Somerset Partnership NHS
NHS Foundation Trust

The Deprivation of Liberty Safeguards Policy

To be read in conjunction with the following policies:

Locked doors and door Control Policy
Consent and Capacity to Consent to treatment
Observation While Maintaining Safety and Patient Engagement
Proactive Care.

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Ratified by:	Senior Managers Operational Group
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DOCUMENT CONTROL

Reference	Version	Status	Author
NW/Apr15/DoLS	1	Final	Mental Health Act Coordination Lead
Amendments	The previous policy had been written by the Primary Care Trust (as was) and was written from their perspective as a supervisory body. This version relates to the Trust in its role as managing authority, brings the policy up to date with caselaw and with the Mental Health Act Code of Practice published April 2015.		
Document objectives: To provide staff with a process and procedure about how to implement and report the Deprivation of Liberty Safeguards. This should prevent the unlawful deprivation of any person's liberty whilst they are an inpatient of any Trust hospital.			
Intended recipients: All clinical staff .			
Committee/Group Consulted: Mental Health Legislation Group			
Monitoring arrangements and indicators: Monitored via the Mental Health Legislation Group- indicators are the percentage of staff trained and details of any claims or litigation against the Trust relating to deprivation of liberty.			
Training/resource implications: Overview at induction, regular training sessions and refresher sessions. Combination of face to face and online.			

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1. INTRODUCTION

1.1 The Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) were introduced in April 2009. These legal safeguards are designed to protect vulnerable adults who lack capacity to make certain decisions regarding their care, treatment or residence and are, or may become, deprived of their liberty within a hospital or care home. A DoLS authorisation is designed to provide a legal framework and protection when a deprivation of liberty is considered to be unavoidable and in a person's best interests.

1.2 DoLS were introduced in response to the 2004 'Bournewood judgment' in the European Court of Human Rights (HL v UK). This case was brought by the carers of an autistic man who was kept without any legal framework at Bournewood Hospital against the carers' wishes. The Court found that the circumstances by which HL was admitted to and kept in hospital breached his human right to liberty (Article 5(1) European Convention of Human Rights) and also of Article 5(4), the right to have the lawfulness of detention reviewed by a court.

1.3 Before 2014 it was very complicated to identify a potential deprivation of liberty. A whole range of factors had to be considered. After a case in the Supreme Court in 2014 (known as 'the Cheshire West case') there is now a deceptively simple test to apply- is a person, for whom the state has some sort of responsibility, **subject to continuous supervision and control,** and then, are they **free to leave?** If they are subject to such supervision and control, are not free to leave and they lack the capacity to consent to their situation, then they are deprived of their liberty and may be eligible for a DoLS authorisation.

1.4 The Law society has published a guide on how to identify a deprivation of liberty. Details of this guidance are given in the reference section. The Trust has developed its own guidance which attempts to provide a one-page flowchart as a way of helping staff to identify when an adult in one of our wards may be in a state of deprivation of liberty. The same guidance document also offers advice about what to do about any such deprivation. See Appendix A.

1.5 A DoLS Authorisation is designed to avoid breaches of The Human Rights Act and provides protection for people:

- Who lack the mental capacity specifically to consent to treatment and care in either a hospital or care home:

And

- The care can only be provided in circumstances that amount to a deprivation of liberty and;
- The care is in their best interests to protect them from harm; and
- Detention under the Mental Health Act 1983 in not available for the person at that time.

1.6 **The DoLS are underpinned by the five key principles of the Mental Capacity Act:**

- A presumption of capacity - every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise;

- The right for individuals to be supported to make their own decisions - people must be given all appropriate help before anyone concludes that they cannot make their own decisions;
- That individuals must retain the right to make what might be seen as eccentric or unwise decisions when they have the capacity to do so;
- Best interests – anything done for or on behalf of people without capacity must be in their best interests; and
- Less restriction– Before an act is done, or a decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

2 PURPOSE & SCOPE

2.1 This policy outlines the legal framework around DoLS and gives guidance on the local policies, practice and procedures that should be followed by Somerset Partnership NHS Foundation Trust staff when working with individuals who may lack mental capacity who are, or may become, deprived of their liberty.

2.2 All persons working in a professional or paid role with people who may lack mental capacity have a legal duty to have regard to the Mental Capacity Act Code of Practice, The Mental Health Act Code of Practice and the DoLS Code of Practice. Staff should view this policy as supplementary to these.

2.3 These Codes of Practice are available here:

DoLS Code of Practice:
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf

MCA Code of Practice
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224660/Mental_Capacity_Act_code_of_practice.pdf

MHA Code of Practice (April 2015 version):
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/396918/Code_of_Practice.pdf

2.4 All clinical staff working within the Trust are likely to come into contact with vulnerable people who may lack the mental capacity to consent to care or treatment where it may be necessary to deprive that person of their liberty in their best interests, in order to protect them from harm.

2.5 DoLS authorisations can only be granted for persons aged 18 years and over.

2.6 Assessing mental capacity and making decisions for those unable to do so for themselves is something which any member of staff who has contact with the public may have to do. Therefore, this policy applies to all permanent, locum, agency and bank staff of Somerset Partnership NHS Foundation Trust, including doctors, nurses, allied health professionals, support staff, social care professionals and managers.

2.7 Whilst the policy outlines how the Trust will manage DoLS it does not replace the personal responsibilities of staff with regard to issues of professional accountability for governance.

2.8 In the event of an infection outbreak, flu pandemic or major incident, the Trust recognises that it may not be possible to adhere to all aspects of this document. In such circumstances, staff should take advice from their manager and all possible action must be taken to maintain ongoing patient and staff safety.

3. DUTIES AND RESPONSIBLITIES

3.1 **Chief Executive –** To ensure that the Trust complies with relevant legal and statutory requirements related to the Deprivation of Liberty Safeguards.

3.2 **Mental Health Act Coordination lead**- will ensure that guidance will be issued when staff need to understand new developments or to change practice as caselaw develops.

3.3 **All Managers of clinical teams responsible for the care of people in hospital, or for admitting people to hospital** should have a working knowledge of this policy, the Codes of Practice for The Mental Capacity Act, the Deprivation of Liberty Safeguards and The Mental Health Act and are responsible for ensuring their teams complete the relevant assessments and documentation. They will also provide guidance within their teams.

3.4 **Ward managers in mental health units and matrons in community hospitals** have the delegated responsibility of signing urgent authorisation forms. If they are unavailable this responsibility falls to the person in charge of the ward at the time. It is a requirement of our registration with the Care Quality Commission that they be notified of every application for a DoLS authorisation and its outcome. Ward managers and matrons must ensure that the appropriate recording process is followed to inform CQC. These procedures are subject to review and pending change at the time of writing.

3.5 **The Learning and Development Department** will facilitate regular face to face training sessions on The Deprivation of Liberty Safeguards as well as electronic training resources available for all staff.

3.6 **Individual members of staff** must ensure they follow this policy.

4. EXPLANATIONS OF TERMS USED

4.1 **Best Interests Assessor (BIA)-** One of the two assessors commissioned by the supervisory body to carry out the assessments required before a standard authorisation may be granted. The best interests assessor can be an employee of the supervisory body or managing authority, but must not be involved in the care or treatment of the person they are assessing nor in decisions about their care. BIAs are often social workers or nurses, but could be from other professional backgrounds.

4.2 **Deprivation of Liberty Safeguards** – a legal framework that allows a managing authority to deprive someone who lacks mental capacity of their liberty in certain situations.

4.3 **Deprivation of Liberty-** for the purposes of this policy a deprivation of liberty occurs when a person who is an inpatient of one of our hospitals is subject to continuous supervision and control, is not free to leave and either does not consent to this arrangement or lacks the capacity to do so. Deprivations of liberty may occur in any setting, but the Deprivation of Liberty Safeguards may only be applied within hospitals or care homes.

