



Optimum  
Workforce Leadership

# Mental Capacity Act, Deprivation of Liberty Safeguards and Best Interest Decision Making Training Pack for Care Homes



supported by



**Nottinghamshire  
County Council**



*Health Education England*



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# Introduction

This training pack has been designed to increase your knowledge on the Mental Capacity and DoLS etc. It has been designed to be a self-learning tool. Based upon the knowledge that you have gained, the training pack has adopted a blended approach to consolidate your learning. The pack will enable you to evaluate your learning through questionnaire, case studies and competency based assessment. Each assessment should be completed with the training pack facilitator/supervisor. Both you and your training facilitator/supervisor should:

- use the Competence Assessment Tool to assess yourself and devise an action plan to meet your individual development needs
- provide evidence for renewal of your registration with the Nursing and Midwifery Council revalidation
- provide evidence of achievement for your personal development plan
- use your assessment results to focus on your development needs, prepare for supervision meetings and support your career development.

While completing the tool it is useful to use the following framework in order to gain the maximum benefit from the training pack.

## Learning and Development Framework

### **Step 1** Review and assess

Your knowledge, skills and attitudes using the training pack compile your evidence to support your assessment.

### **Step 2** Identify and prioritise your learning and development needs

From your assessment results including any 360° feedback. Identify, plan and prioritise your overall learning and development needs with your facilitator/supervisor.

### **Step 3** Plan and action

Discuss suitable learning opportunities with your supervisor and agree relevant learning outcomes. Record these in your learning and development plan.

### **Step 4** Evaluate your learning and development

In relation to improvements in your knowledge, skills and attitudes. Maintain a reflective record of your learning and development in your portfolio, to support your preparation of your supervision sessions or development review meetings.



## What is the Mental Capacity Act (MCA) and who does it apply too?

The Act's starting point is to confirm in legislation that it should be assumed that an adult (aged 16 or over) has full legal capacity to make decisions for themselves (the right to autonomy) unless it can be shown that they lack capacity to make a decision for themselves at the time the decision needs to be made.

The MCA was developed to bring together existing legal requirements and provide consistency in decision making about the care and treatment of people who lack capacity to make a decision.

In the past, it was not unusual for some people, for example people with severe or enduring mental health problems, to have decisions made for them. This resulted in numerous injustices, such as mass institutionalisation, forcible treatment, loss of control of their own finances and loss of the right to vote.

Much of the act built on existing common law (that is, law that is established in judgments made by the courts), and it also brought in important changes including:

- new criminal offences
- IMCAs
- new Court of Protection and the Office of the Public Guardian roles.

The Mental Capacity Act 2005 provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. Everyone working with and/or caring for an adult who may lack capacity to make specific decisions must comply with this Act when making decisions or acting for that person, when the person lacks the capacity to make a particular decision for themselves. The same rules apply whether the decisions are life-changing events or everyday matters.

The MCA was implemented in two distinct phases in 2007.



In April 2007:

- the new Independent Mental Capacity Advocate (IMCA) service became operational in England only
- the new criminal offences of ill-treatment or wilful neglect came into force in England and Wales
- Sections 1–4 of the Act (the principles, assessing capacity and determining best interests), which are essential to how IMCAs do their work, also came into force but only in situations where an IMCA is involved, and for the purposes of the criminal offences. Sections 1–4 of the Act did not apply to other situations until October 2007
- the Code of Practice for the Act was issued and should be followed by those who must have regard to it in situations where an IMCA is involved or in relation to the new criminal offences.

In October 2007 the Code of Practice became a statutory force for all of the Act not solely in relation to where an IMCA was involved and/or the criminal offence.



