



Mental Capacity Act

(Northern Ireland) 2016

Deprivation of Liberty Safeguards Code of Practice



Department of
Health

An Roinn Sláinte

Máinnystrie O Poustie

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CONTENTS

Contents.....	1
List of Flowcharts and figures	2
Glossary of terms	3
Index of forms	5
Chapter 1. Introduction	7
Chapter 2. Deprivation of Liberty	11
Chapter 3. Principles	15
Chapter 4. Protection from liability	19
Chapter 5. Capacity.....	21
Chapter 6. Best interests.....	29
Chapter 7. Deprivation of liberty safeguards	36
Chapter 8. Formal assessment of capacity	44
Chapter 9. Nominated person	48
Chapter 10. Emergencies	53
Chapter 11. Trust panel authorisation.....	57
Chapter 12. Short-term detention authorisation	65
Chapter 13. Extensions	77
Chapter 14. Trust panels.....	83
Chapter 15. The Review Tribunal.....	85
Chapter 16. Children and young people	86
Chapter 17. Offences	89
Chapter 18. Warrants	92
Chapter 19. Money and valuables when a patient is a resident or in-patient.....	94

LIST OF FLOWCHARTS AND FIGURES

Flowcharts

Flowchart 1 - Deprivation of Liberty	43
Flowchart 2 - Formal Assessment of Capacity	47
Flowchart 3 - Emergencies.....	56
Flowchart 4 - Trust Panel Authorisations	64
Flowchart 5 - Short-term detention in hospital.....	76
Flowchart 6 - Extensions	82

Figures

Figure 1 - Meaning of lack of capacity	21
Figure 2 - Meaning of unable to make a decision.....	22
Figure 3 - Causes of impairment of, or disturbance in the functioning of, mind or brain	25
Figure 4 - Unconnected with in relation to nominated persons	49
Figure 5 - Default list for nominated persons.....	51
Figure 6 - Unconnected with in relation to trust panel applications.....	58
Figure 7 - Unconnected with in relation to short-term detentions.....	68
Figure 8 - Timeline for short-term detentions.....	72
Figure 9 - Unconnected with in relation to extensions	80
Figure 10 - Unconnected with in relation to trust panels	83

GLOSSARY OF TERMS

the Act	the Mental Capacity Act (Northern Ireland) 2016
approved social worker	a person appointed under section 280 of the Act
authorisation	a trust panel authorisation, short-term detention authorisation, extension authorisation or a trust panel extension authorisation
best interests	a holistic consideration of all relevant factors, including special regard for P's wishes, feelings, beliefs and values – see Chapter 6
D	usually the person doing an act
dentist	a person registered in accordance with the Dentists Act 1984
the Department	the Department of Health (Northern Ireland)
DoL	deprivation of liberty – see Chapter 2
ECHR	European Convention on Human Rights
emergency	where waiting with a deprivation of liberty to put in place certain additional safeguards would cause an unacceptable risk of harm to P – see Chapter 10
extension authorisation	authorisation to extend a trust panel authorisation – see Chapter 13
formal assessment of capacity	an additional safeguard – see Chapter 8
medical practitioner	a registered person within the Medical Act 1983 who holds a licence to practice
medical report	a report required for authorisations and for certain additional safeguards
midwife	a person registered in under the Nurses and Midwives Order 2001 by virtue of qualification as a midwife
NP	nominated person – see Chapter 9
nurse	a person registered in under the Nurses and Midwives Order 2001 by virtue of qualification as a nurse

occupational therapist	a person registered with the Health and Care Professions Council as an occupational therapist
P	a person who is over the age of 16 and lacks capacity
POSH	prevention of serious harm condition
practitioner psychologist	a person registered with the Health and Care Professions Council as a practitioner psychologist
protection from liability	the legal protection under which acts can be done on behalf of a person who lacks capacity – see Chapter 4
RQIA	the Regulation and Quality Improvement Authority
short-term detention authorisation	see Chapter 12
social worker	a person registered with the Health and Care Professions Council as a social worker
speech and language therapist	a person registered with the Health and Care Professions Council as a speech and language therapist
statement of incapacity	a statement made during a formal assessment of capacity – see Chapter 5
the Tribunal	the Review Tribunal – see Chapter 15
trust panel	a panel constituted by a trust who receives an application for authorisation – see Chapter 14
trust panel authorisation	an authorisation required for all deprivation of liberty where there is no short-term detention authorisation – see Chapter 11
trust panel extension authorisation	authorisation when an extension authorisation cannot be made – see Chapter 13
warrant	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

INDEX OF FORMS

- Form 1 Statement of incapacity
must be used for applications to trust panel, short-term detention authorisations and extensions
- Form 2 Best interests determination statement
must be used for applications to trust panel, short-term detention authorisations and extensions
- Form 3 Consultation with nominated person
must be used for applications to trust panel, short-term detention authorisations and extensions
- Form 4 Not relevant to the Phase 1 Commencement
- Form 5 Application for trust panel authorisation
must be used when applying for a trust panel authorisation
- Form 6 Medical report
must be used when making a medical report for a trust panel application
- Form 7 Statement that the person lacks capacity whether an application should be made to the Review Tribunal
must be used in applications to the trust panel or short-term detention authorisation if the person lacks capacity whether an application should be made to the Review Tribunal
- Form 8 Short-term detention authorisation for examination or examination followed by treatment
must be used when making a short-term detention authorisation
- Form 9 Consultation with an approved social worker
must be used in a short-term detention authorisation if the nominated person provides a reasonable objection to the detention
- Form 10 Short-term detention exception certificate
must be used when making a short-term exception certificate
- Form 11 Short-term detention admission report
must be used when making a short-term detention admission report

- Form 12 Short-term detention further admission report
must be used when making a short-term detention further admission report
- Form 13 Short-term detention further report
must be used when making a short-term detention further report
- Form 14 Extension authorisation (extension by report)
must be used when making an extension authorisation by report
- Form 15 Responsible person statement
must be used for the responsible person statement in the extension authorisation
- Form 16 Application for trust panel extension authorisation
must be used when applying for a trust panel extension authorisation
- Form 17 Notification of application for trust panel authorisation and trust panel extension authorisation
must be used for notifications when an application for a trust panel authorisation or a trust panel extension authorisation has been made
- Form 18 Notification of trust panel decision
must be used for notifications when the trust panel has made a decision
- Form 19 Notification of short-term detention
must be used for notifications of a short-term detention authorisation
- Form 20 Notification of an extension
must be used for notifications of an extension authorisation (extension by report)
- Form 21 Discharge from detention
must be used for discharge from detention
- Form 22 Appointment, revocation, making of a declaration or revoking a declaration in relation to the nominated person
can be used in relation to nominated persons

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. During phase 1 of the Act, the 1986 will continue to operate alongside the Act. Transitional arrangements during this period notes that the first choice to deprive a person of liberty must be the 1986 Order. **That means if a person can be detained under the 1986 Order the person cannot be deprived of liberty under the Act**
- 1.4. 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, as well as a few additional matters (e.g. offences, and money and valuables).
- 1.5. 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.
- 1.6. 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.
- 1.7. 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

- 1.8. 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.

- 1.9. 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.
- 1.10. 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

- 1.11. 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.
- 1.12. 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, a scenario booklet has been developed to supplement the Code. These scenarios provide additional detail using specific examples from specific settings. They are not part of the official Code, therefore they do not have the same legal status.

Who is the Code for?

- 1.13. 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.
- 1.14. 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

- 1.15. 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.
- 1.16. **Chapter 2** explains deprivation of liberty. This includes provisions for what act or combination of acts will amount to a deprivation of liberty.
- 1.17. **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

- 1.18. **Chapter 4** explains how the Act protects people carrying out a deprivation of liberty in relation to a person who lacks capacity.
- 1.19. **Chapter 5** describes what it means to lack capacity and how to determine if a person has capacity or not.
- 1.20. **Chapter 6** details the steps required to carry out a best interests determination.

DoL requirements

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

Additional Safeguards

- 1.22. **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.
- 1.23. **Chapter 9** provides details on the nominated person role and who this is.
- 1.24. **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

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

- 1.26. **Chapter 12** explains what a short-term detention authorisation is and what is required before one can be made.
- 1.27. **Chapter 13** outlines how a trust panel authorisation can be extended by an authorisation report or by an authorisation by trust panel.
- 1.28. **Chapter 14** provides a brief guide on the work of the trust panel to aid those applying to the panel.
- 1.29. **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

- 1.30. **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, Warrants, Research and Money and Valuables

- 1.31. **Chapter 17** outlines the offences in the Act and how they apply to those who interact with persons who lack capacity.
- 1.32. **Chapter 18** explains warrants.
- 1.33. **Chapter 19** describes what acts can be done in relation to a person's money and valuables if the person is an in-patient in a hospital or a resident in a residential care or nursing home, and lacks capacity in relation to the management of their financial affairs.

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 you can only ever be deprived of your liberty if you are deemed to be of unsound mind. A person who lacks capacity is of unsound mind and therefore any act or intervention which fits in with the test below is a DoL. The only way to be protected from liability when carrying out the act is to follow procedures outlined in this Code.
- 2.4. Conversely, anyone who has 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.

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?
 - c. can the care arrangements be attributed to the state?
- 2.7. If P is under continuous supervision and control, is not free to leave and the DoL is attributed to the state, 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. Also, the duration of the detention does not affect the conclusion of a DoL; it can be for a very short period, even minutes, or for a very long period of months or even years. However, an act that is short, time-bound and reactive to an immediate event is likely not to be a DoL but restraint, which remains governed under common law.
- 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. **State involvement** includes anything that may mean that the state is attributed to the actions. This may be that the state is responsible for the care or treatment, as would be the case in a hospital, has placed P at the location, such as in a care home, foster home or anywhere else, or is in any other way involved. The involvement does not have to be direct as long it relates to the care or treatment of P; for example if a person is receiving carers allowance to care for P the care can be attributed to the state. If there is no state involvement at all, the act can never be a DoL and the DoL procedures do not apply.
- 2.12. 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.**
- 2.13. 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 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 HSC system (for example through direct payments or carers allowance).