4.4 **IMCA- Independent Mental Capacity Advocate.** An advocate who has a statutory role within the Mental Capacity Act. Within the DoLS process a relevant person may already be eligible for an IMCA's involvement. If so, the supervisory body must inform the IMCA in writing when it appoints a relevant person's representative (RPR). The RPR is entitled to be supported by an IMCA, and the managing authority and supervisory body should provide details of how to access this support. In some cases the IMCA will be appointed as the RPR, or they may act as a 'temporary' RPR at times when none has been appointed.

4.5 **Mental capacity** - Mental capacity is the ability of an individual to make decisions about specific aspects of their life at specific times.

4.6 **Mental Health Assessor (also known as the 'medical assessor') -** One of the two assessors commissioned by the supervisory body to carry out the assessments required before a standard authorisation may be granted. The 'mental health assessment' must be carried out by a doctor, and the assessing doctor has to either be approved under section 12 of the Mental Health Act 1983, or be a registered medical practitioner with at least three years' post-registration experience in the diagnosis or treatment of mental disorder, such as a GP with a special interest. This includes doctors who are automatically treated as being section 12 approved because they are approved clinicians under the Mental Health Act 1983.

4.7 **Mental Incapacity (or 'lacking capacity')** - an inability to make a particular decision at a particular time due to "an impairment of or disturbance in the functioning of their mind or brain".

A person may be assessed as lacking capacity if they have any impairment of the brain or mind, and are unable to do one or more of the following four things:

- Understand information given to them
- Retain that information long enough to be able to make the decision
- Weigh up the information available to make the decision
- Communicate their decision

4.8 **Managing Authority** - In the case of an NHS hospital, the managing authority is the NHS body responsible for the running of the hospital in which the relevant person is, or is to be, an inpatient. This policy relates to the Somerset Partnership NHS Foundation Trust.

4.9 **Relevant Person**- a person who is, or may become, deprived of their liberty in accordance with the deprivation of liberty safeguards.

4.10 **Relevant Person's representative** - The supervisory body must appoint a relevant person's representative for every person to whom they give a standard authorisation for deprivation of liberty. The representative is appointed at the

time the authorisation is given or as soon as possible and practical thereafter. The role of the relevant person's representative, once appointed, is:

- to maintain contact with the relevant person, and
- to represent and support the relevant person in all matters relating to the deprivation of liberty safeguards, including, if appropriate, triggering a review, using an organisation's complaints procedure on the person's behalf or making an application to the Court of Protection.

4.11 **Standard authorisation-** An authorisation granted by a supervisory body to a managing authority which provides authority for the managing authority to deprive the relevant person of liberty. Standard authorisations are granted following assessments by a medical assessor and a best interests assessor. They last up to 12 months. The BIA decides on the duration, and has total discretion on any timescale up to 12 months.

4.12 **State Detention-** a term from The Coroners and Justice Act 2009. The Chief coroner sated in 2015: "on the law as it now stands, the death of a person subject to a DoL should be the subject of a coroner investigation because that person was in state detention within the meaning of the Coroners and Justice Act 2009."

4.13 **Supervisory Body-** the Local Authority which covers the area within which the relevant person is 'ordinarily resident'. 'Ordinary residence' is defined in Section 39 of The Care Act 2014. In some situations the supervisory body may not be the Local Authority where the relevant person physically is at the point of requiring an authorisation. The relevant Local Authority is responsible for considering a DoLS request, arranging the required assessments and agreeing or denying a DoLS authorisation.

4.14 **Urgent authorisation-** An authorisation granted by a managing authority to itself when it unavoidably has to deprive a relevant person of their liberty in their best interests. An urgent authorisation lasts for up to 7 days- within which time the supervisory body should arrange for an assessment for a standard authorisation. Urgent authorisations may be extended for a further 7 days in exceptional circumstances. The DoLS Code of Practice says that, wherever possible, a standard authorisation should be made without an urgent authorisation needing to be used first.(see appendix C).

5. PROCESS

5.1 Applying for a DoLS Authorisation

- Decide if the current situation may amount to a deprivation of liberty. See Appendix A
- In the situation where the person to be admitted into one of our hospitals is already subject to a DoLS authorisation in a care home, then it is very likely that the Trust will need to apply for DoLS authorisation in order to effect admission. For elective cases this should be applied for in advance of the planned admission date and it is the admitting clinicians' responsibility to ensure this is completed.
- Complete form 1 (appendix C)

5.2 Situations where a DoLS authorisation cannot be used

- The person is 'within the scope' of the Mental Health Act (see appendix 1)
- The person is under 18 years of age;
- The use of the safeguards would conflict with a decision of the person's attorney or Deputy of the Court of Protection or with any requirements imposed upon them as part of a Guardianship order under The Mental Health Act.
- Outside a hospital or care home.

5.3 Completing the DoLS application forms.

5.3.1 Form 1 is used to make an urgent authorisation and to request a standard authorisation at the same time. (Appendix C)

5.3.2 Form 1 is also used when no urgent authorisation is required, but a request for a standard authorisation is- i.e. for elective admissions where it is believed a deprivation of liberty will or is likely to occur on admission.

5.3.3 Form 2 is used when an existing DoLS authorisation is nearing its expiry date and a new authorisation is needed. (Appendix D)

5.3.4 The forms can be completed electronically or by hand. If using a PDF version an electronic signature is expected. If signatories have no 'electronic signature' forms will need to be printed and signed by hand, then scanned and e-mailed to the Local Authority DoLS office (details below).

5.4 Who completes the DoLS forms?

5.4.1 It is the responsibility of the hospital where the person is (or will be) being deprived of liberty to apply for a DoLS authorisation. Trust signatories for DoLS forms are:

- Ward managers, matrons, or the person in charge of the ward at the time.

5.4.2 When an admission is being planned by community staff, and it is known that a DoLS authorisation will be required, the care coordinator (or whoever is leading the plans for admission) must discuss the need for an authorisation with the ward manager urgently. It will usually be appropriate for the care coordinator to complete the details on form 1, and then ask the relevant signatory from the list above to sign it and submit it.

5.5 What happens to the forms once completed?

5.5.1 DoLS forms need to be sent to the Local Authority DoLS office via e-mail. Contact details are:

Email: DOLS@somerset.gov.uk

5.5.2 E-mails from a Trust e-mail address to the DoLS e-mail address are secure, and confidential information may be sent without encryption (see section C3 of the Information Security Policy). Do not put the forms in the post.

5.6 **Who else needs a copy of the forms?**

- A copy of the forms should be saved in the patient's notes.
- The relevant person must be given a copy of the DoLS forms, and attempts must be made to explain their situation to them. It may not be appropriate to do this at the time of the application, however they must be given prior to discharge and staff should document that they have done so.

5.7 What happens next?

5.7.1 The Supervisory Body makes arrangements for the required assessments to be undertaken. Clinical staff should support this assessment process but do not undertake the assessments themselves. Access to the medical records will be required by the assessors.

5.7.2 The assessments will be undertaken by a best interests assessor and a mental health (or medical) assessor and will normally be within the 7-day period of the urgent authorisation.

5.7.3 An urgent authorisation lasts for only 7 days, with day 1 being the day of application. It is possible for the supervisory body to extend this 7 day period for a further 7 days when there are 'exceptional reasons' to do so. If such exceptional reasons exist, then we must:

- request an extension by completing the relevant section in Form 1 Appendix C,
- send it to the Local Authority DoLS office (details above)
- save a copy of the completed form in the patient record
- notify the relevant person in writing that the request has been made.

5.7.4 If our supervisory body has been unable to carry out a standard authorisation assessment within 7 days, this is not usually classed as an 'exceptional reason'. Details about how to proceed in this situation are given in Appendix B

5.7.5 On completion of the assessment process, the Supervisory Body will either grant or deny the DoLS authorisation. The DoLS Office will send the outcome forms to the ward and these forms must be filed in the patient record.