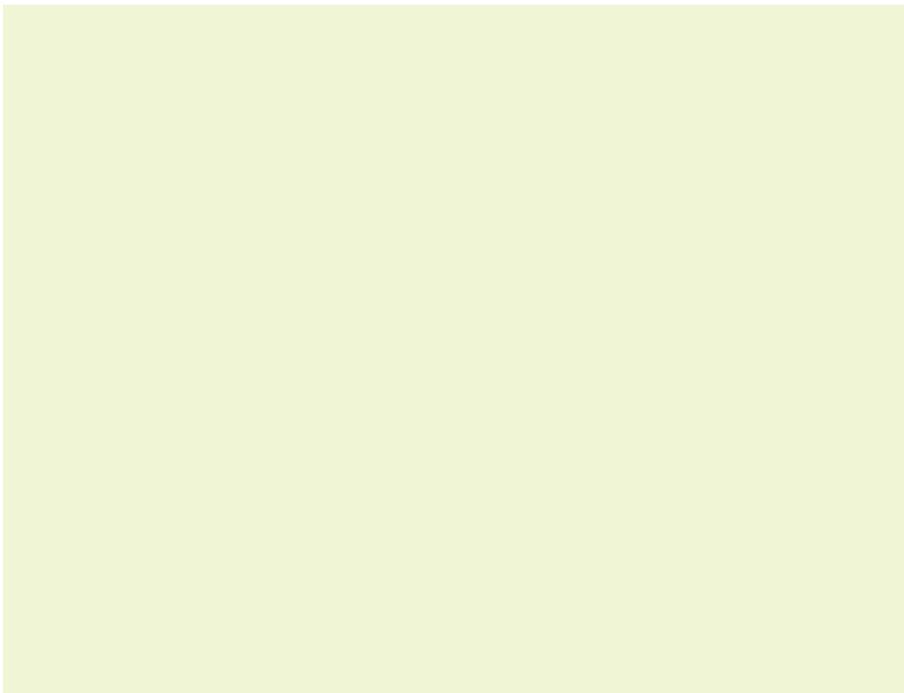
# Decisions

## What decisions are covered by the Act, and what decisions are excluded?

The Act covers a wide range of decisions made, or actions taken, on behalf of people who may lack capacity to make specific decisions for themselves. These can be decisions about day-to-day matters like what to wear, or what to buy when doing the weekly shopping. It can also include decisions about major life changing events, such as whether the person should move into a care home or undergo a major surgical operation.

### Time Out 1

Take a few minutes to list as many decisions as you can that you make on a daily basis on behalf of your residents. Consider as many ways as possible that you can involve your resident in the decision making process.



## Decisions NOT covered under the act

There are certain decisions which can never be made on behalf of a person who lacks capacity. This is because they are either so personal to the individual concerned, or governed by other legislation.

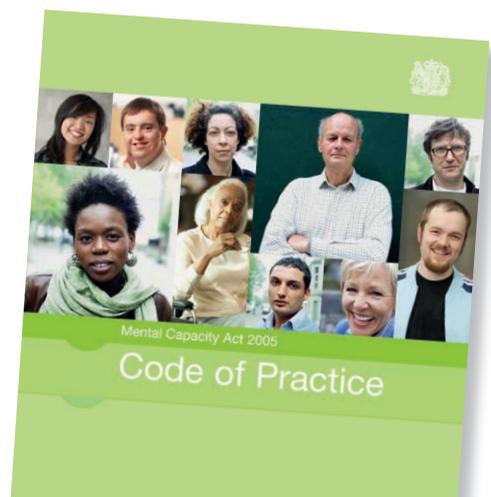
Sections 27–29 and 62 of the Act set out the specific decisions which can never be made or actions which can never be carried out under the Act, whether by family members, carers, professionals, attorneys or the Court of Protection.

These are summarised below.

### Decisions concerning family relationships (section 27)

Nothing in the Act permits a decision to be made on someone else's behalf on any of the following matters:

- consenting to marriage or a civil partnership
- consenting to have sexual relations
- consenting to a decree of divorce on the basis of two years' separation
- consenting to the dissolution of a civil partnership
- consenting to a child being placed for adoption or the making of an adoption order
- discharging parental responsibility for a child in matters not relating to the child's property, or
- giving consent under the Human Fertilisation and Embryology Act 1990.



## Mental Health Act matters (section 28)

Where a person who lacks capacity to consent is currently detained and being treated under Part 4 of the Mental Health Act 1983, nothing in the Act authorises anyone to:

- give the person treatment for mental disorder, or
- consent to the person being given treatment for mental disorder.

Further guidance is given in chapter 13 of the Code.

## Voting rights (section 29)

Nothing in the Act permits a decision on voting, at an election for any public office or at a referendum, to be made on behalf of a person who lacks capacity to vote.

## Unlawful killing or assisting suicide (section 62)

For the avoidance of doubt, nothing in the Act is to be taken to affect the law relating to murder, manslaughter or assisting suicide.

Although the Act does not allow anyone to make a decision about these matters on behalf of someone who lacks capacity to make such a decision for themselves (for example, consenting to have sexual relations), this does not prevent action being taken to protect a vulnerable person from abuse or exploitation.



# The Mental Capacity Act process

## The two-stage test of capacity (Code of Practice, 4.11– 4.13)

Prior to any decisions needing to be made you must consider the following:

- Consider:** 1. Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?
- If so:** 2. Is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision?

