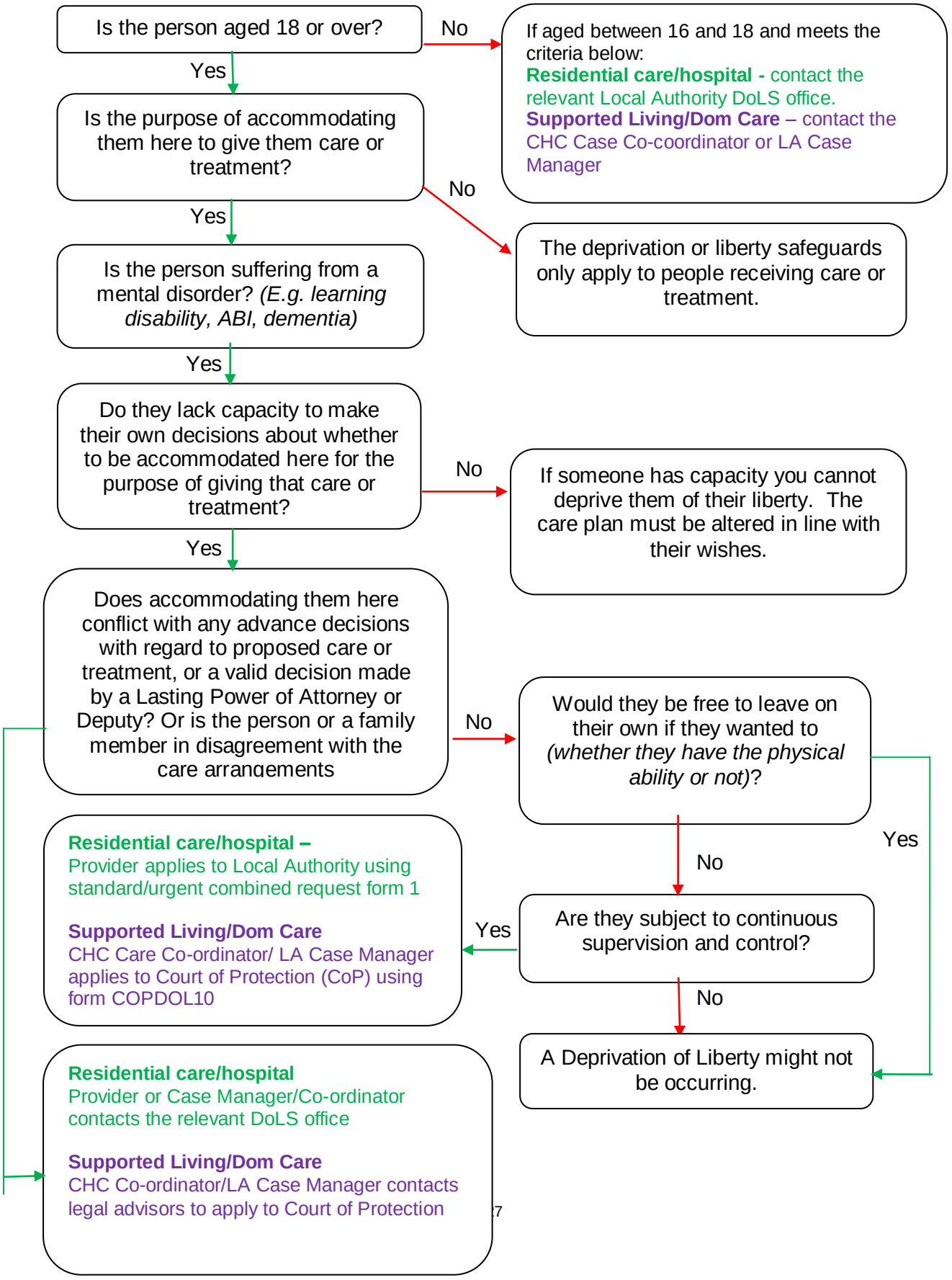
Conditions:

The Best Interest Assessor may recommend that conditions are attached to the authorisation. For example they may make recommendations around their culture or other major issues relating to the person's deprivation of liberty, for example opportunities to go out or become involved in activities or being referred for medication reviews. If conditions are not met it would mean the Deprivation of Liberty would cease to be in their best interests.

Care Homes and Hospitals need DoLS policies to identify:

- whether deprivation of liberty is or may be necessary
- what action to take if a DoLS application is required
- how to record DoLS applications and authorisations
- how to give information to those involved
- how to monitor the person's representative
- how to ask for a review if necessary
- how to end a DoLS authorisation
- how to re-apply for DoLS authorisation if necessary

Flowchart and Guidance for identifying whether resident or patient may be deprived of their liberty



Guidance from the Coroner for Care Providers re a death which is expected

Deprivation of Liberty Safeguards (DoLS) and the Dorset Coroner's Office

Guidance for Care Providers for a death that is expected

Following the Coroner's guidance for reporting the death of a person subject to DoLS, the following is clarification of what Care Providers (Managing Authorities) should do.

If a person dies while subject to a DoLS Authorisation (this can be either an Urgent Authorisation or a Standard Authorisation), this is classed as a 'death in custody'. The Coroner's Office **must** be informed and a copy of the authorisation will need to be sent to the Coroner's Office by secure email: coroners@bournemouth.gcsx.gov.uk or fax: 01202 780423 - **before** a death certificate can be issued.