5.8 **When a Standard DoLS Authorisation is granted**

5.8 1 Ward manager completes the CQC notification form "Statutory notification- Notification about an application to deprive a person of their liberty" (appendix E)

5.8.2 The care plan should include ongoing review of the treatment plan and the need for a continuing DoLS order.

5.8.3 A person ('the relevant person') held under the DoLS may be kept in hospital for as long as has been authorised. A DoLS authorisation is 'permissive' rather than 'prescriptive' which means it allows for the relevant person to be deprived of liberty only when necessary. The relevant person may not need to be

deprived of liberty constantly, for example, but just at certain times or in certain circumstances within the hospital. A DoLS authorisation should not prevent less restrictive things from happening when it is in the person's best interests for less restrictive things to happen. Also, a DoLS authorisation applies only to the place where the person was when it was granted. A move to another hospital or care home would require a new authorisation to be granted should the person continue to be deprived of liberty in the new place.

5.9 **A DoLS authorisation will come to an end when**:

- The relevant person no longer needs to remain in hospital.
- Arrangements have been made for on-going care to continue in another location eg care home or other hospital (if the person will be, or is likely to be deprived of liberty in the other location another DoLS authorisation will be required. It may be possible to arrange for an authorisation to be made in advance.)
- The DoLS authorisation is judged no longer to be required. The clinical team must inform the Local Authority DoLS Office.
- The DoLS authorisation expires. If continuing treatment and care is required and this would mean that the person continues to be deprived of their liberty then an extension to the Standard Authorisation will be required. A DoLS form 2 should be completed and sent off to the Local Authority DoLS Office as above.

Or

- The person's mental capacity returns and they are able to make their own decision about continuing with treatment and care. In this circumstance the DoLS is no longer valid, even if the person decides to leave hospital or refuses to comply with treatment and care against medical advice.

5.10 **Moving between wards or hospitals**

5.10.1 In this respect the DoLS are significantly different to The Mental Health Act. The Mental Health Act has specific powers to enable transfers between hospitals, but the DoLS do not. A simple way of understanding this is to think of The Mental Health Act as applying to a patient, and a DoLS authorisation as applying to the place where the person is.

5.10.2 A DoLS Authorisation is specific to the hospital named in the authorisation. The legislation describes a managing authority as a 'hospital' and not a 'ward'. Therefore if the relevant person transfers to another ward in the same hospital any DoLS authorisation goes with them, unless the conditions of their care arrangements are so different that the DoLS authorisations or any conditions attached to it should be reviewed anyway. For example moving from one ward to another might involve a significant change in the nature of the restrictions applied.

5.10.3 If a move to another hospital is indicated, then a new DoLS authorisation would be required at the new hospital, and an advance assessment should be requested.

5.11 When a Standard DoLS Authorisation is refused

5.11.1 The ward manager, matron, or the person in charge of the ward at the time completes the CQC notification form “Statutory notification- Notification about an application to deprive a person of their liberty” (appendix E)

5.11.2 One potential outcome of the assessment by the medical assessor and the best interests assessor is that no deprivation of liberty is occurring. In that case the care and treatment should continue in the person’s best interests if the person continues to lack capacity to consent to it, or their wishes should be respected where they have the capacity to make decisions for themselves.

5.11.3 If the authorisation is refused or cannot be granted because the qualifying criteria have not been met, then the treatment and care plan should be reviewed again to see if less restrictive alternatives can be put in place.

5.11.4 Alternatively consideration could be given to whether a different treatment option or care location can be arranged which would be acceptable to the relevant person.

5.11.5 However if there are major concerns about the person’s safety should they leave hospital and fail to comply with what is deemed essential treatment and care, senior clinical and legal advice should be sought. In some cases it may be possible to apply the Mental Health Act or in others an application to the Court of Protection may be required.

5.12 Unauthorised Deprivations of Liberty

5.12.1 If staff are concerned that an unauthorised deprivation of liberty has occurred or is likely to occur within the Trust then a senior clinician should review the situation as a matter of urgency and steps taken to avoid any further, or prevent a potential future, deprivation of liberty.

5.12.2 Any unauthorised deprivation of liberty must be reported via DATIX.

5.12.3 If a member of staff has concerns that a deprivation of liberty may be occurring in non-Trust accommodation then staff should discuss the concerns with their line manager as soon as possible and the also the Managing Authority of the care home or hospital. The Supervisory Body should be notified if the Managing Authority’s response is not deemed sufficient.

5.12.4 There may be occasions when no easy agreement can be reached about which legal framework is the most appropriate to apply. See Appendix 2 for guidance about resolving such disputes.

5.13 Death of a person subject to a DoLS authorisation

5.13.1 A person subject to a DoLS authorisation is deemed to be ‘in state detention’, so the death of any such person should be reported to the coroner, and the coroner should commence an investigation.

5.13.2 Guidance on the need for post-mortem and the ‘state detention’ status will come from the Coroner’s Office. See ‘explanation of terms used’ for a definition of ‘state detention’

5.14 The Court of Protection

5.14.1 The relevant person's representative has the right to lodge an appeal with the Court of Protection asking the Court to review the lawfulness of the deprivation of liberty.

5.14.2 In the event of the Court, or the solicitor representing the relevant person, requesting (or ordering) access to various parts of the patient record, any such requests should be forwarded **immediately** to the Information Governance Manager. These usually have a seven day turnaround

6. TRAINING REQUIREMENTS

6.1 All clinical staff working directly with patients should have a basic understanding of DoLS. An introduction will be included during induction.

6.2 All designated Trust signatories for DoLS authorisations must undertake additional training. A variety of training is available via classroom and e-learning.

7. EQUALITY IMPACT ASSESSMENT

7.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

8. MONITORING COMPLIANCE AND EFFECTIVENESS

8.1 Monitoring of compliance with this guidance will be undertaken via the Mental Health legislation Group and reported to the Regulation Governance Group.

Key Performance Indicators

Indicator	Measure	Frequency
75% of all clinical staff based on in-patient areas will have completed training in DoLS	Report from Learning & Development Department	Annually
Number of DoLS authorisations granted	Report from performance management team	Quarterly at Mental Health Legislation Group
Number of incidents of unauthorised deprivations of liberty reported	Report from DATIX	Quarterly at Mental Health Legislation Group

9. COUNTER FRAUD

9.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

10. RELEVANT CARE QUALITY COMMISSION (CQC) –

10.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3), the fundamental standards** which inform this procedural document, are set out in the following regulations:

Regulation 9: Person-centred care
Regulation 10: Dignity and respect
Regulation 11: Need for consent
Regulation 12: Safe care and treatment
Regulation 13: Safeguarding service users from abuse and improper treatment
Regulation 15: Premises and equipment
Regulation 16: Receiving and acting on complaints
Regulation 17: Good governance
Regulation 18: Staffing
Regulation 19: Fit and proper persons employed
Regulation 20: Duty of candour
Regulation 20A: Requirement as to display of performance assessments.

10.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 16: Notification of death of service user
Regulation 18: Notification of other incidents

10.3 Detailed guidance on meeting the requirements can be found at http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20pro

viders%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf

11. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

11.1 References

CQC, Monitoring the use of the MCA Deprivation of liberty safeguards in 2013/14, 2015.