**\*\*\* This two-stage test must be used and your records should show that this has been applied.**

In assessing capacity you must apply these core principles:

- a person must be assumed to have capacity unless it is established that they lack capacity
- a person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success
- a person is not to be treated as unable to make a decision merely because they make an unwise decision
- an act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.

It is important to remember that an 'unwise decision' made by the person is not an indication of lacking capacity in itself.

Anyone who is being assessed for capacity should be assessed at their best level of functioning for the decision to be taken. The assessor should be aware that circumstances can change and an assessment of capacity may have to be repeated or reviewed, over time and for each different decision.



Before assessing capacity the assessor should consider several factors as follows:

- general intellectual ability
- memory
- attention and concentration
- reasoning
- information processing – how a person interprets what they are told
- verbal comprehension and all forms of communication
- cultural influences
- social context
- ability to communicate.

Each assessment of capacity will vary according to the type of decision and the individual circumstances. The more complex or serious the decision, the greater the level of capacity is required.

## Some key questions to consider when assessing capacity: (Code of Practice, 4.44 – 4.49)

- Does the person have a general understanding of what decision they need to make and why they need to make it?
- Do they understand the consequences of making, or not making, the decision, or of deciding one way or another?
- Are they able to understand the information relevant to the decision?
- Can they weigh up the relative importance of the information?
- Can they use and retain the information as part of the decision-making process?
- Can they communicate their decision?



It is important that all people involved in assessing a person's capacity should understand the nature and effect of the decision and any actions/consequences relating to the assessment and decision being made.

**Time Out 2**

Look at your assessment documentation and think about how you assess a resident in your home.

Does the process cover all aspects involved in accordance with MCA legislation?



# Best interest decision making

Before the process is done, or the decision is made, you must consider whether the purpose for which the decision is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action. The MCA requires any decision or act made on behalf of a person who lacks capacity to be made in the person's best interests. Decisions can also be made under the MCA by people officially appointed to do so, such as attorneys, deputies and the Court of Protection.

However, decisions will often be made by staff involved in the care and treatment of the resident concerned. Staff can also undertake most acts in connection with care or treatment which are made on behalf of a resident who lacks capacity to consent if they **reasonably believe** those acts are in the residents' best interests.

The MCA **does not define** best interests but identifies a range of factors that need to be considered when determining the best interests of individuals, who have been assessed as lacking capacity to make a particular decision or consent to acts of care or treatment. The MCA makes it clear that, when determining what is in someone's best interests, you **must not** base the decision on the person's age or make unjustified assumptions based on their condition.

## Acts in connection with care and treatment (Mental Capacity Act, Section 5; Code of Practice, Chapter 6)

When carrying out acts of care and treatment in the best interests of a person who lacks capacity, staff will be legally protected. This means that staff will be protected under Section 5 of the MCA against legal challenges provided that they:

- have taken reasonable steps to assess the person's capacity to consent to the act in question.
- reasonably believe that the person lacks the capacity to consent.
- reasonably believe that the act they are carrying out is in the person's best interests.

**However, staff will not be protected if they act negligently (see wilful neglect).**

The member of staff who delivers care or treatment to the resident who lacks capacity to consent is the **decision maker** even if a number of professionals in a multidisciplinary/ integrated team have been involved in the decision. Where care is provided, the carer is the decision-maker.



Staff do not always recognise when they are deciding on the appropriate care and treatment in the best interests of a resident who lacks capacity. Many of these decisions are day-to-day ones that carers are already making on behalf of service users i.e.

- assistance with physical care, e.g. washing, dressing, toileting.
- catheter and colostomy care
- help with eating and drinking
- help with travelling
- shopping
- paying bills
- household maintenance
- support relating to community care services.

**Acts connected to healthcare and treatment may include:**

- administering medication
- diabetes injections
- diagnostic examinations and tests
- medical and dental treatment
- nursing care
- emergency procedures.

**\*\*\*To re confirm as long as a staff member is always acting in the person's best interests, they would be protected from any liability in relation to what they are doing under Section 5 of the MCA.**

The steps that should be taken to assess best interests will vary according to individual circumstances. However, the MCA (Section 4, Code of Practice, Chapter 5) sets out a checklist of common factors which must **always** be taken into account in any situation where an action is being undertaken or a decision is being made for a person lacking capacity. Staff must be confident that they have made every effort to work out what might be in the best interests of the person.