2.14. 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.

Exception for persons receiving life-saving treatment in hospital

2.15. 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.

- 2.16. 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.
- 2.17. 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.
- 2.18. This means that, in general, no persons are deprived of liberty in an intensive care setting.

Detention amounting to DoL under the Act

- 2.19. 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.

Children under 18

- 2.20. It is important to note that special rules apply to children under 18 (see Chapter 16). This includes the right of the parent or guardian to consent to a deprivation of liberty of the child. If a parent has provided a valid consent to the deprivation no further safeguards are required. If the parent withholds consent the child cannot be deprived. Only if the parent does not make a decision, i.e. does not provide, or withhold consent, does the protection from liability apply¹. Where there are concerns or significant disagreements, a decision can be sought through the courts.

¹ *D (a child)* [2017] EWCA Civ 1695.

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 proven that they do

- 3.5. The first principle is founded on personal autonomy. It requires anyone who is considering the need to deprive P of liberty to consider capacity carefully. It is

important to balance a person's right to make their own decisions with their right to safety and protection when they lack capacity to do so themselves.

- 3.6. A person who is thinking about carrying out a deprivation of liberty must not misinterpret the first principle as requiring them to presume or assume that the person has capacity. The principle places the onus on a person intending to carry out the DoL to have **properly established a person's capacity**. However, the starting point when establishing capacity should be that the person has capacity. This is so that no one finds himself or herself in the position where they feel they are being asked to prove they have capacity to make the decision. No decision or act can be done unless it is established that P does not have capacity.
- 3.7. This principle is therefore not intended to prevent or obviate the need for proper checks to be made where there are doubts about a person's capacity to make a decision. Proceeding on the basis of a mere assumption or presumption that the person has capacity to make a decision could end in liability if, in fact, the person lacks capacity. There should be no outright presumption or assumption of capacity or lack of capacity.

Principle 2 – No assumptions can be made

- 3.8. 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; and
 - d. not be able to communicate his or her decision (whether by talking, using sign language or any other means).
- 3.9. 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

- 3.10. 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.
- 3.11. 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.
- 3.12. 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 on behalf of 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

- 3.13. 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.
- 3.14. 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.
- 3.15. 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

- 3.16. 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.
- 3.17. 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.
- 3.18. 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.
- 3.19. 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.**
- 3.20. 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, any attorney appointed under an enduring power of attorney and any deputy appointed by the court.
- 3.21. 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” which provides the legal basis for people to carry out a deprivation of liberty.
- 4.2. Protection from liability is a protection in law for a person (“D”) doing an act (such as a deprivation of liberty) in relation to the care, treatment or personal welfare of a person (“P”), aged 16 and over, who lacks capacity to consent to the act. However the protection will only apply where the required safeguards have been firstly put in place to ensure that the rights and best 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 and the rights of persons with parental responsibilities.
- 4.4. Young persons aged between 16-18 years old are in a unique position because the Act applies to persons aged 16 and over, but a child is defined as someone under the age of 18. Where P is under 18 a parent or guardian may consent to a deprivation of liberty in relation to P and does therefore not require protection from liability. More information on children and young persons can be found in Chapter 16.

Emergencies

- 4.5. 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 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.
- 4.6. 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, the act can be regarded as an emergency and can be carried out without the additional safeguard(s) in place.

- 4.7. 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.

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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.

5.3. There are therefore three elements 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.

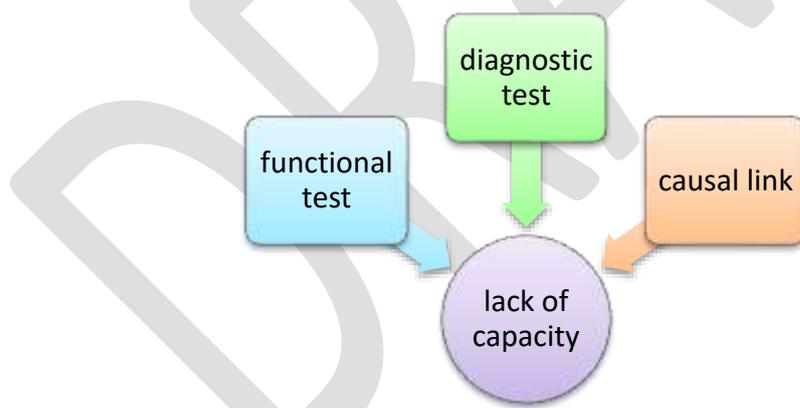


Figure 1 - Meaning of lack of capacity

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 (which includes information about the reasonably foreseeable consequences of deciding one way or another or failing to make the decision (or an appropriate explanation of such));
 - (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; or
 - (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 is 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 an anorexic person 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 being unable to make a decision due to the appreciation element.
- 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 diagnostic 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 diagnostic test.
- 5.18. It does not matter what the cause of the impairment or disturbance is (see diagram below for 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

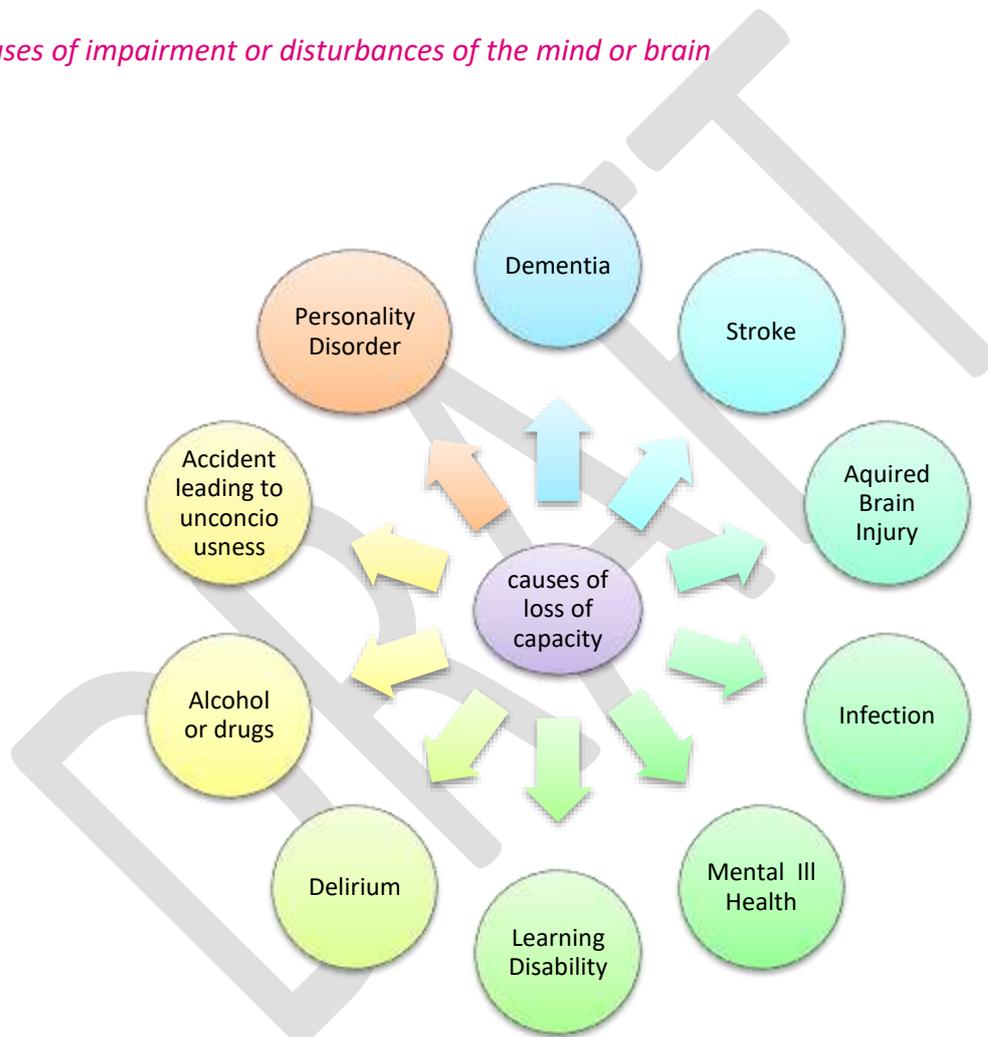


Figure 3 - Causes of impairment of, or disturbance in the functioning of, mind or brain

- 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 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 diagnostic 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 no decisions can be made and no acts can be carried out on behalf of the person.

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 as he or she does not appreciate the complicated nature of his or her illness.

5.27. If P's capacity is known to be fluctuating it is often appropriate to wait to make a decision until a time when P has capacity, if it is possible to do so. It may be that P has capacity in the morning, but loses capacity as the day progresses. In such circumstances it would not be appropriate to make a decision in the evening if it can be done in the morning.

5.28. However, deprivation of liberty is not a one off act but should be understood as a continuous act. In such cases P may regain some capacity for moments of time but may not regain sufficient long-term capacity to be understood to have capacity sufficient to make decisions. P can therefore continue to be deprived of liberty even in such times, as the fluctuations will lead to P lacking capacity again shortly.

Establishing lack of capacity

5.29. 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.

5.30. 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.

5.31. 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

5.32. 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.

5.33. **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.**

5.34. 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.

5.35. 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.

5.36. 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 provides a guarantee 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.

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 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.

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

6.16. 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.

6.17. 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.
- 6.18. 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

- 6.19. 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.
- 6.20. 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

- 6.21. 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.
- 6.22. 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.

- 6.23. **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.
- 6.24. **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.
- 6.25. 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

- 6.26. 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.

- 6.27. 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, an attorney acting under an Enduring Power of Attorney and any deputy appointed for P.
- 6.28. 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.