Department for Constitutional affairs, Mental Capacity Act 2005 Code of Practice, 2007

Department of Health, Deprivation of Liberty Safeguards: A guide for hospitals and care homes. 2009

Department of Health, Mental Health Act 1983 Code of Practice, 2015

Mental Capacity Act 2005 – found at:
http://www.opsi.gov.uk/acts/acts2005/ukpga_20050009_en_1

Mental Health Act 1983 as amended in 2007- found at:
http://www.legislation.gov.uk/ukpga/2007/12/contents

Ministry of Justice, Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice to supplement the main MCA 2005 Code of Practice, 2008

Ruck Keene A., Tying ourselves into (Gordian) Knots, 2012

Supreme Court, P (by his litigation friend the Official Solicitor) (Appellant) v Cheshire West and Chester Council and another (Respondents) P and Q (by their litigation friend, the Official Solicitor) (Appellants) v Surrey County Council (Respondent), 2014.
The Law Society, Identifying a deprivation of liberty: a practical guide, 2015

11.2 Cross reference to other procedural documents

Consent and Capacity to Consent to Treatment Policy

Information Security Policy

Learning Development and Mandatory Training Policy

Record Keeping and Records Management Policy

Risk Management Policy and Procedure

Training Prospectus

Untoward Event Reporting Policy and procedure

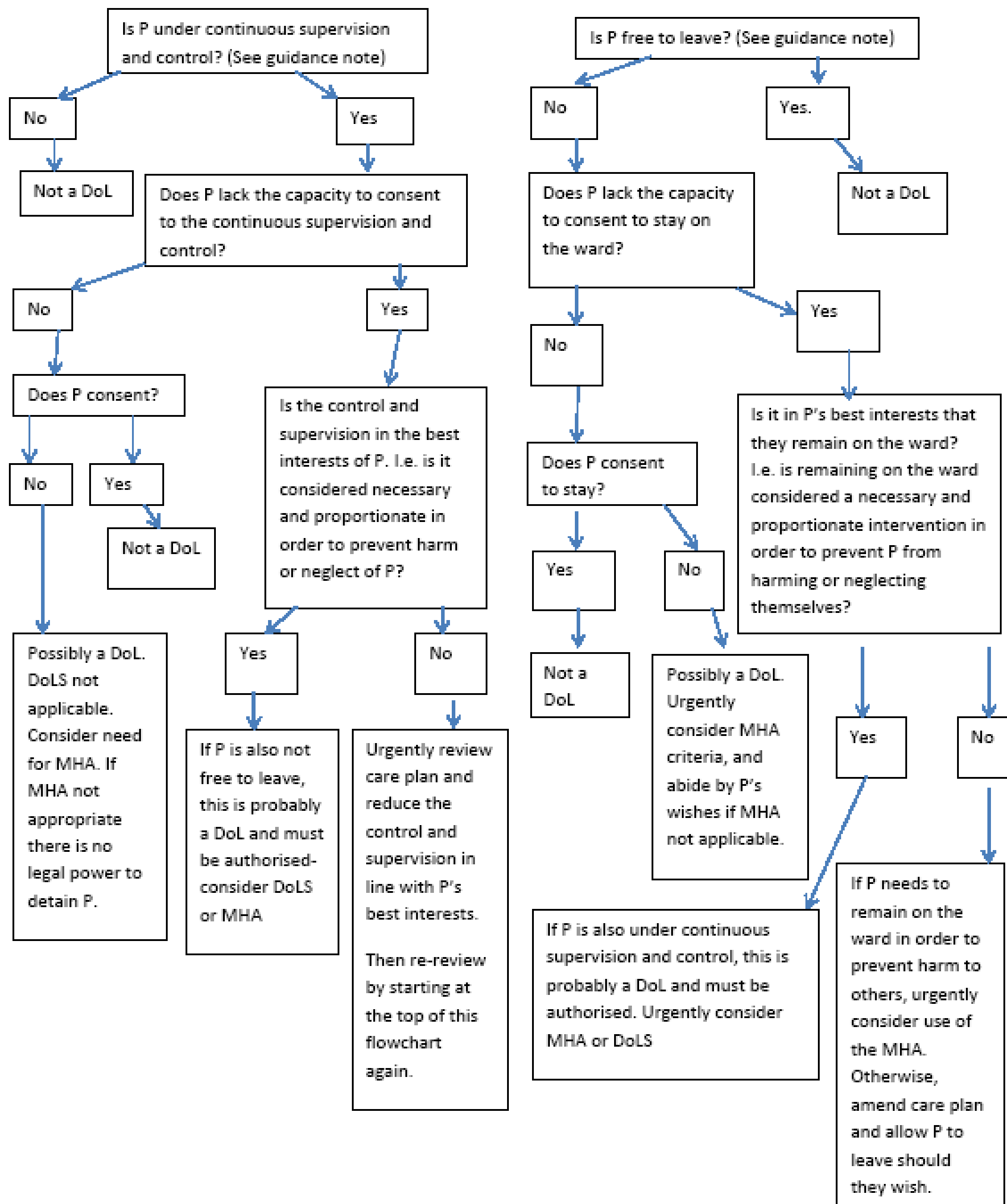
All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

12. APPENDICES

12.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such. This should include any relevant Clinical Audit Standards.

Appendix A	Identifying a potential deprivation of liberty in a hospital (for an adult).
Appendix B	How to respond to concerns about deprivations of liberty in our hospitals.
Appendix C	DoLS Form 1- urgent authorisation/request for standard authorisation.
Appendix D	DoLS Form 2- Request for renewal of a standard authorisation
Appendix E	CQC Statutory notification

APPENDIX A



Guidance note to accompany the Flowchart
"*Identifying a potential deprivation of liberty in a hospital*"

1. The Supreme Court in March 2014 provided a new definition of 'deprivation of liberty'. The new definition must now be applied- the use of any other definition or the exercise of any personal or professional discretion is highly likely to be unlawful. There are two parts to the new definition, and both must exist together for a situation to be a deprivation of liberty. If a person is *subject to continuous supervision and control* AND they are *not free to leave*, then they are deprived of liberty and, if the person is unable or unwilling to consent to their situation, this should either be authorised (by the MHA, DoLS or via an order from the Court of Protection) or the person's care should be changed immediately to either reduce the level of supervision and control or to allow them to leave should they wish.

2. It is important to understand that if a person lacks capacity to consent to the supervision/control and inability to leave they may still be deprived of liberty even if they are 'compliant' and making no attempt to leave whatsoever. The Supreme Court said 'A gilded cage is still a cage'

Explanations

Best Interests

3. Only of relevance when a patient lacks the capacity to consent to a treatment. Patients with capacity are responsible for their own 'best interests' and are able to make 'unwise decisions' with which professionals may not agree. When it is established that a patient lacks the capacity to make a decision, and we are making a decision for them, we must act in their best interests. The Code of Practice to the Mental Capacity Act (MCA) says:

4 "Section 4 of the Act explains how to work out the best interests of a person who lacks capacity to make a decision at the time it needs to be made. This section sets out a checklist of common factors that must always be considered by anyone who needs to decide what is in the best interests of a person who lacks capacity in any particular situation. This checklist is only the starting point: in many cases, extra factors will need to be considered.
When working out what is in the best interests of the person who lacks capacity to make a decision or act for themselves, decision-makers must take into account all relevant factors that it would be reasonable to consider, not just those that they think are important. They must not act or make a decision based on what they would want to do if they were the person who lacked capacity." (Paras 5.6 and 5.7)

5 **Consent**
The voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent. Patients who lack the capacity to consent cannot consent- compliant acceptance of a treatment or intervention is NOT consent.

Continuous supervision and control

6 Sadly not defined in law or in case law other than various different definitions from the European Court of Human Rights. The Supreme Court in March 2014 said "I believe that we should err on the side of caution in deciding what

constitutes a deprivation of liberty." Therefore in situations where you are unsure whether or not you are providing 'continuous supervision and control', assume that you are and, if the person is also not free to leave, either issue an urgent DoLS authorisation, or request a MHA assessment.

7 It may help to remember the European Court of Human Rights decision in Bournewood (2004)- the Court observed that the hospital's health care professionals assumed full control of the liberty and treatment of a vulnerable incapacitated individual solely on the basis of their own clinical assessments completed as and when they considered fit. While the Court did not question the good faith of those professionals or that they acted in what they considered to be the applicant's best interests, the very purpose of procedural safeguards was to protect individuals against any misjudgement or professional lapse.

8 **DoL**- Deprivation of liberty. Not to be confused with;

9 **DoLS-** Deprivation of Liberty Safeguards- a legal framework within the Mental Capacity Act which authorises the deprivation of liberty of a person in a hospital or care home when the person lacks the capacity to consent to stay and to be subject to continuous supervision and control.

10 **Free to leave**
Again not defined in law or case law other than varying interpretations by the European Court. Importantly whether or not P is trying to leave is irrelevant. Also irrelevant are the risks which the person would pose to themselves if they left. Ask yourself 'If this person tried to leave the ward, would we stop them?" If the answer is yes, AND the person is subject to continuous supervision and control (see above), then a deprivation of liberty is probably occurring and must be authorised.