The factors that need to be taken into account when determining what is in someone's best interests should be set out in the best interests checklist as follows:

- considering all relevant circumstances – these are circumstances of which the decision maker is aware and those which it is reasonable to regard as relevant.
- regaining capacity – can the decision be put off until the person regains capacity?
- permitting and encouraging participation – this may involve finding the appropriate means of communication or using other people to help the person participate in the decision-making process.
- special considerations for life-sustaining treatment – the person making the best interests decision must not be motivated by the desire to bring about a person's death.
- considering the person's wishes, feelings, beliefs and values especially any written statements made by the person when they had capacity.
- taking into account the views of other people – take account of the views of family and informal carers and anyone with an interest in the person's welfare or appointed to act on the person's behalf.
- taking into account the views of any IMCA or any attorney appointed by the person or deputy appointed by the Court of Protection.
- considering whether there is a less restrictive alternative or intervention that is in the person's best interests.

*(Mental Capacity Act, Section 4; Code of Practice, Chapter 5)*

**Other good practice points include:**

- demonstrating that you have carefully assessed any conflicting evidence before providing clear, objective reasons as to why you are acting in the person's best interests.

### Time Out 3

**Based upon the information you have read so far please complete the following questions.**



# Assessment

Question	Answer
1 Why was the Mental Capacity Act introduced in England/ Wales and when?	
2 What does the two stage capacity assessment mean and what should you ask?	
3 What is the role of the Office of Public Guardian?	
4 What are the five core principles you need to consider when assessing capacity?	
5 What does a Lasting Power of Attorney consider?	



**Question**

**Answer**

<p>6 Who should be involved in a best interest decision and what should be considered?</p>	
<p>7 What does the Act say about someone who presents with fluctuating capacity?</p>	
<p>8 What decisions are not covered under the Mental Capacity Act?</p>	
<p>9 What is the role of an IMCA?</p>	
<p>10 Whose responsibility is it to assess individual capacity?</p>	



# Case Study 1

A 67 year old lady with mild to moderate dementia lives in a care home.

The lady has always taken pride in her appearance, and had an active social life when she was well. She has worked previously in the field of tailoring sewing and hairdressing.

She remains fairly physically active and at times can become upset at the home but on the whole has settled in and mixes well with the other residents.

She has dental problems causing her a lot of pain but refuses to open her mouth to have her teeth cleaned.

The staff suggests it would be a good idea to give the patient an occasional general anaesthetic (GA) so the dentist can clean her teeth and fill any cavities.

Her husband is worried about the effects of the GA. He hates to see his wife distressed and suggests instead that she should be given strong painkillers when needed.

Having talked to others the dentist tries to find ways of involving the patient in the decision with help of key worker and advocate. This is to try and ascertain cause and location of the problem, and to explain to her that they are trying to stop the pain.

The dentist then tries to find out if any other form of dental care would be better, such as mouth wash or dental gum.

The dentist concludes that it would be in the patient's best interest for:

- a proper investigation to be carried out under anaesthetic so that immediate treatment can be provided
- options for future dental care to be reviewed by the care home team involving patient as much as possible.

**Using the statutory BI checklist can you work through and discuss some of the dentist's thinking that led to the decision?**



## Case Study 2

Ms M is a 73 year old woman with history of schizophrenia. In her early 20's she worked as a hospital cleaner. She lost her job due to mental illness and spent many years as an inpatient in a long stay hospital.

When the hospital closed she was discharged and lived in a series of hostels. Ms M has no known relatives.

Two years ago her behaviour and functioning began to deteriorate. She was neglecting self and not following her usual routines, becoming erratic in her behaviour and threatening to those around her.

She had been seen by local services and diagnosed with dementia in addition to her chronic schizophrenia.

She was placed in a nursing home for people suffering with dementia, but continued to be disruptive and aggressive.

She had developed difficulties with swallowing (thought to be due to long term use of antipsychotic medication) and her speech was also indistinct and hard to understand.

She was however able to indicate whether she agreed or disagreed with somethings that was said to her. Her reading and writing skills were limited. A capacity assessment completed by two independent professionals ENT surgeon and Consultant Psychiatrist deemed she did not have capacity but did express preference to some forms of treatment.

The nursing home tried to implement a soft diet with thickened drinks but she refused to cooperate and continued to eat ordinary food (especially biscuits and cakes which she loved).

If she was not given them she would go into the kitchen and take them, or take them from other residents in the home.