Less restrictive actions

- 6.29. 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.

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.

- 6.30. 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.
- 6.31. 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.
- 6.32. 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

- 6.33. 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.
- 6.34. 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 determination regarding P's best interests was made, which can be justified if challenged, the protection from liability will still apply.

Best Interest Form and Written Record-Keeping

- 6.35. 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 exist with both the 1986 Order and the Act providing statutory frameworks for DoL.
- 7.2. During phase 1 of the Act, the 1986 will continue to operate alongside the Act. Transitional arrangements during this period notes that the first choice to deprive a person of liberty must be the 1986 Order. **That means if a person can be detained under the 1986 Order the person cannot be deprived of liberty under the Act.**

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 Chapter 8);
 - 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 serious risk of harm to P or serious risk of 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 harm to P, all available factors can be considered, including harm to others with resulting harm to P (see paragraph 6.30).
- 7.9. When considering if there is risk of serious physical harm to others only violent acts towards others and acts that put other persons in reasonable fear of serious physical harm can be taken into account. **Hypothetical harm cannot be considered.** 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 if POSH is met, as X has not been put in reasonable fear or harm. However, if P directly threatens X and X is put in reasonable fear this threat can be used when considering POSH.
- 7.10. 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

- 7.11. 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 (under schedule 2 of the Act – see 0). 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).
- 7.12. 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.
- 7.13. 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 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

- 7.14. 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 P must be **discharged from detention**. The discharge is a formal end of the detention in circumstances amounting to a deprivation of liberty, and also **ends 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.
- 7.15. **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 detention, 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

- 7.16. In an emergency situation a detention amounting to DoL can be done without all the safeguards. 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 doing 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.
- 7.17. 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.

- 7.18. 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.

In what setting does the Act allow a DoL?

- 7.19. A trust panel authorisation must specify where P will be detained and it can only be a place 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.
- 7.20. *An emergency detention amounting to DoL must also be in a place where care or treatment is available for P.*
- 7.21. 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

- 7.22. 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.
- 7.23. 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.
- 7.24. 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

- 7.25. 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.
- 7.26. 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 by the trust panel. This can include when a person who is normally resident in a nursing home and is subject to a DoL but has to go to hospital for treatment.
- 7.27. 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.
- 7.28. 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

- 7.29. Restraint and detention amounting to DoL are closely interlinked as it relates to compulsory limitations to a person's liberty. Restraint will continue to be governed by common law. However, restraint that is ongoing, planned or regular will most likely become DoL.

Disregard of certain detentions

- 7.30. 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.
- 7.31. 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.

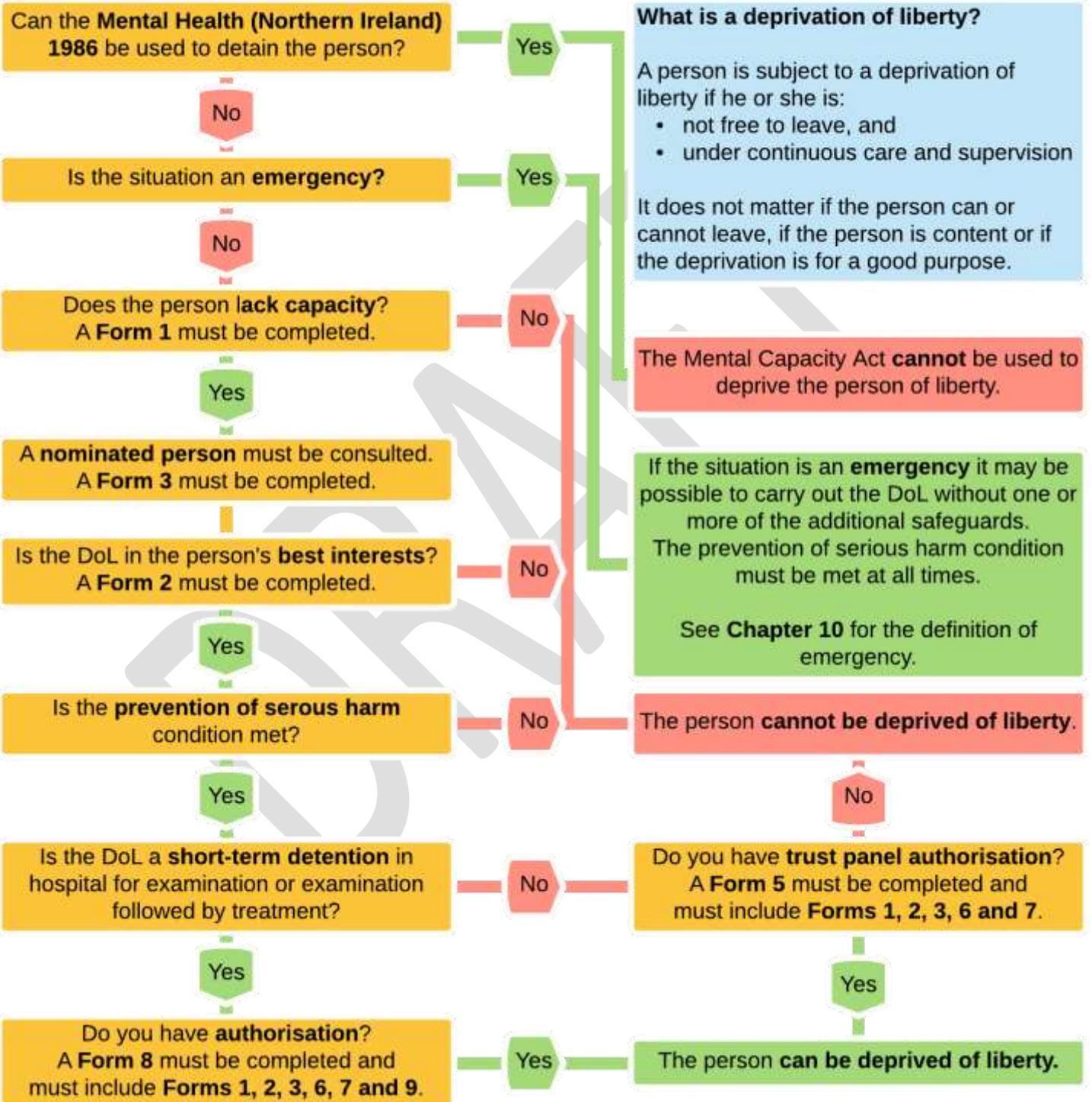
- 7.32. It may be prudent and helpful to advise P of this fact as a point of reassurance in the event that they may have concerns with any perceived implications of being deprived of their liberty.

Information to be provided in relation to deprivation of liberty

- 7.33. 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.
- 7.34. 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 forms of leaflets or general guidance.
- 7.35. 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**.
- 7.36. At all steps of the authorisations processes P, and others, must also 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 on the next page.

Event	Who to be informed	What information	How to inform
P is detained			
<i>Detention</i>	<ul style="list-style-type: none"> • P • NP • Anyone P has asked to be informed 	<ul style="list-style-type: none"> • Under what provisions P is detained • A person's rights under the Act • Information on the Review Tribunal 	Generic leaflets / information
P is discharged			
<i>Discharge</i>	<ul style="list-style-type: none"> • P • Anyone P has asked to be informed 	<ul style="list-style-type: none"> • That P has been discharged • The effect of the discharge 	Form 21
Application for trust panel authorisation or trust panel extension authorisations			
<i>Application</i>	<ul style="list-style-type: none"> • P • NP • Anyone P has asked to be informed 	<ul style="list-style-type: none"> • Notification of application • Procedures of the panel • A person's rights under the Act 	Form 17 and generic leaflet
Decision by trust panel			
<i>All decisions</i>	<ul style="list-style-type: none"> • P • NP • Anyone P has asked to be informed 	<ul style="list-style-type: none"> • Notification of panel decision • A person's right under the Act 	Form 18 and generic leaflet
<i>Authorisation is provided</i>	<ul style="list-style-type: none"> • P • NP • Anyone P has asked to be informed 	<ul style="list-style-type: none"> • Information on the Review Tribunal 	Generic leaflet
<i>Authorisation is provided</i>	<ul style="list-style-type: none"> • The person who made the application • The managing authority where the DoL will take place 	<ul style="list-style-type: none"> • Information to facilitate the DoL 	Trust specific
<i>Form 7 statement is made</i>	<ul style="list-style-type: none"> • Attorney General 	<ul style="list-style-type: none"> • Notification • All relevant information 	Notification with all information relied on by the panel
Short-term detention authorisation			
<i>Authorisation</i>	<ul style="list-style-type: none"> • P • NP • Anyone P has asked to be informed 	<ul style="list-style-type: none"> • Notification of decision • Information on short-term detentions • A person's rights under the Act • Information on the Review Tribunal 	Form 19 and generic leaflets
<i>Authorisation</i>	<ul style="list-style-type: none"> • The managing authority of the hospital 	<ul style="list-style-type: none"> • Information to facilitate the DoL 	Trust specific
<i>Form 7 statement is made</i>	<ul style="list-style-type: none"> • Attorney General 	<ul style="list-style-type: none"> • Notification • All relevant information 	Notification with all information
Extension report			
<i>Extension</i>	<ul style="list-style-type: none"> • P • NP • Anyone P has asked to be informed 	<ul style="list-style-type: none"> • Notification of extension • A person's rights under the Act • Information on the Review Tribunal 	Form 20 and generic leaflets
<i>Extension</i>	<ul style="list-style-type: none"> • The managing authority where the DoL will take place 	<ul style="list-style-type: none"> • Information to facilitate the DoL 	Trust specific
<i>Form 7 statement is made</i>	<ul style="list-style-type: none"> • Attorney General 	<ul style="list-style-type: none"> • Notification • All relevant information 	Notification with all information

Flowchart for Deprivation of Liberty



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 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 diagnostic 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. Failure to record adequate information may lead to civil or criminal liability.