11 **Lacking capacity to consent**
When it comes to assessing a person's capacity to consent to admission to hospital 'it is not necessary for the person to comprehend every detail of the issue' (Macur J in LBL v RYJ [2010] EWHC 2664), but rather that they are able to comprehend and weigh the salient details relevant to the decision.

12, It is suggested that, in order to consent to admission, a person must be able to understand and weigh up the following points (where relevant):

(1) that the person is being admitted to hospital to receive care and treatment for a mental disorder;
(2) the nature of the care and treatment – i.e. that it may include varying levels of supervision (including supervision in the community), use of physical restraint and the prescription and administration of medication to treat the mental disorder
(3) that staff at the hospital may be entitled to carry out property and personal searches;
(4) that the person may need to seek permission of the nursing staff to leave the hospital, and, until the staff at the hospital decide otherwise, will only be allowed to leave under supervision;
(5) that if the person left the hospital without permission and without supervision, the staff would take steps to find and return them, including contacting the police.

(6) that if they decide to leave that they might nonetheless be subject to an application made under the statutory holding power under section 5 of the MHA so that they might not in fact be able to leave when they wanted to if those treating them thought they were too mentally unwell to be allowed to leave.

13 This list is based on the findings in A PCT v LDV (2013).

14 **MCA**- The Mental Capacity Act 2005

15 **MHA**- The Mental Health Act 1983 as amended by the Mental Health Act 2007.

16 **P.-** For the purposes of this document ‘P’ stands for the person who may or may not be deprived of liberty. In some places in the flowchart ‘P’ may have capacity to make their own decisions. This is slightly different to the definition of ‘P’ used by The Court of Protection where ‘P’ is: “any person (other than a protected party) who lacks or, so far as consistent with the context, is alleged to lack capacity to make a decision or decisions in relation to any matter that is the subject of an application to the court.”(Court of protection Fees Order 2007, paragraph 2).

Once a Potential Deprivation of Liberty has been Identified-
Which Legal Framework Should be Considered?

Status of Patient	Legal framework options
Consenting to admission and treatment The patient has the capacity to understand the implications of hospital admission and treatment and is validly consenting. 'Valid' means that they are not being placed under undue pressure to agree to the admission. Undue pressure might include the offer of admission being: "I'd prefer you to come in informally, but if you won't we will use the Mental Health Act." Consent given in such circumstances is probably not valid. The 2015 MHA Code of Practice states: *"The threat of detention must not be used to coerce a patient to consent to admission to hospital or to treatment (and is likely to invalidate any apparent consent)." (para 14.17).*	Possibly no legal process required. Informal admission is usually appropriate. S131 of the MHA: "***Informal admission of patients*** *(1) Nothing in this Act shall be construed as preventing a patient who requires treatment for mental disorder from being admitted to any hospital or registered establishment in pursuance of arrangements made in that behalf and without any application, order or direction rendering him liable to be detained under this Act, or from remaining in any hospital or registered establishment in pursuance of such arrangements after he has ceased to be so liable to be detained."* However, The MHA Code of Practice (2015) says: "14.15. *This should not be regarded as an absolute rule, especially if the reason for considering admission is that the patient presents a clear risk to themselves or others because of their mental disorder.* *14.16 Compulsory admission should, in particular, be considered where a patient's current mental state, together with reliable evidence of past experience, indicates a strong likelihood that they will have a change of mind about informal admission, either before or after they are admitted, with a resulting risk to their health or safety or to the safety of other people."*
Status of Patient	**Legal framework options**
Not consenting to admission. The patient has the capacity to consent to admission, and is refusing to be admitted or (if already an inpatient) to remain in hospital.	If the patient needs to be in hospital for treatment of mental disorder, then the best option is to carry out a Mental Health Act assessment. Section 5(2) or 5(4) may be applicable if the patient is already an inpatient. The Mental Capacity Act does not apply when a person has the capacity to make their own decisions. DoLS cannot be applied to a person with capacity. Unless the patient is made subject to the

	Mental Health Act (or unless temporarily restrained using Common Law powers) there is no power other than persuasion to take them to hospital or to make them stay in hospital or to make them accept treatment. Common Law is something which may be relied upon in an unpredicted emergency situation when a failure to intervene would result in potential harm to the patient or others. Common law is not something to incorporate into a care plan- if there is a known risk that compulsory powers will be needed, then consideration should be given to carrying out a MHA assessment.
Status of Patient	**Legal framework options**
Lacks capacity to consent to admission, and appears to be objecting to admission. If a patient lacks the capacity to consent to admission it is quite difficult to know whether or not they are objecting. How can someone object to something they do not understand? However, **'o**bjecting' is described in the MHA Code of Practice: "*whether a patient is objecting has to be considered in the round, taking into account all the circumstances, so far as they are reasonably ascertainable. The decision to be made is whether the patient objects to treatment – the reasonableness of that objection is not the issue. In many cases the patient will be perfectly able to state their objection. In other cases doctors and AMHPs will need to consider the patient's behaviour, wishes, feelings, views, beliefs and values, both present and past, so far as they can be ascertained. If there is reason to think that a patient would object, if able to do so, then the patient should be taken to be objecting.*" (Para 14.20.) The following principle from the Supreme Court's judgement should also be borne in mind: "*Because of the extreme vulnerability of people like P, MIG and MEG, I believe that we should err on the side of caution in deciding what constitutes a deprivation of liberty in their case. Nor should we regard the need for (the imposition of a legal framework) as in any*	The concept of objection is vital here. If the patient is objecting to their admission or treatment for mental disorder, then DoLS cannot apply. The patient is considered to be ineligible for a DoLS authorisation. If the admission to hospital is in order primarily to treat a mental disorder, then an assessment under The Mental Health Act is required. To work out whether or not the admission is primarily to treat a mental disorder, when physical treatment is also required, ask yourself: "If no physical treatment were required, would we be admitting this person to treat their mental disorder?" If the answer is yes, then a Mental Health Act assessment is required. If the answer is no, then the Mental Health Act cannot apply, and a DoLS authorisation should be sought. In some cases neither the MHA nor DoLS will be applicable. For example: • The result of a MHA assessment may be that the doctors decide that the patient is potentially eligible to be detained, but they (the doctors) wish to exercise their discretion and not sign medical recommendations. Or, • The Nearest Relative may object to the imposition of a S3. Or,

way stigmatising of them or of their carers. Rather, (it is) a recognition of their equal dignity and status as human beings like the rest of us."(para 57)	• A Tribunal has discharged the patient and nothing significant has changed since that discharge. Or, • The AMHP may decide to exercise discretion and not sign an application despite having valid medical recommendations. In these scenarios it may be possible to ask the Court of Protection to invoke its inherent jurisdiction and grant an Order authorising a deprivation of liberty.
Status of Patient	**Legal framework options**
Lacks capacity to consent admission, and is not objecting to admission. (Sometimes called 'the compliant incapacitated patient.') The patient lacks the capacity to consent to be in hospital, does not appear to be objecting, but is under constant supervision and control and is not free to leave (i.e. would be stopped from leaving if they tried).	In this situation it may be possible to apply The Mental Health Act, a DoLS authorisation or possibly even an Order from The Court of Protection. It may sometimes be possible to apply any of these and be acting lawfully (i.e. sometimes any of the available legal frameworks may be 'correct'- and none would clearly be 'wrong') On deciding between the MHA and the DoLS the MHA Code of Practice (2015) says: *"13.59 Both regimes provide appropriate procedural safeguards to ensure the rights of the person concerned are protected during their detention. Decision-makers should not therefore proceed on the basis that one regime generally provides greater safeguards than the other. However, the nature of the safeguards provided under the two regimes are different and decision-makers will wish to exercise their professional judgement in determining which safeguards are more likely to best protect the interests of the patient in the particular circumstances of each individual case."* To help the decision-making process here is a comparison of the safeguards provided by The Mental Health Act as opposed to those of the DoLS scheme: **MHA safeguards**: • Prescribed time limits to detention. • Automatic access (without the need for lodging an appeal) to regular court reviews of detention via the Tribunal service. • Right to appeal to a Tribunal or to