Because of her swallowing difficulties and her insistence on eating the wrong food, she developed aspiration pneumonia. This happened on several occasions. She recently became seriously ill and had been admitted to the local acute hospital.

Once there, questions were raised regarding her capacity and also what possible treatment options she should receive.



The three options were as follows:

1. to provide no active treatment and restrict diet to liquids
2. to insert PEG tube and give all nutrition through this
3. to use other methods of feeding such as a drip (short term solution).

The patient was referred to the older adult specialist mental health team. An initial assessment of capacity to consent to the three options outlined above had been undertaken by the ENT surgeon. His view was that the patient lacked capacity for this decision at this time.

The mental health team thought it was not clear as to whether or not Ms M had capacity as did the care home staff. Ms M was also seen by Consultant Psychiatrist who thought on the balance of probability, that she did lack capacity. She did however appear to express a preference for some form of treatment.

As the three opinions were broadly in agreement it was judged that Ms M did lack capacity and a decision would need to be made in her best interests.

Ms M had no known relatives. An IMCA was therefore instructed as the decision was one which involved serious medical treatment.

A best interest meeting was called with all relevant parties. During the meeting the ENT consultant expressed concerns that Ms M may not co-operate with the PEG tube and may be impractical. There was also some concern that by not inserting the PEG feed this would lead to a negative outcome. However not all were in agreement and the meeting discussed all implications to Ms M health and overall well-being.

Using the BI checklist can you consider all options and agree a best interest decision?



## Deprivation of Liberty Safeguards (DoLS)

The Mental Capacity Act Deprivation of Liberty Safeguards (MCA DoLS) provide a legal framework around the deprivation of liberty.

### What is the purpose of DoLS?

The safeguards are designed to protect the interests of an extremely vulnerable group of individuals and to:

- ensure people can be given the care they need in the least restrictive regimes
- prevent arbitrary decisions that deprive vulnerable people of their liberty
- provide them with rights of challenge against unlawful detention
- avoid unnecessary bureaucracy.

### Who does DoLS apply too?

**It applies to the following:**

- anyone aged 18 and over
- anyone who has a mental disorder
- anyone who lacks capacity to consent to the arrangements made for their care or treatment in either a hospital or a care home (registered under the Care Standards Act 2000)
- those for whom a deprivation of liberty may be necessary in their best interests to protect them from harm
- to anyone where a detention under the Mental Health Act 1983 is not appropriate at that time.



## What is Deprivation of Liberty Safeguards?

The Supreme Court recently clarified that there is a deprivation of liberty in circumstances where a person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements.

A deprivation of liberty can also occur in domestic settings where the state is responsible for imposing the arrangements. In such cases any deprivation of liberty must be authorised by the Court of Protection.

All appropriate steps should be taken to remove the risk of a deprivation of liberty by reducing restraint and restrictions on an individual where possible.

## Why are these safeguards necessary?

MCA DoLS address the October 2004 European Court of Human Rights judgment in *HL v the United Kingdom* (the Bournemouth judgment).

The Bournemouth case concerned an autistic man with severe learning disabilities who was informally admitted to Bournemouth Hospital. It was held that he was unlawfully deprived of his liberty because of the absence of a legal procedure that provided safeguards against arbitrary detention and speedy access to court.