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 three 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?

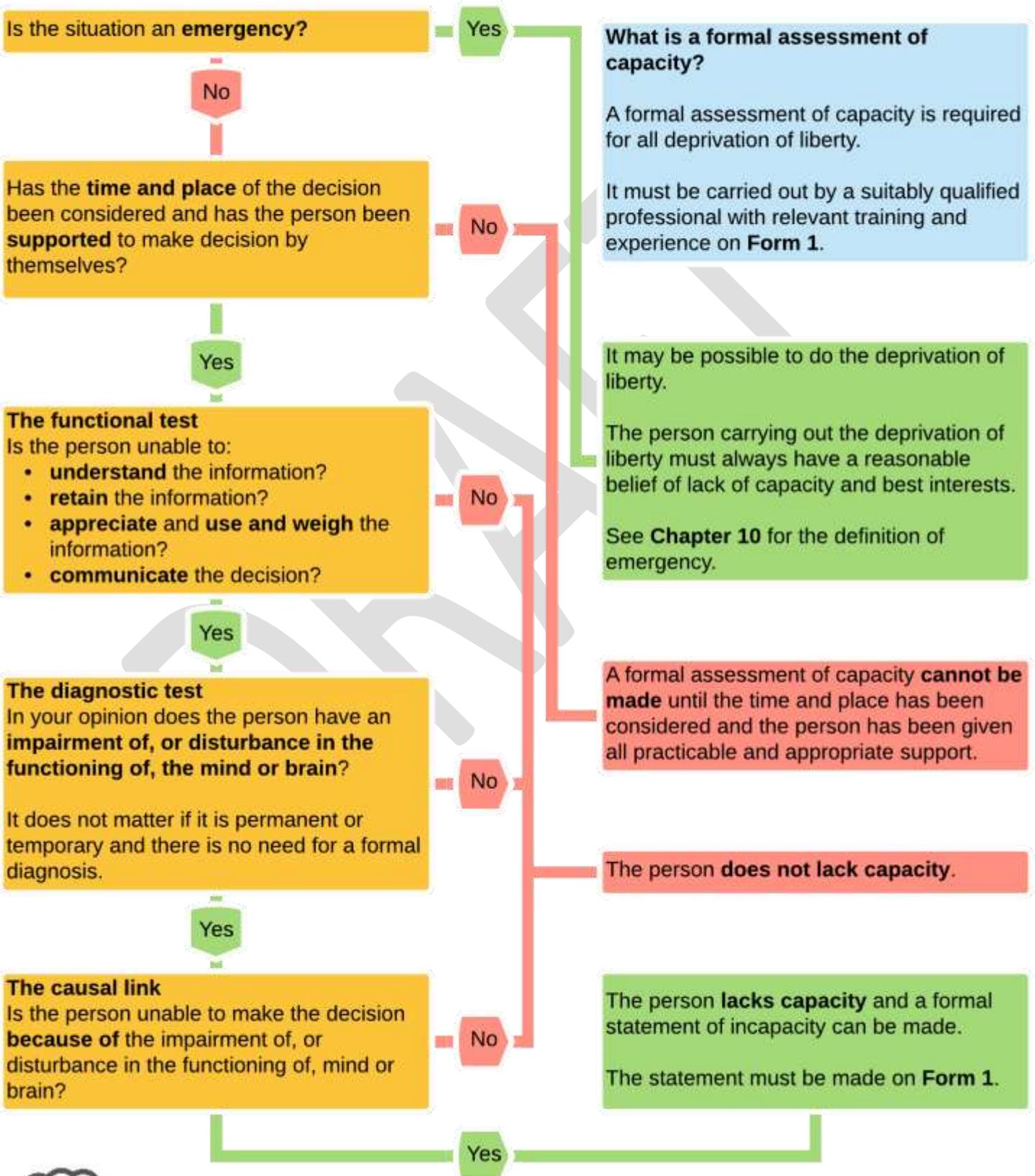
- 8.11. No one can be forced to participate in an assessment of capacity. Where P refuses to participate, efforts should be made to understand their reasoning and provide support and information to encourage their participation.
- 8.12. If P still refuses to participate, it may still be possible to establish 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.

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Flowchart for formal assessment of capacity



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 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.
- 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 consult with the NP would create an unacceptable risk of harm to P the act can be done without consultation. However, the NP should be involved as soon as possible.
- 9.6. The consultation with the nominated person must be noted on Form 3. This form then has to be attached to the application for trust panel authorisation, extension report, application for trust panel extension authorisation or short-term detention authorisation report.

Appointment of nominated person by P

- 9.7. 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 (see below) 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.

- 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; two or more certain persons; or persons of a description specified, are not to be his or her NP. The declaration can also be revoked if the person has capacity to do so.
- 9.11. Where P has not nominated someone and lacks capacity to do so, a NP can, in some circumstances, be appointed by the Review Tribunal or is appointed from a default list (see below for detail on both).

Formalities

- 9.12. 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 declaration;
 - (2) P has not been subjected to any undue pressure in making that revocation; 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.
- 9.13. 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:

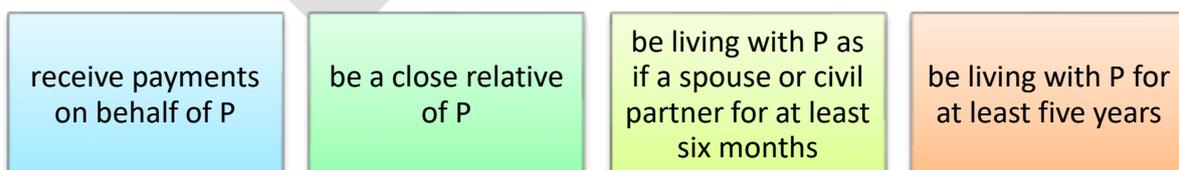


Figure 4 - Unconnected with in relation to nominated persons

- 9.14. A person who is physically unable to sign a declaration can still make a 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.

- 9.15. There are no requirements on what form an appointment, revocation, declaration or revocation of declaration can take. However, a form (Form 22) is provided for ease of use.

Appointment by the Review Tribunal

- 9.16. In some circumstances the Review Tribunal can appoint a NP. This is where:
- a. the person who is P's NP is unsuitable 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 there is a NP; or
 - d. P has a NP, but it is not practicable to establish who that is.
- 9.17. 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. a deputy;
 - e. any relative of P; or
 - f. any person interested in P's welfare.
- 9.18. 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.
- 9.19. When determining if a person is to be considered unsuitable 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.
- 9.20. A person appointed as NP by the Tribunal may resign as NP by giving notice in writing to that effect to P.
- 9.21. 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.

The Default List

9.22. 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.



Figure 5 - Default list for nominated persons

9.23. 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.

9.24. If there are two or more persons falling within the same paragraph, the default NP will be the oldest of the persons. Step-children, step-parents and half-blood siblings are to be treated as whole blood except when there is a whole blood child, parent or sibling where they are preference. Adoptive children or parents are to be treated as whole blood children or parents.

9.25. 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

9.26. There may be circumstances where D proceeds with the intervention on the mistaken belief that a particular person is the NP, when in fact, the NP is someone else and there may be circumstances when it is impossible to determine who the NP is. In these cases D will be protected from liability as long the mistake was reasonable and all reasonable steps were taken to establish if there is a NP appointed and who that is.

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Chapter 10. EMERGENCIES

Introduction

- 10.1. When a DoL is done on behalf of a person who lacks capacity (“P”) 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 the safeguards required 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.

Emergency

- 10.3. 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.
- 10.4. For a situation to be an emergency two conditions have to be met:
 - a. that D knows that the 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.
- 10.5. What is unacceptable risk of harm to P depends on the circumstances in the individual situation. What determines unacceptable risk of harm will be for the person that is carrying out the DoL to decide. In general, a risk is unacceptable if the seriousness of the harm in waiting and the likelihood of that harm is such as to outweigh the risk of harm to P in not complying with the safeguard.
- 10.6. **Purposefully delaying a safeguard for any other reason than risk 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.**

10.7. 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.

Safeguards that can be disregarded in emergency

10.8. 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 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 of a deprivation of liberty.

10.9. 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.**

10.10. 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.

Medical reports in emergency situations

10.11. When creating a medical report for the purpose of DoL (be it in regards 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.

10.12. 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.