	the hospital managers for discharge. • Nearest Relative power of discharge and of blocking the imposition of a Section 3. • Statutory right to an Independent Mental Health Advocate. • Consent to treatment rules (including the statutory need to involve a Second Opinion Appointed Doctor in certain situations) • MHA Commissioners appointed by CQC have the right to carry out unannounced inspections, to access patients' notes and interview patients in private. • Appropriate treatment must be available for people detained for treatment. **DoLS safeguards:** • An authorisation may last no longer than 12 months before a fresh assessment is carried out. • A person subject to an authorisation will have a 'representative' appointed. • The representative can appeal to the Court of Protection to review the authorisation. • In some situations an Independent Mental Capacity Advocate must become involved. Despite the MHA Code stating that the two regimes offer equal safeguards, it is widely accepted that the safeguards provided by the Mental Health Act are more robust than those within the Deprivation of Liberty Safeguards. Some people have suggested that the lack of an automatic access to a Court review means that the DoLS scheme is incompatible with The Human Rights Act. It should also be noted that the House of Lords concluded in March 2014:"The *(DoLS) provisions are poorly drafted, overly complex and bear no relationship to the language and ethos of the Mental Capacity Act. (…)The only appropriate recommendation in the face of such criticism is to start again. We therefore*

	recommend a comprehensive review of the Deprivation of Liberty Safeguards with a view to replacing them with provisions that are compatible in style and ethos to the rest of the Mental Capacity Act." Decision-makers should also remember that the DoLS scheme provides no explicit powers to: • Convey a person to hospital • Transfer a person between hospitals • Grant leave • Return a person if they leave the premises. The Mental Health Act does explicitly provide all these powers.

APPENDIX B

Somerset Partnership NHS
NHS Foundation Trust

How to respond to concerns about deprivations of liberty in our hospitals. Nick Woodhead, MHA Coordination Lead, 28 January 2015.

1 In March 2014 the Supreme Court provided a broad and fairly clear definition of what is a deprivation of liberty (the 'Cheshire West 'case). Overnight thousands of people around the country suddenly fell within the definition, with no quick or easy legal procedure available to authorise their situation. The CQC and the DoH expect all organisations to be working towards a situation where no person is unlawfully deprived of their liberty, but have both acknowledged that resource limitations mean that it cannot be achieved immediately. They expect organisations to be working towards the ideal.

2 Now that it is relatively straightforward to identify a deprivation of liberty, the challenges we face are how to work out which legal framework we should apply, and how to prioritise any application.

3 We (our hospitals) are able to authorise ourselves with an urgent DoLS authorisation, but that only lasts 7 days and requires that our supervisory body (the Local Authority) organises a full assessment (by a best interests assessor and a medical assessor) before the 7 days are up. The Local Authority is currently struggling to meet demand, and sometimes urgent authorisations expire before a full assessment has happened.

4 The Court of Protection has developed 'fast-track' system to authorise deprivations of liberty, but it is not certain whether this will apply to situations where an urgent authorisation has expired. At the moment Somerset County Council's view is (we are the 'managing authority'):

5 "*The managing authority will be unlawfully depriving the person of their liberty from the point the urgent authorisation expires but will have done all it can to seek authorisation. There are probably several thousand individuals in this situation nationally*." (e-mail from the DoLS lead, 05.11.2014)

6 The clear inference here from our supervisory body is that we will have done everything we can by issuing ourselves with an urgent DoLS authorisation, and it is not our 'fault' that we have to knowingly deprive a person of their liberty with no legal authority to do so when the urgent authorisation runs out. Whilst there may be other things we could potentially do, none are practical solutions. The Local Authority is promising to prioritise standard authorisation assessment requests from acute and community hospitals, and have asked to be informed of any delays (via their DoLS e-mail address).

7 If an urgent authorisation expires before a full assessment has happened, please complete a DATIX report, and continue to treat the patient in their best

interests as per the Mental Capacity Act, even if doing so means the person is deprived of their liberty.

8 Within our hospitals (all hospitals, not just the mental health wards) there may be situations where the Mental Health Act is the legal framework which will have to be applied. The decision about whether or not the Mental Health Act should be used is an enormously complicated one, and is explained in the flowchart and guidance previously issued. Concerns about potential future cost implications (i.e. section 117) have no place in considering whether or not the MHA should apply.

9 It is likely that professionals will find themselves disagreeing about which legal framework is appropriate. When there is doubt the best solution is to contact the relevant approved mental health professional (AMHP) on duty and request a Mental Health Act assessment. A Mental Health Act assessment is not the same as 'sectioning' someone. It is an assessment process with many possible outcomes, only one of which is the imposition of a section of the Mental Health Act. Part of the assessment by the doctors and the AMHP will be whether the Mental Health Act is required, or whether a DoLS authorisation should be sought.

10 In situations where a consensus decision cannot be reached, and any member of staff remains concerned that something unlawful may be happening, they should raise their concerns with their manager. Any member of staff may also contact the MHA Coordination Lead (Nick Woodhead) to discuss the situation.

11 We are in genuinely confusing times at the moment, and it is inevitable that situations will arise where a person may be deprived of their liberty potentially unlawfully due to delays in the system or to disagreements between staff about what should be done. Whilst we remain in confusing times the key points are:

- Apply the flowchart “Identifying a potential deprivation of liberty in a hospital (for an adult)” to every new admission.
- Issue an urgent DoLS authorisation and request a standard authorisation when that is indicated
- Contact the Local Authority DoLS team urgently prior to an urgent authorisation expiring, and complete a DATIX form if no standard authorisation assessment happens.
- Request a MHA assessment when that seems appropriate.
- Be open and honest with each other and discuss differences of opinion in a respectful manner.
- Follow the processes above, and discuss unresolved situations with colleagues as part of the care planning procedure.
- Keep accurate records of discussions.
- Continue to treat our patients, their families and carers with the respect and dignity which has become the hallmark of services in Somerset.

adass — directors of adult social services

Department of Health

APPENDIX C

Case ID Number:				

DEPRIVATION OF LIBERTY SAFEGUARDS FORM 1

REQUEST FOR STANDARD AUTHORISATION AND URGENT AUTHORISATION

Request a **Standard Authorisation** only (***you DO NOT need to complete pages 6 or 7***)	☐
Grant an **Urgent Authorisation** (***please ALSO complete pages 6 and 7***)	☐

Full name of person being deprived of liberty		Sex :
Date of Birth *(or estimated age if unknown)*		Est. Age :
Relevant Medical History		

Sensory Loss		Communication Requirements	

Name and address of the care home or hospital requesting this authorisation		
Telephone Number		
Person to contact at the care home or hospital, (including ward details if appropriate)	Name	
	Telephone	
	Email	
	Ward (if appropriate)	
Present address of the person, (if different to above)		
Telephone Number		
Name of the Supervisory Body where this form is being sent		

How the care is funded	Local Authority *please specify*	☐	NHS	☐
	Local Authority and NHS (jointly funded)	☐	Self funded by person	☐
	Funded through insurance or other	☐		

REQUEST FOR STANDARD AUTHORISATION

THE DATE FROM WHICH THE STANDARD AUTHORISATION IS REQUIRED: *If standard only – within 21 days* *If an urgent authorisation is also attached – within 7 or 14 days*	

PURPOSE OF THE STANDARD AUTHORISATION

- *Please describe the care and / or treatment this person is receiving day-to-day and attach a relevant care plan.*
- *Please give as much detail as possible about the type of care the person needs, including personal care, mobility, medication, support with behavioural issues, types of choice the person has and any medical treatment they receive.*