## Bournemouth case in summary

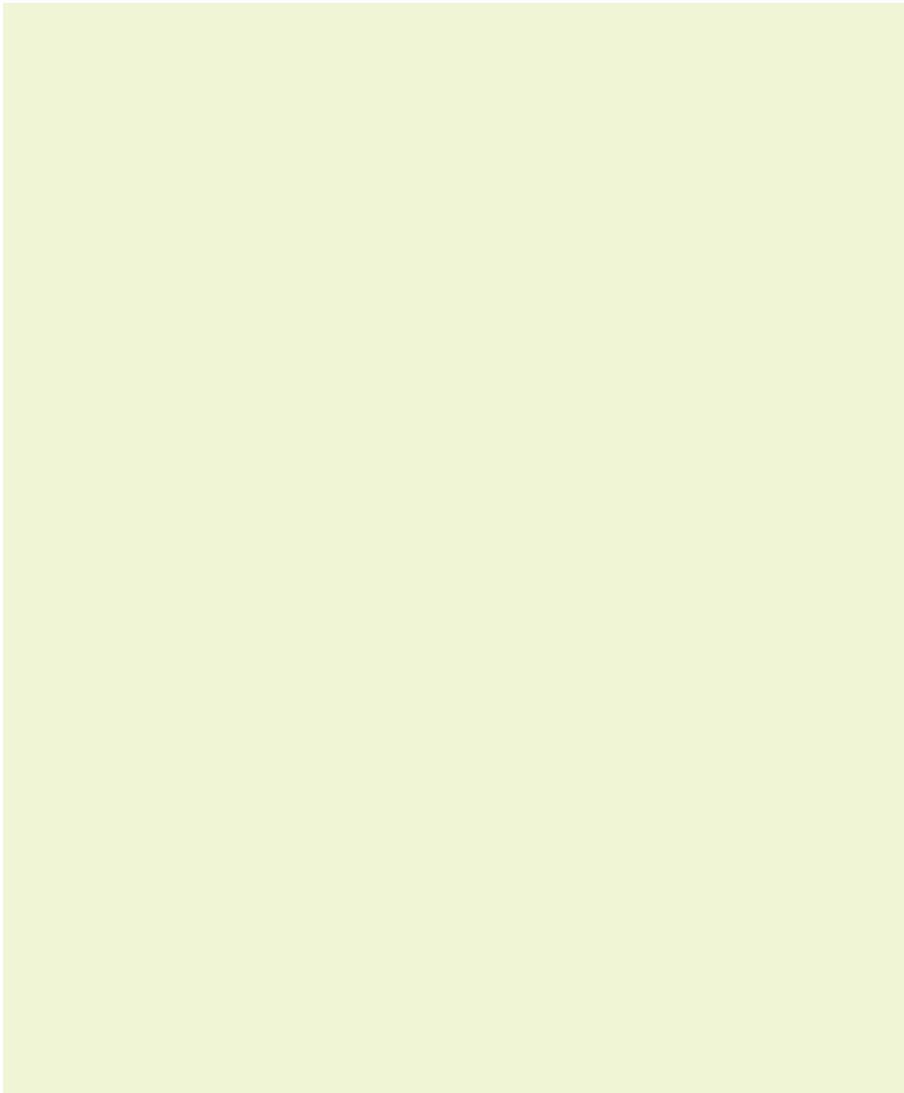
*"HL was a 48-year-old man with autism who was unable to speak, and whose level of understanding was limited. He was living with carers, and in July 1997, he self-harmed whilst at a day centre. In response, he was taken to Bournemouth Hospital without consulting his carers. When they learnt where he was they requested that he be allowed to come home and asked to see him. They were refused both of these requests. It was agreed by all parties that he lacked the capacity to consent to staying in hospital. He was subsequently detained under Section 3 of the Mental Health Act 1983 in October 1997.*

*HL v United Kingdom looked at the three-month period between being taken to the hospital and detention under the Mental Health Act 1983. The ECtHR found HL had been deprived of his liberty unlawfully."*



**Time Out 4**

What implications do you think the judicial court considered in which supported their decision making?



# How does DoLS work?

When a hospital or care home (the managing authority) identifies that a person who lacks capacity is being, or risks being, deprived of their liberty, they must apply to the local authority (the supervisory body) for an authorisation of deprivation of liberty.

Authorisation should be obtained in advance except in urgent circumstances. The supervisory body must obtain six assessments:

- age assessment
- no refusals assessment
- mental capacity assessment
- mental health assessment
- eligibility assessment
- best interests assessment.

The assessments must usually be completed in 21 days of the request for the authorisation. 'Assessors' appointed by the managing authority will carry out the assessments. 'Assessors' will usually be doctors, nurses, social workers, or psychologists depending on the particular type of assessment. Detailed provisions about the selection and appointment of assessors are set out in legislation. A representative – either a suitable relative or friend of the person concerned, or alternatively an Independent Mental Capacity Advocate (IMCA) – will be appointed to represent the individual's interests. Legislation provides for the selection and appointment of representative.

The duration of an authorisation will be determined on a case-by-case basis but may not be longer than 12 months. The managing authority can apply for a further authorisation when the authorisation expires. The authorisation can be reviewed at any time, and must be reviewed if this is requested by the individual or their representative.

If any of the assessments determine that the individual does not satisfy the criteria for an authorisation, the supervisory body must refuse the request for authorisation.



There is **no simple definition** of deprivation of liberty.

Whether someone has been deprived of their liberty depends on the particular circumstances of each case. Staff should consider whether any steps they are taking, or are proposing to take, might amount to depriving someone of their liberty.

The quote below comes directly from the MCA Code of Practice.