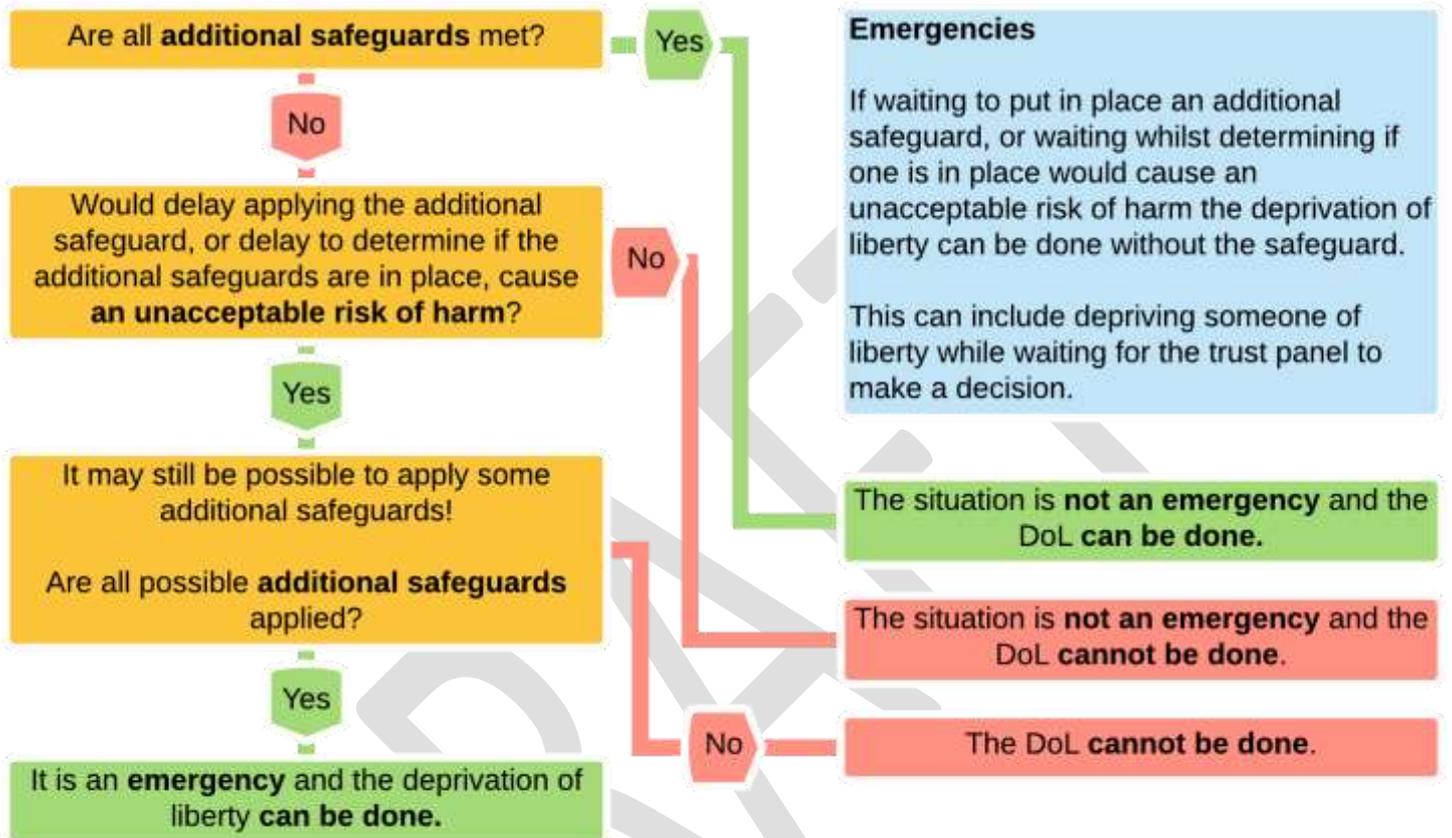
Safeguards and conditions that cannot be disregarded

10.13. For the protection of liability to apply in relation to DoL **there must be a reasonable belief of lack of capacity and best interests in all situations**, 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.

10.14. DoL also has the **prevention of serious harm (POSH) condition that must always be met** before the act can be carried out, even when the situation is an emergency.

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Flowchart for Emergencies



Chapter 11. TRUST PANEL AUTHORISATION

Introduction

- 11.1. A DoL requires the additional safeguard of authorisation by trust panel as found in Schedule 1 of the Act. This chapter sets out the process for such an 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. That means if a person can be detained under the Mental Health Order the person cannot be deprived of liberty under the Act and a trust panel authorisation cannot be made.

What is a trust panel authorisation?

- 11.3. A trust panel authorisation is a process where the person wanting to carry out a deprivation of liberty applies to the relevant health and social care trust who, in turn, appoints a panel to consider the case. The trust panel must make a decision to grant or refuse the application 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 reasonable and practicable, ensure that an authorisation is applied for. What is reasonable and 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 reasonable and 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 0) 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:

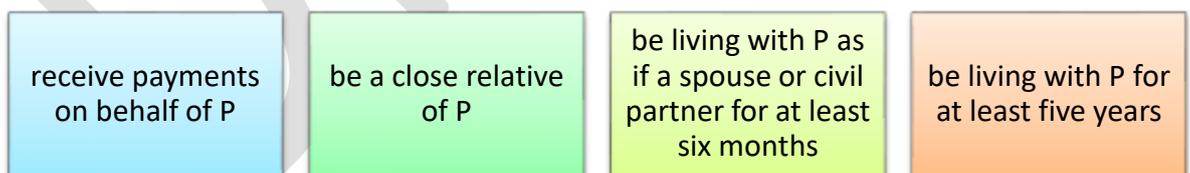


Figure 6 - Unconnected with in relation to trust panel applications

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. how long authorisation is being sought;
- e. details about the deprivation of liberty; and
- f. annexes consisting of:
 - A. statement of incapacity on Form 1 (see Chapter 8);
 - B. best interests determination statement on Form 2 (see below)
 - C. consultation with nominated person on Form 3 (see 0);
 - 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); and
 - F. care plan (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 taking place after the medical report has been completed.

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 deprivation of liberty including why it is necessary;
- b. the options available including what they are and explanation of the least restrictive option;
- c. P's views on the options;
- d. the opinions of others that have been consulted, who has been consulted, what their views are and how any disagreements have been dealt with;
- e. all relevant circumstances including the social circumstances and views of carers and social workers where their involvement is relevant to the decision;

- f. the person's past and present wishes, feelings, beliefs and values; and
- g. 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 (see paragraph 11.8 above). 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. how the criteria for authorisation (lack of capacity and best interests);
- d. how the prevention of serious harm condition is met; and
- e. a statement noting that in the medical practitioner's opinion the criteria for authorisation are met.

11.13. The two steps that the medical practitioner must always carry out is to examine P and consult with P's nominated person (unless it is an emergency).

11.14. For the avoidance of any doubt, 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 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. It must include:

- a. the name and address of P and P's current location;
- b. if P is receiving treatment during the DoL, all treatment P is to receive;
- c. how P's care or treatment is to be managed;
- d. what actions will be taken to ensure the DoL can be ended as soon as practicable; and
- e. provisions for review of the intervention.

Statement of incapacity whether to apply to Tribunal

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. This is to ensure that the panel's decision can be challenged even when P lacks capacity to express an opinion in relation whether a challenge should be made, as required under the European Convention of Human Rights.

11.18. Capacity whether an application should be made to the Review Tribunal is different from having capacity in relation to the DoL or capacity in making an application. **In general the threshold for capacity whether an application to the Tribunal should be made is much lower than the threshold for capacity in relation to the DoL**. If P can express a wish or thought in relation to the care arrangements that amount to a DoL, such as if P is happy to live in the place of the DoL, P probably has capacity in relation to whether an application should be made. The question solely relates to if P wants to challenge the care arrangements that amount to a deprivation of liberty.

11.19. 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 relate 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.

11.20. It is important to note that P does not have to have capacity to make an application to the Tribunal himself or herself. It is sufficient that P has capacity whether an

application should be made. It is therefore expected that in most circumstances P will have capacity whether an application to the Review Tribunal should be made or not.

11.21. If P has such capacity 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

11.22. 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.

11.23. 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.

11.24. **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.

11.25. A decision by the panel to authorise the intervention 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 only with P's consent if they have capacity). Such an application can be made at any time during the period of the authorisation.

11.26. 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.

Information in relation to trust panel applications and authorisations

11.27. 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.

- 11.28. 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.
- 11.29. 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.
- 11.30. 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.

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Chapter 12. SHORT-TERM DETENTION AUTHORISATION

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. That means if a person can be detained under the Mental Health Order the person cannot be deprived of liberty under the Act and a short-term detention authorisation cannot be made.

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:

position	requirements	role in short-term detention authorisation
alternative medical practitioner	<ul style="list-style-type: none"> not in charge of P's care in hospital; must be qualified to be a responsible medical practitioner. 	<ul style="list-style-type: none"> make exception certificate if responsible medical practitioner is unavailable; examination on admission if responsible medical practitioner not available; and make a further report if the responsible medical practitioner is unavailable.
appropriate healthcare professional	<ul style="list-style-type: none"> must be an approved social worker; or 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 three years experience in the last 10 years working with people who lack capacity. 	<ul style="list-style-type: none"> authorise a short-term detention authorisation; 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 provide information to relevant persons upon authorisation.
approved social worker	<ul style="list-style-type: none"> must be appointed by a HSC trust in accordance with section 280 of the Act. 	<ul style="list-style-type: none"> must be consulted if the nominated person objects to the intervention (even if the appropriate healthcare professional is an approved social worker); and can be the appropriate healthcare professional.
medical practitioner	<ul style="list-style-type: none"> registered person within the meaning of the Medical Act 1983 and who holds a license to practice. 	<ul style="list-style-type: none"> make medical report (to be attached to short-term detention authorisation); and examination on admission if responsible medical practitioner and alternative medical practitioner not available – this requires a further admission report within 48 hours.
responsible medical practitioner	<ul style="list-style-type: none"> in charge of P's care in hospital; must be qualified to make formal assessments of capacity; and must have membership of a relevant Royal college and holds a full-time or part-time appointment at a Consultant, Specialty or Associate Specialist level 	<ul style="list-style-type: none"> in charge of P's examination and treatment; make exception certificate; make examination on admission; and make a further report.

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 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 three 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:

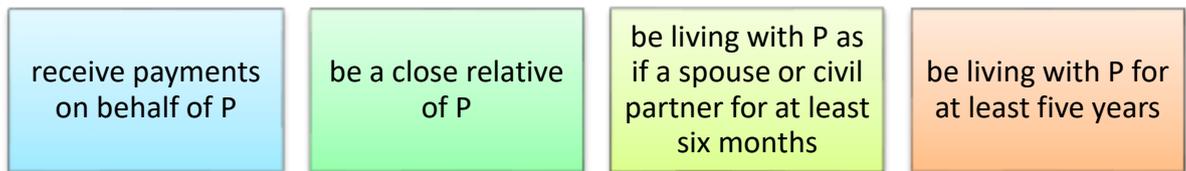


Figure 7 - Unconnected with in relation to short-term detentions

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 in the majority of circumstances an ASW should make the report authorising the short term detention. However, if, by exception, it is determined that it would be in the best interests of P for another healthcare professional to carry out this role, another person who meets the criteria listed above can make the report.