- *Explain why the person is not free to leave and why they are under continuous or complete supervision and control.*
- *Describe the restrictions you have put in place which are necessary to ensure the person receives care and treatment. (It will be helpful if you can describe why less restrictive options are not possible including risks of harm to the person.)*
- *Indicate the frequency of the restrictions you have put in place.*

INFORMATION ABOUT INTERESTED PERSONS AND OTHERS TO CONSULT		
Family member or friend	Name	
	Address	
	Telephone	
Anyone named by the person as someone to be consulted about their welfare	Name	
	Address	
	Telephone	
Anyone engaged in caring for the person or interested in their welfare	Name	
	Address	
	Telephone	
Any donee of a Lasting Power of Attorney for Health and Welfare granted by the person	Name	
	Address	
	Telephone	
Any Deputy for Health and Welfare appointed for the person by the Court of Protection	Name	
	Address	
	Telephone	
Any IMCA instructed in accordance with sections 37 to 39D of the Mental Capacity Act 2005	Name	
	Address	
	Telephone	

WHETHER IT IS NECESSARY FOR AN INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA) TO BE INSTRUCTED *Place a cross in EITHER box below*	
Apart from professionals and other people who are paid to provide care or treatment, this person has no one whom it is appropriate to consult about what is in their best interests	☐
There is someone whom it is appropriate to consult about what is in the person's best interests who is neither a professional nor is being paid to provide care or treatment	☐

WHETHER THERE IS A VALID AND APPLICABLE ADVANCE DECISION *Place a cross in one box below*	
The person has made an Advance Decision that may be valid and applicable to some or all of the treatment	☐
The Managing Authority is not aware that the person has made an Advance Decision that may be valid and applicable to some or all of the treatment	☐
The proposed deprivation of liberty **is not** for the purpose of giving treatment	☐

THE PERSON IS SUBJECT TO SOME ELEMENT OF THE MENTAL HEALTH ACT (1983)				
Yes	☐	No	☐	*If **Yes** please describe further*

OTHER RELEVANT INFORMATION
Names and contact numbers of regular visitors not detailed elsewhere on this form:
Any other relevant information including safeguarding issues:

PLEASE NOW SIGN AND DATE THIS FORM BELOW			
Signature		Print Name	
Position			
Date		Time	
I HAVE INFORMED ANY INTERESTED PERSONS OF THE REQUEST FOR A DoLS AUTHORISATION *(Please sign to confirm)*			

RACIAL, ETHNIC OR NATIONAL ORIGIN *Place a cross in one box only*			
White	☐	Mixed / Multiple Ethnic groups	☐
Asian / Asian British	☐	Black / Black British	☐
Not Stated	☐	Undeclared / Not Known	☐
Other Ethnic Origin *(please state)*			

THE PERSON'S SEXUAL ORIENTATION *Place a cross in one box only*			
Heterosexual	☐	Homosexual	☐
Bisexual	☐	Undeclared	☐
Not Known	☐		

DISABILITY THAT IS CAUSING THEIR CURRENT INCAPACITY *Place a cross in one box only*	
Physical Disability: Hearing Impairment	☐
Physical Disability: Visual Impairment	☐
Physical Disability: Dual Sensory Loss	☐
Physical Disability: Other	☐
Mental Health needs: Dementia	☐
Mental Health needs: Other	☐
Learning Disability	☐
Other Disability (none of the above)	☐
No Disability	☐

ONLY COMPLETE THIS SECTION IF YOU NEED TO GRANT AN URGENT AUTHORISATION BECAUSE IT APPEARS TO YOU THAT THE DEPRIVATION OF LIBERTY IS ALREADY OCCURING AND ALL THE FOLLOWING CONDITIONS ARE MET	
URGENT AUTHORISATION ***Place a cross in EACH box to confirm that the person appears to meet the particular condition***	
The person is aged 18 or over	☐
The person is suffering from a mental disorder	☐
The person is being accommodated here for the purpose of being given care or treatment. ***Please describe further on page 2***	☐
The person lacks capacity to make their own decision about whether to be accommodated here for care or treatment	☐
The person has not, as far as the Managing Authority is aware, made a valid advance decision that prevents them from being given any proposed treatment	☐
Accommodating the person here, and giving them the proposed care or treatment, does not, as far as the Managing Authority is aware, conflict with a valid decision made by a donee of a Lasting Power of Attorney or Deputy for Health and Welfare appointed by the Court of Protection under the Mental Capacity Act 2005	☐
It is in the person's best interests to be accommodated here to receive care or treatment, even though they will be deprived of their liberty	☐
Depriving the person of liberty is necessary to prevent harm to them, and a proportionate response to the harm they are likely to suffer otherwise	☐
The person concerned is not, as far as the managing authority is aware, subject to an application or order under the Mental Health Act 1983 or, if they are, that order or application does not prevent an urgent authorisation being given	☐
The need for the person to be deprived of their liberty here is so urgent that it is appropriate for that deprivation to begin immediately	☐

AN URGENT AUTHORISATION IS NOW GRANTED

This urgent authorisation comes into force immediately.

It is to be in force for a period of: [ ] days

The maximum period allowed is seven days.

This urgent authorisation will expire at the end of the day on: [ ]

Signed		Print name	
Position			
Date		Time	

REQUEST FOR AN EXTENSION TO THE URGENT AUTHORISATION

If Supervisory Body is unable to complete the process to authorise the deprivation of liberty

A standard authorisation has been requested for this person and an urgent authorisation is in force.

The Managing Authority now requests that the duration of this urgent authorisation is extended for a further period of [ ] DAYS (***up to a maximum of 7 days***)

It is essential for the existing deprivation of liberty to continue until the request for a standard authorisation is completed because the person needs to continue to be deprived and exceptional reasons are as follows (*please record your reasons):*

Please now sign, date and send to the SUPERVISORY BODY for authorisation

Signature		Date	

RECORD THAT THE DURATION OF THIS URGENT AUTHORISATION HAS BEEN EXTENDED

This part of the form must be completed by the **SUPERVISORY BODY** if the duration of the urgent authorisation is extended. **The Managing Authority does not complete this part of the form.**

The duration of this urgent authorisation has been extended by the Supervisory Body.

It is now in force for a **further** [ ] days

Important note: The period specified must not exceed seven days.

This urgent authorisation will now expire at the end of the day on: [ ]

SIGNED (on behalf of the Supervisory Body)	Signature			
	Print Name			
	Position			
	Date		Time	

directors of adass adult social services

Department of Health

Case ID Number:			
DEPRIVATION OF LIBERTY SAFEGUARDS FORM 2 **REQUEST FOR A FURTHER STANDARD AUTHORISATION**			
Full name of person being deprived of their liberty		Sex :	
Date of Birth *(or estimated age if unknown)*		Est. Age :	
Name and Address of Managing Authority (care home or hospital) requesting this authorisation			
Person to contact at the care home or hospital, (include ward details if appropriate)	Name		
	Telephone		
	Email		
	Ward (*if appropriate)*		

THE PURPOSE OF THE AUTHORISATION is to enable the following care and / or treatment to be given:

Describe the care / treatment the person is receiving on a day-to-day basis. This will include details of personal care, support, supervision, help with mobility and medication. Types and duration of restraint used if any and descriptions of all care plans, behaviour charts or other indications of the level of the person's care needs.

THE DATE FROM WHICH THE STANDARD AUTHORISATION IS SOUGHT:

A further standard authorisation is required to start on this date because the existing standard authorisation expires at this time.	