*“The difference between deprivation of liberty and restriction upon liberty is one of degree or intensity. It may therefore be helpful to envisage a scale, which moves from ‘restraint’ or ‘restriction’ to ‘deprivation of liberty.’”*

## Cheshire West case

The Supreme Court judgment of 19 March 2014 in the case of Cheshire West clarified an ‘acid test’ for what constitutes a ‘deprivation of liberty’.

The ‘acid test’ states that an individual is deprived of their liberty for the purposes of Article 5 of the European Convention on Human Rights if they:

- lack the capacity to consent to their care/ treatment arrangements
- are under continuous supervision and control
- are not free to leave.

**All three elements must be present for the ‘acid test’ to be met.**

If someone is subject to that level of supervision, and is not free to leave, then it is likely that they are being deprived of their liberty. But even with the ‘acid test’ it can be difficult to be clear when the use of restrictions and restraint in someone’s support crosses the line to depriving a person of their liberty.

Each case must be considered on its own merits, but in addition to the two ‘acid test’ questions, if the following features are present, it would make sense to consider a deprivation of liberty application:

- frequent use of sedation/medication to control a residents behaviour
- regular use of physical restraint.



- the person concerned objects verbally or physically to the restriction and/or restraint
- objections from family and/or friends to the restriction or restraint
- the person is confined to a particular part of the home in which they are being cared for
- the placement is potentially unstable
- possible challenge to the restriction and restraint being proposed to the Court of Protection or the Ombudsman, or a letter of complaint or a solicitor's letter
- the person is already subject to a deprivation of liberty authorisation which is about to expire.

The Mental Capacity Act allows restrictions and restraint to be used in a person's support, but only if they are in the best interests of a person who lacks capacity to make the decision themselves.

Restrictions and restraint must be proportionate to the harm the care giver is seeking to prevent, and can include further examples such as:

- using locks or key pads which stop a person going out or into different areas of a building
- the use of some medication, for example, to calm a person
- close supervision in the home, or the use of isolation
- requiring a person to be supervised when out
- restricting contact with friends, family and acquaintances, including if they could cause the person harm
- physically stopping a person from doing something which could cause them harm
- removing items from a person which could cause them harm
- holding a person so that they can be given care, support or treatment



- bedrails, wheelchair straps, restraints in a vehicle, and splints
- the person having to stay somewhere against their wishes or the wishes of a family member
- repeatedly saying to a person they will be restrained if they persist in a certain behaviour.

Such restrictions or restraint can take away a person's freedom and so deprive them of their liberty. They should be borne in mind when considering whether the support offered to a person is the least restrictive way of providing that support.

Decisions about what amounts to a deprivation of liberty are made by courts. The Code of Practice for the Deprivation of Liberty Safeguards gives examples of where courts have found people being and not being deprived of their liberty. These examples, together with other cases which have gone to the courts, can be used as a guide.

When care providers are putting together the care plans of persons who are unable to consent to their care, they should consider whether any restrictions or restraint being proposed in the best interests of the person amount to a deprivation of liberty.

## Death while resident is still subject to DoLS legislation

The death of a person subject to a DoLS authorisation is legally classified as a death in 'state detention'. Such deaths must be reported to, and investigated by, a coroner under the Coroners and Justice Act 2009. Such deaths are also reportable to the CQC regulator.



### Question

### Answer

1 Describe the legal implications in which a DoLS authorisation may be applicable.

2 In what time frame and in what circumstances should an urgent application take place?

3 What is meant by the 'acid test' and what criteria needs to be met for its consideration?

4 Describe the difference between deprivation of liberty and restriction upon liberty?

5 What six assessments are required by the supervisory body in which to apply a DoLS authorisation?



Question	Answer
<p>6 What is the death of a resident classed as if a DoLS is in place and what are you legally required to do?</p>	
<p>7 Identify with as many examples that could be identified as requiring DoLS consideration.</p>	
<p>8 Explain the role of both the managing authority and supervisory body.</p>	
<p>9 Who does the MCA DoLS apply too?</p>	
<p>10 In what time frame must a standard authorisation take place under DoLS?</p>	



# Case Study 1

DE was a 76-year-old man with dementia who lived at home with his wife JE. Following a stroke he was assessed as lacking capacity to make a decision about where he lived, although he often expressed his wishes to live with JE.

JE felt that she could not care for DE, and one day placed him outside in front of the house and called the police. DE was placed in two care homes where he had a considerable amount of freedom and lots of contact with the outside world. However he repeatedly expressed the wish to live with JE, and JE also wanted DE to live with her again.