12.16. If a healthcare professional other than an ASW makes the authorisation report, that report must contain the reasons why it has been deemed to be in P's best interests not to involve an ASW. For further information on how to determine best interests, please refer to Chapter 6.

12.17. It is important to note that the short term detention authorisation relates to the detention (deprivation of liberty) only.

Form of short-term detention authorisation

12.18. 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. if a person other than an ASW is making the authorisation, an explanation why an ASW cannot make it;

- d. name and address of the person in charge of P's care (if known);
- e. the hospital where the detention will take place;
- f. what examination or examination followed by treatment that will take place; and
- g. annexes consisting of:
 - A. statement of incapacity on Form 1 (see Chapter 8);
 - B. best interests determination statement on Form 2 (see below)
 - C. consultation with nominated person on Form 3 (see 0);
 - 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); and
 - F. approved social worker information on Form 9 (see below).

Best interests determination statement

12.19. A best interests determination must follow the best interests steps (see Chapter 6). A best interests determination statement must be made on Form 2 and must include details of best interests determination. This must include, but is not limited to details about:

- a. the deprivation of liberty and why it is required;
- b. the options available, including what they are and explanation of the least restrictive option;
- c. P's views on the options;
- d. the opinions of others that have been consulted, who has been consulted, what their views are and how any disagreements have been dealt with;
- e. all relevant circumstances including the social circumstances and views of carers and social workers where their involvement is relevant to the decision;
- f. P's past and present wishes, feelings, beliefs and values; and
- g. anything else that is relevant to the decision.

Approved social worker information

12.20. 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.

Medical report

12.21. 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 (if available);
- b. the name of the medical practitioner and a statement that he or she is unconnected with P;
- c. how the criteria for authorisation (lack of capacity and best interests) are met;
- d. how the prevention of serious harm condition is met; and
- e. a statement noting that that in the medical practitioner's opinion the criteria for authorisation are met.

12.22. 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.

12.23. 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.

12.24. For the avoidance of doubt the two steps that the medical practitioner **must** carry out is to examine P and consult with P's nominated person (unless it is an emergency).

Statement of incapacity to apply to Tribunal

- 12.25. The person making the short-term detention authorisation must consider if P has the capacity to make a decision whether to apply to the Review Tribunal or not in respect of the short-term detention 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 report. This is to ensure that the authorisation can be challenged even when P lacks capacity to express an opinion in relation whether a challenge should be made, as required under the European Convention of Human Rights.
- 12.26. Capacity whether an application should be made to the Review Tribunal is different from having capacity in relation to the DoL or capacity in making an application to the Tribunal. **In general the threshold for capacity whether an application to the Tribunal should be made is much lower than the threshold for capacity in relation to the DoL.** If P can express a wish or thought in relation to the care arrangements that amount to a DoL, such as if P is happy to live in the place of the DoL, P probably has capacity in relation to whether an application should be made. The question solely relates to if P wants to challenge the care arrangements that amount to a deprivation of liberty.
- 12.27. 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 relate *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.
- 12.28. It is important to note that P does not have to have capacity to make an application to the Tribunal himself or herself. It is sufficient that P has capacity whether an application should be made. It is therefore expected that in most circumstances P will have capacity whether an application to the Review Tribunal should be made or not.
- 12.29. If P has such capacity 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 of the short-term detention. This will allow the Attorney General to refer the case to the Review Tribunal for consideration.

Information on making a short-term detention authorisation

12.30. 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:

- a. P;
- b. the nominated person;
- c. any person P has asked the information to be given to;
- d. the managing authority of the hospital where P will be detained; and
- e. 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

12.31. 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.

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

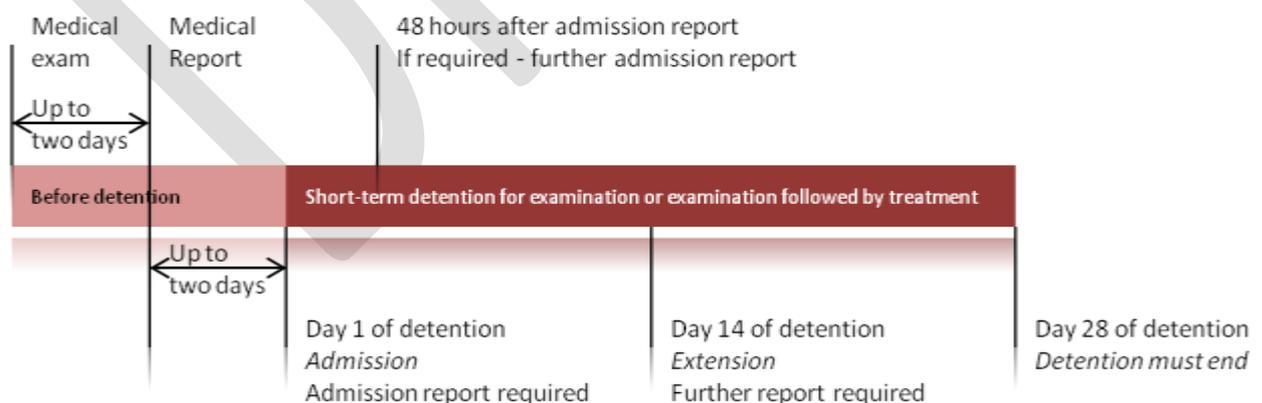


Figure 8 - Timeline for short-term detentions

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

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

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

Admission

12.34. 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).

12.35. 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

- 12.36. 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:
- 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;
 - the detention is proportionate to the likelihood of harm and the seriousness of the harm;
 - P lacks capacity in relation to the detention; and
 - it would be in the best interests of P to be detained.
- 12.37. 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.
- 12.38. 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.
- 12.39. Both the admission report and further admission report must include the statement noted above and must also include:
- the name and date of birth of P and P's home address before detention;
 - the name of the person making the admission report and a statement that he or she is unconnected with P;
 - if the person is the responsible medical practitioner, the alternative medical practitioner or a normal medical practitioner;
 - a statement of incapacity;
 - how the criteria for authorisation are met; and
 - how the nominated person has been consulted, his or her views and how any disagreements have been dealt with.

12.40. 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 be released.

12.41. 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 be released from the detention (but may remain in the setting voluntarily).

Extension of detention

12.42. 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:

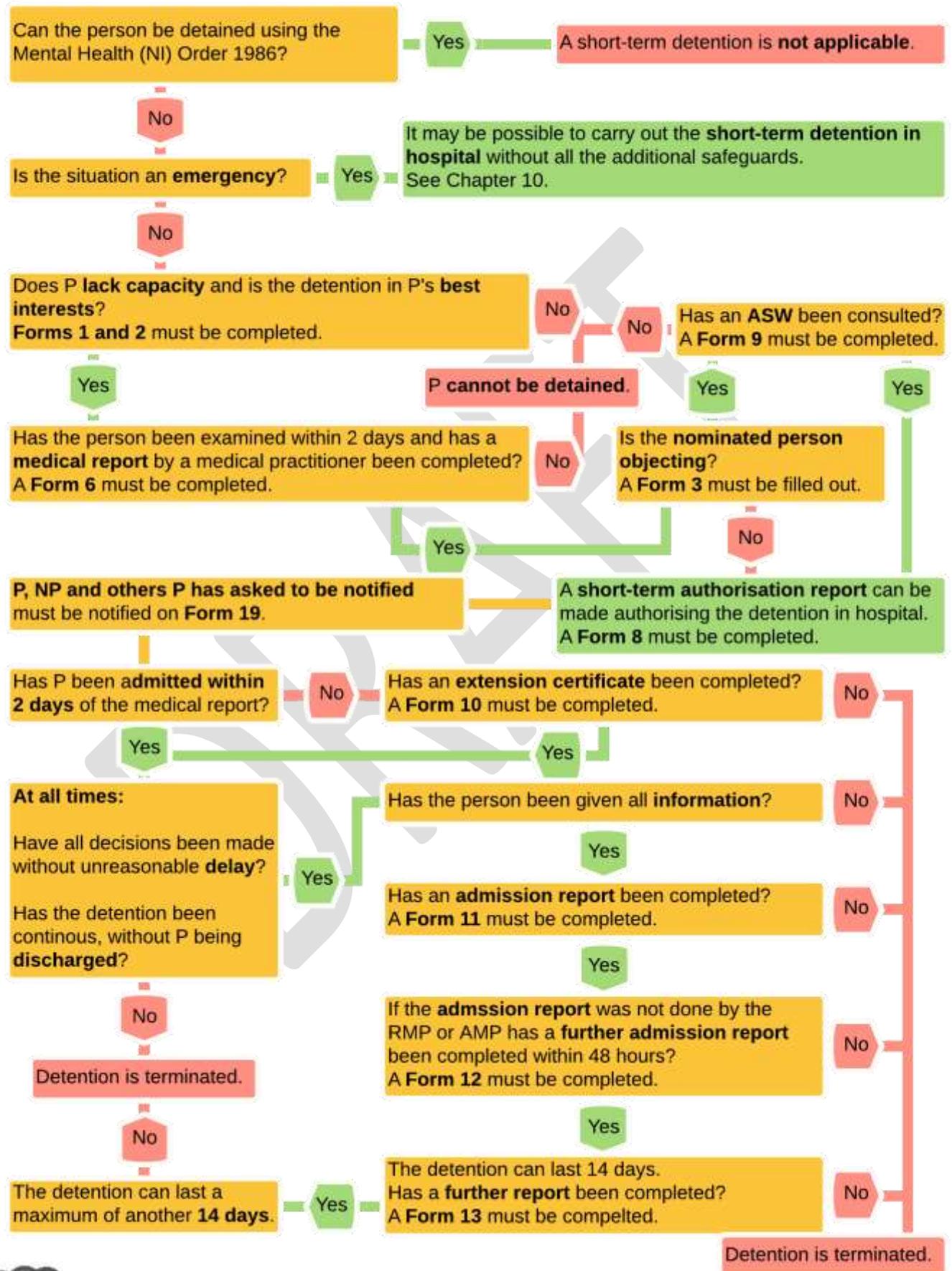
- a. failure to detain P for the purposes of examination or care would create a risk of serious harm to P or of serious physical harm to other persons;
- b. the detention is proportionate to the likelihood of harm and the seriousness of the harm;
- c. P lacks capacity in relation to the detention; and
- d. it would be in the best interests of P to be detained.