January 2015 — Deprivation of Liberty Safeguards Form 2 Request for Further Authorisation — Page 1 of 2

OTHER RELEVANT INFORMATION			
Please include details of any changes in the care plan, medical information, person's behaviour or visitors since the current standard authorisation was given.			
Signature		Print name	
Position			
Date		Time	
I HAVE INFORMED ANY INTERESTED PERSONS OF THE REQUEST FOR A DoLS AUTHORISATION, *(Please sign to confirm)*			

adass — directors of adult social services

Department of Health

Case ID Number			
DEPRIVATION OF LIBERTY SAFEGUARDS FORM 12 **NOTIFICATION OF DEATH WHILST DEPRIVED OF LIBERTY**			
Full name of person who was deprived of their liberty			
Date of Birth (*or estimated age if unknown)*		Est. Age	
Date of Death			
Location of person at time of death			
Name and address of the care home or hospital where the person was being deprived of their liberty			
Name and contact details of family member / RPR			
Name of the Supervisory Body			
Person to contact at Supervisory Body	Name		
	Telephone		
	Email		
Contact details of the GP	Name		
	Address		
	Telephone		
SUBMITTING THIS NOTIFICATION In accordance with Section 1(2) of the Coroners & Justice Act 2009, before the doctor has signed the Death Certificate, **the Managing Authority must send a copy of this notice to the local Coroner's office.**			
As soon as practicable the Managing Authority must also give a copy of this notice to the following: 1. The Supervisory Body for the hospital or care home 2. Any IMCA instructed for the person 3. Every person named by the Best Interests Assessor in their report as an interested person whom they have consulted in carrying out their assessment			
Signed *(on behalf of the Managing Authority)*	Name		
	Print Name		
	Position		
	Date		

adass
directors of adult social services

Department of Health

Case ID Number:

DEPRIVATION OF LIBERTY SAFEGUARDS FORM 9

STANDARD AUTHORISATION CEASED

Full name of the person being deprived of liberty	
Name and address of the care home or hospital where the person is being deprived of liberty	

A STANDARD AUTHORISATION GRANTED ON [ ]

UNTIL [ ]

has **ceased** to be in force because:

Please tick the box that applies

It has expired.	☐
It has been reviewed and the person no longer meets the requirements for being deprived of their liberty.	☐
The person has moved and a new Standard Authorisation has been granted which replaces the existing one.	☐
The person has died.	☐
The person ceased to meet the eligibility requirement at least 28 days ago.	☐
The Court of Protection has made an order that the Standard Authorisation is invalid or shall no longer have effect.	☐
It has ceased to be in force for some other reason which is:	☐

Signed	
Print Name	
Position	
Dated	

adass — directors of adult social services

Department of Health

Case ID Number:			
DEPRIVATION OF LIBERTY SAFEGUARDS FORM 10 **REVIEW**			
Full name of person being deprived of liberty			
Date of Birth *(or estimated age if unknown)*		Est. Age	
Name and address of care home or hospital where the person is deprived of liberty			
Name and address of organisation or person requesting the review			
Contact details of organisation or person requesting the review	Name		
	Telephone		
	Email		
Name of the Supervisory Body where this form is being sent			

A REVIEW OF THE CURRENT AUTHORISATION IS REQUESTED ON THE FOLLOWING GROUNDS *(place a cross in all boxes that apply)*	
The person may no longer be eligible	☐
The conditions attached to the authorisation need to be varied because there has been a change in the person's circumstances.	☐
Please give details:	

REVIEW TO CEASE A DOLS AUTHORISATION	
The Managing Authority requests a review, as a result of which the DoLS Authorisation will no longer be required. This is on the grounds that the person no longer meets the best interest's requirement.	
The person has left / is due to leave the care home on	
The person is due to be / has been discharged from hospital on	
The person's new address is	
This follows a best interest decision (attached) made on	
It is no longer in their best interest to be accommodated in this care home or hospital because:	

Signed *(on behalf of the Managing Authority)*	Signature	
	Print Name	
	Position	
	Date	

SUPERVISORY BODY'S DECISION with regard to whether ANY QUALIFYING REQUIREMENTS ARE REVIEWABLE			
The Supervisory Body has decided to refuse the request for a review for the following reasons:			
This review is therefore complete and the existing standard authorisation will continue to be in force until:			
The Supervisory Body has decided that at least one of the qualifying requirements is reviewable, as a result of which the following review assessments were carried out:			
REQUIREMENT	**MET**	**NOT MET**	**CHANGE OF REASON**
Age requirement	☐	☐	
No Refusals requirement	☐	☐	
Eligibility requirement	☐	☐	
Mental Health	☐	☐	
Mental Capacity	☐	☐	
Best Interests requirement	☐	☐	

OUTCOME OF REVIEW (select one option below)	
At least one of the requirements were not met and the standard authorisation will therefore cease with effect from:	
Based on the assessments that were carried out, the reasons given in the standard authorisation as to why the person meets the requirements have been varied as described above.	
All the review assessments carried out concluded that the person continues to meet the requirements to which they relate. The standard authorisation continues to be in force until: subject to any variation in conditions shown below:	
1	
2	
3	
4	
5	
6	

REVIEW OF CONDITIONS		
There has not been any **significant** change in the person's circumstances and any changes there have been do not result in the need to vary the conditions. Therefore the existing conditions remain in force.		☐
The Supervisory Body has decided to vary the conditions either because of a significant change or because some change has occurred which makes this appropriate. The new conditions are described below.		☐
1		
2		
3		
4		
5		
6		

Signed *(on behalf of the Supervisory Body)*	Signature	
	Print Name	
	Position	
	Date	

Care Quality Commission

APPENDIX E

Statutory notification

Regulation 18(2), Care Quality Commission (Registration) Regulations 2009

Notification about an application to deprive a person of their liberty

Provider's notification reference: [ ]

Statistical notification about an application to deprive a person of their liberty
Care Quality Commission (Registration) Regulations 2009 Regulation 18(4A and 4B)

Please read our **guidance for providers about making statutory notifications** and our **Guidance about compliance: Essential standards of quality and safety** for detailed advice on how and when to make statutory notifications, available at www.cqc.org.uk.

You must provide information in the mandatory sections (marked*). Please also provide all other requested information, and **enter dates in** the format dd/mm/yyyy.

Please email your completed form to: **HSCA_notifications@cqc.org.uk**

1. The provider and location*

Provider:			
CQC provider number:			
Location name and address:			
Location postcode:			
CQC location number:			
Regulated activity(ies):			
This form filled in by:		Date submitted	
Contact for more information (where different):			
Telephone number:			
Email address:			

2. The person*

Unique identifier:	Date began to use service:	Their age range:	Age ranges:
			18–24, 25–34, 35–44 45–54, 55–64, 65–74, 75–84, 85+

3. The application*

The application was made to:

The Court of Protection	☐	
A supervisory body	☐	
The application was made on (date)		

If made to a supervisory body:

Supervisory body's name:	

Repeat/follow-on applications

Was this a repeat/follow-on application? Yes	☐	No	☐	

4. The outcome of the application

Was the application approved? Yes	☐	No	☐	

5. Reason for the application and other additional relevant information

Please describe any conditions attached to an approved application. If the application was refused, please explain why.

Continue on additional numbered sheets if necessary. Box will expand if used on a computer.

6. Additional information about the person

Funding (this item for non-NHS services only)

Self funded	☐	PCT (whole or part)	☐	Local authority (whole or part)	☐
Name of PCT/LA					

Gender

Male	☐	Female	☐
Not specified	☐		

Ethnicity

White			
British	☐	Irish	☐
Other	☐		
Mixed			
White / Black Caribbean	☐	White / Black African	☐
White / Asian	☐	Other mixed background	☐
Asian			
Indian	☐	Pakistani	☐
Bangladeshi	☐	Other Asian background	☐
Black or Black British			
Caribbean	☐	African	☐
Other	☐		
Chinese			☐
Other			
Other	☐	Unknown	☐

Disability

Physical	☐	Learning	☐
Sensory	☐		

Mental health difficulties

Please tick/check here if the person has mental health difficulties	☐

Religion/belief

Baha'i	☐	Buddhist	☐
Christian	☐	Hindu	☐
Jain	☐	Jewish	☐
Muslim	☐	None	☐
Pagan	☐	Sikh	☐
Zoroastrian	☐	Unknown	☐
Other			

Sexual identity

Heterosexual / Straight	☐	Gay or Lesbian	☐
Bisexual	☐	Other	☐
Unknown	☐		

Please email your completed form to: HSCA_notifications@cqc.org.uk

For CQC use only, please leave blank