It is important that the Care Provider has the relevant information available for the Coroner (even at night) including:

- Date of the DoLS application and, if applicable, the dates authorisation was granted and will expire.
- Details about the circumstances of the death.
- Details of who identified the body to the funeral directors (this is likely to be the senior member of staff on duty at the time the body is collected).

During office hours (8am - 4pm, 7 days a week) the Care Home/Hospital should contact the Coroner's Office. 01202 454910 – Coroner's Court
01202 454930 – Ian Parry
01202 454939 – Nikki Muller
01202 454943 – Carolyn Stuart
01202 454934 – Allan Young
01202 454926 – Andy Lord

The Coroner's officer will contact their contracted funeral director and arrange for the body to be collected and will advise the Care Home/Hospital on what they should do next.
Outside of these times, the police should be contacted through the 101 number. Ask them to contact the Coroner's Office - A Coroner's Officer is on call between 4pm -11pm

If the person is subject to an Urgent Authorisation but this has expired without the DoLS assessments being completed, (i.e. the person may still be being deprived of their liberty but there is no Authorisation in place), **the Coroner's Office still needs to be notified** but, as this is not technically a death in custody, an inquest will not be required (unless there is some unusual feature to the death). The Coroner will deal with the notification by supporting the GP to issue the death certificate.

Checklist authorised DoLS - expected death
Treated as a 'death in custody' and an inquest is required. (Unless there is some unusual feature to the death this will be a 'paper based' inquest- family will not be required to attend). The aim is to deal with this within 48 hours.

- Verification of death by a Nurse/ECP (if trained).
- Ring the GP and/or OOHs – GP can issue death certificate once the Coroner allows.
- Ring the Coroner - after 4pm ring the Police on 101.
- GP will be contacted by Coroner's Office.
- Do not interfere with the body.
- Coroner/Police will arrange for transportation of body to their contracted funeral director.
- Once satisfied the Coroner will arrange for transportation to the chosen funeral director.

Checklist for unauthorised DoLS - expected death
This is not a death in custody, but the Coroner's Office must still be informed.

- Verification of death Nurse/ECP (if trained)
- Ring the GP and/or OOHs
- Inform the Coroner's Office immediately in working hours or the next working day if appropriate, e.g. if very close to the start of office hours. If not appropriate to wait, ask for the Duty Coroner.
- Death certificate can be issued by GP – if supported by the Coroner.
- Please note - the body can only be released to chosen funeral director once the Coroner's Office has agreed.

Final Version updated 21 July 2015: Coroner's Office/NHS Dorset CCG

Useful Guidance and Information References

If you are applying the DoLS Safeguards then please send the relevant DoLS form(s) to the **Mental Capacity Act Team** to **mcateam@dorsetcc.gov.uk** or by fax to: **01305 224325**.

For general advice or guidance please call the office number: 01305 225650 or see our web pages www.dorsetforyou.com/mental-capacity-act.

Useful links to guidance:

- CQC guidance: http://www.cqc.org.uk/sites/default/files/20140416_supreme_court_judgment_on_deprivation_of_liberty_briefing_v2.pdf
- Supreme Court Judgement – press summary http://supremecourt.uk/decided-cases/docs/UKSC_2012_0068_PressSummary.pdf

Useful Websites:

- Office of Justice: www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act
- SCIE: www.scie.org.uk/publications/mca/index.asp
- 39 Essex Street Newsletters: www.39essex.com/resources-and-training/mental-capacity-law/
- Community Care Magazine: www.communitycare.co.uk/
- Local Government Lawyer: www.localgovernmentlawyer.co.uk/

Useful Publications:

- Deprivation of Liberty Code of Practice http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476
- Mental Capacity Act Code of Practice http://webarchive.nationalarchives.gov.uk/20130107105354/http://justice.gov.uk/protecting-the-vulnerable/mental-capacity-act
- Advance Decisions & Proxy Decision-making in Medical Treatment & Research - BMA (2007) http://bma.org.uk/-/media/files/pdfs/practical%2520advice%2520at%2520work/ethics/advancestatements2007.pdf&sa=U&ved=0CBkQFjAAahUKEwicqpfntZzIAhXJWxoKHUyMC2A&usg=AFQjCNHFt9LRx00YPtmRfdUI2GhCcM50EQ
- Making Decisions – A Guide for People Who Work in Health & Social Care – Ministry of Justice & Office of the Public Guardian (2007)
- MCA tool kit - http://bma.org.uk/practical-support-at-work/ethics/mental-capacity

Useful Pre course reading:

- Assessing Capacity Guidance from 39 Essex: www.39essex.com/docs/newsletters/capacityassessmentsguide31mar14.pdf
- Law Society – Practical Guides on Deprivation of Liberty www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/

Important Case Law (additional reading):

- Cheshire West : https://www.supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf
- Re X http://www.39essex.com/content/wp-content/uploads/2015/02/LG-talk-2015-COP-DOLs-.pdf
- Manuela Skyes : http://www.39essex.com/cop_cases/westminster-city-council-v-manuela-sykes/
- Re AJ http://www.39essex.com/cop_cases/aj-v-a-local-authority/
- Re NRA and Ors: http://www.39essex.com/cop_cases/re-nra-ors/?utm_source=Newsletters&utm_campaign=40e920fbfa-judicial+auth+eflash&utm_medium=email&utm_term=0_0dd23690b2-40e920fbfa-76891705