12.43. 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.

12.44. 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.

12.45. 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 for Short-term Detention in Hospital



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 a maximum of six months and any further extension can extend the authorisation for a maximum of 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. An authorisation (apart from a short-term detention authorisation) can be extended by the making of a report for a maximum of six months in the first instance if the authorisation has not been revoked and has not come to an end. Subsequent extensions can be made by the making of a report for a maximum of 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 (lack of capacity and best interests);
- g. how the prevention of serious harm condition are met;
- h. information on opinion of the responsible person; and
- i. annexes consisting of:
 - A. statement of incapacity on Form 1 (see Chapter 8);
 - B. best interests determination statement on Form 2 (see below)
 - C. consultation with nominated person on Form 3 (see 0);
 - D. statement whether P has capacity to decide to apply to the Review Tribunal on Form 7 (see below);
 - E. responsible person statement on Form 15 (see below); and
 - F. care plan.

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 deprivation of liberty and why it is required;
- b. the options available, including what they are and explanation of the least restrictive option;
- c. P's views on the options;
- d. the opinions of others that have been consulted, who has been consulted, what their views are and how any disagreements have been dealt with;

- e. all relevant circumstances including the social circumstances and views of carers and social workers where their involvement is relevant to the decision;
- f. P's past and present wishes, feelings, beliefs and values; and
- g. anything else that is relevant to the decision.

Statement of incapacity to apply to Tribunal

- 13.8. The person making an extension authorisation 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 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 authorisation. This is to ensure that the authorisation can be challenged even when P lacks capacity to express an opinion in relation whether a challenge should be made, as required under the European Convention of Human Rights.
- 13.9. Capacity whether an application should be made to the Review Tribunal is different from having capacity in relation to the DoL or capacity in making an application to the Tribunal. **In general the threshold for capacity whether an application to the Tribunal should be made is much lower than the threshold for capacity in relation to the DoL.** If P can express a wish or thought in relation to the care arrangements that amount to a DoL, such as if P is happy to live in the place of the DoL, P probably has capacity in relation to whether an application should be made. The question solely relates to if P wants to challenge the care arrangements that amount to a deprivation of liberty.
- 13.10. 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 relate *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.
- 13.11. It is important to note that P does not have to have capacity to make an application to the Tribunal himself or herself. It is sufficient that P has capacity whether an application should be made. It is therefore expected that in most circumstances P will have capacity whether an application to the Review Tribunal should be made or not.
- 13.12. If P has such capacity 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 of the extension authorisation. This will allow the Attorney General to refer the case to the Review Tribunal for consideration.

Responsible person

13.13. 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”

13.14. 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.

13.15. The responsible person must be suitably qualified to make a formal assessment of capacity (see Chapter 8), 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. a social worker who is involved in the care or treatment of P if the care and treatment where the 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.

13.16. In addition the person making the application must be suitably qualified to make formal assessments of capacity and unconnected with P. That means that the person cannot:

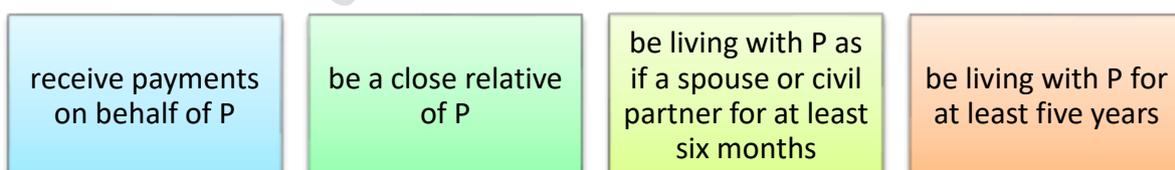


Figure 9 - Unconnected with in relation to extensions

13.17. 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

13.18. 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.

13.19. 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

13.20. 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**.

13.21. 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.

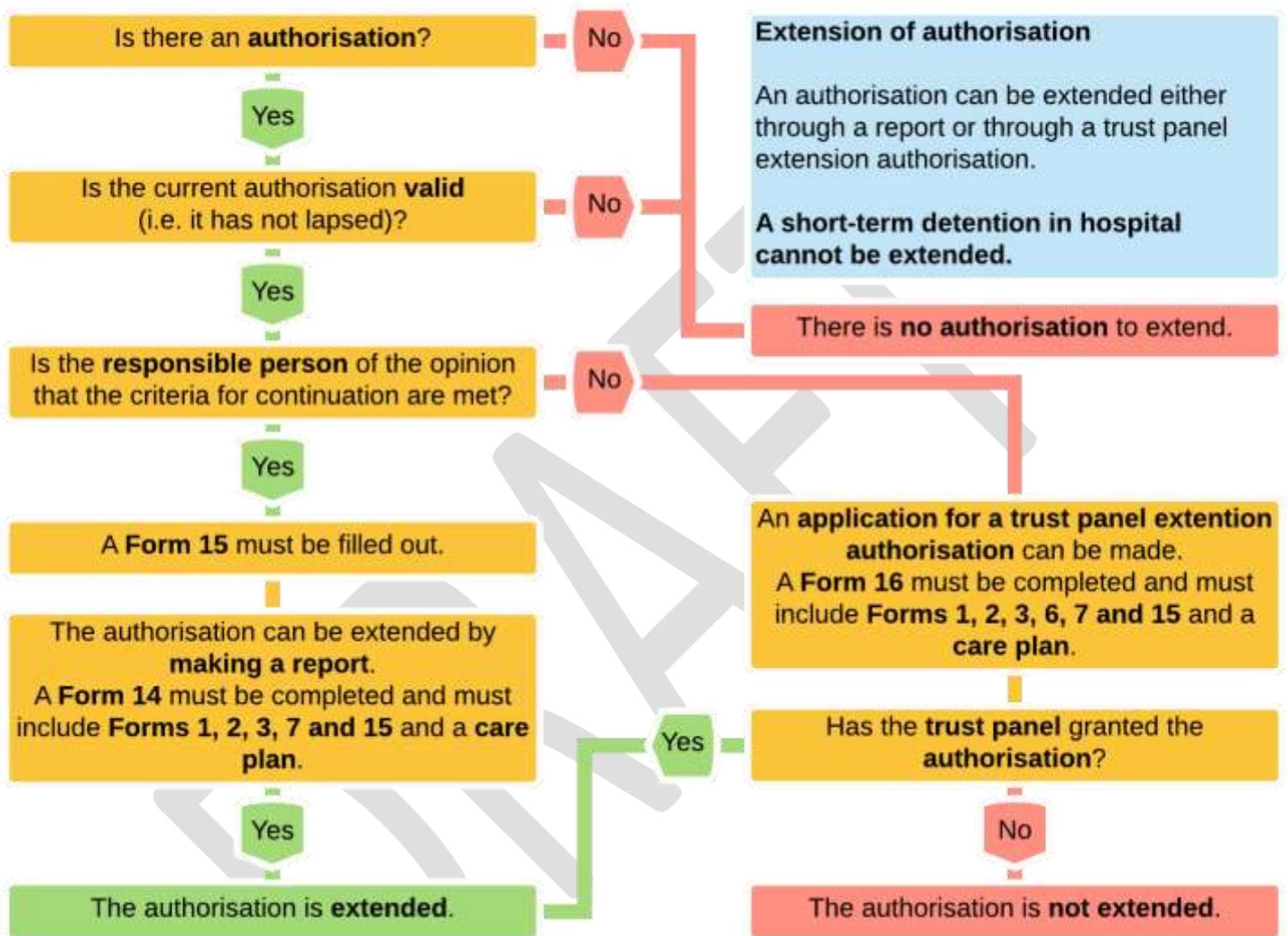
13.22. To apply for a trust panel extension authorisation Form 16 must be used. The information in the application form is the same as for a trust panel authorisation (see Chapter 11) with the exception the application must note if it is a first or subsequent application and what the views of the responsible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

13.23. 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. See also paragraph 7.31-7.34.

Lapsing of authorisation

13.24. 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.

Flowchart for Extensions



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

14.5. All three panel members must be suitably qualified to make formal assessments of capacity (see Chapter 8) 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 be unconnected with P. That means they must not:

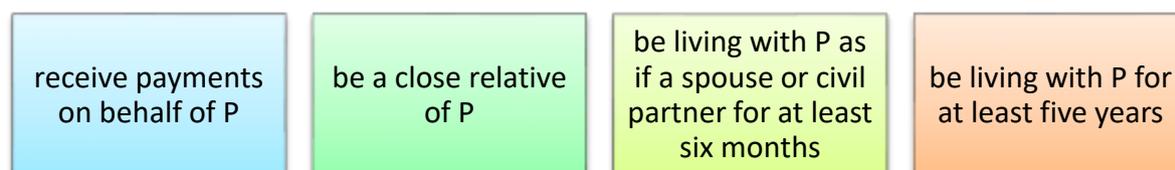


Figure 10 - Unconnected with in relation to trust panels

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. The panel then has seven working days to make a decision to grant or refuse the authorisation or to issue an interim authorisation. There are no exceptions to this timeline; the panel **must** make a decision within seven working days.
- 14.7. 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. These persons can make representation in writing to the panel as soon as the application has been received by the trust. The panel can, in exceptional circumstances, allow representation in other forms, including oral representation. During its deliberation the panel may request further information, in any form, from anyone the panel considers relevant. However, the timeline of making a decision within seven working days must always be met, even when the panel decide to hear oral evidence.
- 14.8. When the panel meets all three members must be present. The panel can 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.
- 14.9. The trust panel has 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.
- 14.10. 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.
- 14.11. **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.

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.

When can applications be made to the Tribunal?

15.2. 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?

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

15.4. 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.

15.5. 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

15.6. Upon reaching a decision the Tribunal may revoke the authorisation, vary the conditions of the authorisation or decide to take no action in respect of the authorisation.

15.7. A decision by the Tribunal cannot be appealed. However, 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 and 17 year olds

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. As it is recognised that as children 16 and 17 years old are not adults, parents or guardians of a 16 or 17 year old have a role to play in the decision making process and it is assumed that the greatest protection of the rights of the child are provided by the parents.

16.3. The Age of Majority Act (NI) 1969 provides that a person reaches the age of majority when he or she turns 18. That Act also provides that a person who is 16 or over may consent to surgical, medical and dental treatment without first acquiring consent by the parent or guardian. However, the Age of Majority Act does not remove the right of the parent or guardian to consent on behalf of a 16 or 17 year old.

16.4. This means **if a person is 16 or 17 years old and lacks capacity, a parent or guardian can consent to the deprivation of liberty without relying on the protection from liability and without complying with any of the safeguards**. Recent court cases have indicated the parental right to make decisions includes deprivation of liberty².

16.5. Only if a parent or guardian decides not to make a decision regarding consent (i.e. does not explicitly provide consent or explicitly withhold consent) does the protection from liability and the safeguards apply. This is consistent with the European Court of Human Rights' position to ensure the right to family life under Article 8 of the European Convention on Human Rights³.

16.6. To ensure that 16 and 17 year olds are provided with as much protection as possible, parents or guardians should be always be advised that if they do not make a decision, the safeguards under the Act will apply to ensure that the rights of the child are protected as far as possible. Parents are not obligated to make the decision and

² *D (a child)* [2017] EWCA Civ 1695.

³ See *Nielsen v Denmark* (1998) 11 EHRR 175, para 61.

should be aware that this option is available if they wish to avail of the safeguards under the Act rather than provide or withhold consent as is their right as a parent.

- 16.7. **If the guardian is a corporate parent, best practice is that the guardian should neither provide consent nor withhold consent to ensure that arbitrary decisions are not made and the safeguards provided by the Act are applied.**
- 16.8. For the avoidance of any doubt, where the State has parental responsibility for a 16 or 17 year old they should not make a decision regarding any DoL in relation to the child, and instead should allow the decision to be taken under the provisions of the Act as set out in this Code.
- 16.9. If in any way there are concerns that a parent is not acting in the child's best interests, existing guidance regarding safeguarding procedures and relevant legislation, such as The Children (Northern Ireland) Order 1995, should be followed. Where there are significant differences of opinion between clinicians and parents, and where there are significant implications for the child, decisions can be sought from the Courts.

Age appropriate environment

Please note: DoH is currently seeking legal advice if there are permissible options to commence age appropriate accommodation in phase 1. It is the policy want by DoH to do so, but we are still awaiting legal advice before a final decision can be made.

- 16.10. If a person aged 16 or 17 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.
- 16.11. 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.

16.12. 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 16 and 17 year olds; the environment must be suitable to the individual's needs.

16.13. In most cases this means that the 16 or 17 year old 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 the 16 or 17 year old 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

16.14. 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.

16.15. Immediately on a person's 16th birthday the Act applies and all safeguards must be in place for DoL to be lawful (in the absence of any decision made by a parent). 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.

16.16. 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.

16.17. 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. For example, it would be wilful negligence for a care worker in a care home to purposefully fail to provide a meal to a resident or purposefully fail to correctly fill in care records.

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 is provided if P is continued 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.

Assisting persons to absent themselves without permission

17.10. **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. There are three distinct offences:

- 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.

17.11. 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.

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

Obstruction

17.13. 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.

17.14. **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.

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

Offences by bodies corporate

17.16. 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:

- a. it was done with their consent;
- b. they connived in the offence; or
- c. 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. 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 liable to be detained in a place in circumstances amounting to a DoL 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.
- 18.3. 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?

- 18.4. 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?

- 18.5. 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.
- 18.6. 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

- 18.7. 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.
- 18.8. 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

- 18.9. 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.
- 18.10. 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

- 18.11. 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.

Who is liable to be detained?

- 18.12. 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.

Chapter 19. MONEY AND VALUABLES WHEN A PATIENT IS A RESIDENT OR IN-PATIENT

Introduction

- 19.1. The Act provides for the spending of a person (“P”) who lacks capacity’s money and valuables in certain circumstances and for certain things. The managing authority of a hospital or care home may receive and hold money and valuables for P and spend it for the benefit of P. This chapter provides how P’s money and valuables can be held and used when P is a resident or an in-patient.
- 19.2. Valuables may mean different things to different people. For the purpose of this chapter a valuable is an item of worth, an item of personal property or a costly article of personal effect.

Money and valuables

- 19.3. The managing authority of a hospital or care home (both residential and nursing) can hold and receive money and valuables on behalf of P up to a maximum value of £20,000. The managing authority may also spend the money and dispose of any valuables if this would benefit P. This may, for example, include using P’s money to buy new clothes for P or to sell a non-sentimental valuable so a new TV can be bought for P.
- 19.4. The managing authority of a hospital or care home means the person registered as the person who manages the establishment or the person registered as the person who carries on the establishment. This person, or persons, must be registered to operate the hospital, residential care or nursing home.
- 19.5. If a residential care or nursing home carries out services commissioned from a HSC trust the managing authority of the home is still the person registered as the person managing the home or carrying on the home. The trust does not become the managing authority in such circumstances. Similarly simply because a trust places a person in a residential care or nursing home does not make the trust the managing authority.
- 19.6. When spending money or selling valuables the managing authority must consider the sentimental value of the things being disposed of. The sentimental value depends on the individual circumstances, but, in general, if P would have been unwilling to part with the item if P had capacity it should be considered sentimental. The managing authority must also consult P’s nominated person, if one is appointed and if it is reasonable and practicable to do so. The managing authority cannot use P’s money

or valuables in a way which would limit P's future options, unless it is to meet a contractual commitment or to ensure P's best interests.

- 19.7. If the combined total of the money and valuables for one individual exceeds £20,000 consent from the Regulation and Quality Improvement Authority ("RQIA") is required. The purpose of requiring consent is to ensure that only hospitals and residential care or nursing homes with adequate procedures can hold money and valuables over such amounts. RQIA's role is not to determine if holding the money or valuables are in the person's best interests or to decide (or approve) how the money or valuables should be used. It is merely to ensure that there are procedures that protect the person from unwarranted loss.

Power to act

- 19.8. The managing authority has a power to receive, hold and spend or dispose of money or valuables. This power is separate from the protections in the protection from liability. The protection from liability, does therefore not apply to any acts done by the managing authority in relation to receiving, holding, spending or disposing of money and valuables on behalf of P. However, any acts done must adhere to the principles of the Act (see Chapter 3), P must lack capacity and the act must be in P's best interests (see Chapter 6). Also, any decision made by the court on behalf of P or any decision made by an enduring power of attorney or by a controller takes precedent over the power.
- 19.9. The power in relation to money and valuables cannot be used to pay for regular cost in relation to the care and treatment of P, such as residential or nursing care home fees. This includes costs in relation to assessed needs that would be provided for even if P did not have any money to spend.
- 19.10. Costs that are expected to be included in such fees, such as routine upgrading of paint or wallpaper, the provision of mobility aids, high profiling mattresses should not be considered as a separate expenditure that could be spent on behalf of the individual from their own resource. Other, non-essential, furnishings such as TVs, radios or internet access that would normally not be included in fees would be appropriate, if spending such money would be in P's best interests.

Lack of capacity in relation to property and affairs

- 19.11. Decisions surrounding money and valuables are not time and matter specific in the same way that most other decisions are. The courts have found that the management of property and affairs is a continuing decision and the person's capacity over a longer time has to be considered. To do an act in relation to money

and valuables therefore requires a reasonable belief of lack of capacity in relation to the management of P's property or affairs generally, and not to the individual decision. However, cognisance should be had that a person who has been assessed as lacking capacity in relation to property and affairs may regain capacity. If capacity is regained no decision can be made without the person's consent.

Holding of money and valuables and record keeping

19.12. A managing authority that holds money and valuables for P must do so securely, such as keeping the money and valuables in a safe place. The way the managing authority considers safe should be clear in the authority's policies. Any losses of money or valuables are the responsibility of the managing authority which must replace any losses.

19.13. A managing authority must also keep records of what money and valuables has been received, where it is being stored, when it was received, how, why and by whom it has been spent or disposed of and the reasons for expenditure or disposal. An annual return must also be sent to the RQIA upon their request, and include such information as they require.

Oversight

19.14. The RQIA has an oversight function in relation to P's money that is being held or used by managing authorities. The managing authority must be aware of its responsibility to comply with the requirements of the Act and the requirements to send relevant information to the RQIA. The RQIA can also consent to money and valuables exceeding £20,000 being received and held on behalf of P. When RQIA considers such consent requests it must consider if the hospital or care home can safely store the money and valuables.

19.15. The provisions in relation to money and valuables means that there is no requirement to refer the routine handling of money and valuables under the limit of £20,000 to the High Court. Neither is there a requirement for the handling of money and valuables with a value over £20,000 to be referred to the High Court if the RQIA has consented to the handling.

19.16. The purpose of RQIA consent is not to make individual decisions in relation to specific money queries. Rather, it is a high level oversight role. If a residential care, nursing home or hospital has been compliant and can show good working practices in relation to money and valuables, consent should in general be provided. Only where the RQIA is of the belief that providing such consent would jeopardise P's assets should consent be withheld.