The local authority would not agree to DE visiting or returning to live with JE and stated that if she attempted to remove him they would call the police. DE and JE applied to the courts that this was a deprivation of his liberty.

**Based on this case what factors need to be considered and what the possible outcomes do you think there are?**

**Please use the care home best interest documentation to support decision making.**



## Case Study 2

TG was a 78 year old man with dementia and cognitive impairment. He lived in a care home but was admitted to hospital with pneumonia and sepsis. While he was in hospital, there was a dispute between the local authority and TG's family about his future once he was discharged. His family believed TG should come and live with them, but the local authority believed that TG needed 24-hour care in a residential care home.

The local authority obtained an order from the court, directing that TG be delivered to the relevant care home. TG's family were not aware that this order had been sought. It was subsequently changed and TG went to live with his family, who then claimed that the period of time he had spent at the care home amounted to a deprivation of his liberty.

**What do you think was the outcome to this case?**



# Care plan example

## Why is support needed?

Ann has a diagnosis of XXXXXXXX Dementia. Ann is able to make most day-to-day decisions but can feel overwhelmed by too many options and too much information at once.

Ann sometimes finds it difficult to hear what is being said because of her hearing impairment and sometimes forgets to put her hearing aids in.

Ann can find it difficult to concentrate if there is a lot of noise and activity around her.

Ann can be sleepy first thing in the morning and following her medication and becomes very tired in the afternoon and evening.

Ann can become anxious if hurried.

Ann has a very good relationship with her sister Joan and Key Worker Sally. Ann feels reassured in her company.

## What support to be provided?

Sometimes Ann needs support to make decisions such as what to wear, or what to have for breakfast, as well as to make more significant decisions.

Ann needs the information about the decision to be explained using clear and uncomplicated language. Ann finds it easiest to make decisions when she is given clear choices and sometimes needs to have the information repeated several times, and in different ways before she can understand the information about the decision which needs to be made.

Please ensure Ann is wearing her hearing aids and that they are clean, switched on and working properly. Ann finds it best to make decisions in a quiet familiar room on a one to one basis where she can concentrate without distractions, like in her bedroom. The best time of day for Ann to make decisions is usually early afternoon when she is not sleepy from medication or too tired. Where the decision does not need to be made urgently Ann needs to be given plenty of time to make decisions. Ann finds it helpful if Joan and Sally are there to support her to make more signature decisions.



## What to look for in the care and support plan and other records

1. How any decisions made on behalf of a person who lacks capacity are made in their best interests.
2. A summary of the person's care and support needs.
3. The person's wishes past or present (obtained from the person, an advance statement or others such as family members or paid carers).
4. How the person was supported to understand the nature of the decision and the options available.
5. How the person was supported to express their views.
6. Other factors that the person would be likely to consider if they were making the decision for themselves.
7. Who else was consulted (e.g. family, close relatives, anyone previously named by the person as someone to be consulted, or other people involved in the person's welfare), and their views.
8. A record of any family members who were not consulted and why.
9. The options for care and support that were considered. This includes the option of doing nothing and options suggested by family members, even though these may have been discounted.
10. The risks and benefits of each option.
11. The likelihood of each risk occurring and the seriousness of impact if they did occur.
12. The care and support that is being proposed and why this option was decided upon as being in the person's best interests.
13. Promoting least restrictive care / consideration of least restrictive option if not chosen justify why.
14. How and when the care and support plan will be reviewed to see if a less restrictive option can be applied in the future.



## To conclude

The DoLS authorisation itself does not cause a Deprivation of Liberty rather it is the nature of the care and treatment being provided to the individual that results in a DoLS.

Remember deprivation of liberty are a safeguard and a positive tool in that they provide independent scrutiny to ensure that such situations are made in the best interests of the individual concerned.

A DoLS can be an entirely appropriate result of providing an individual with good quality care and DoLS exist to ensure that this is the case.

Care providers don't have to be experts about what is and is not a DoLS. You just need to consider at all times where a person may be deprived of their liberty and take action.

**\*\* Please note at the time of print the current DoLS legislation has been reviewed by the House of Lords who have made several urgent recommendations and suggestions for change.**



# Case Study answers

## DoLS case study 1

The court decided that this was a deprivation of liberty. The judgment stated that the fundamental issue in this case was whether DE has been and is deprived of his liberty to leave the care homes permanently in order to live where and with whoever he chooses, in this case JE.

The judge decided that DE was not 'free to leave', and was completely under the control of the local authority, because it was they who decide where DE can live, whether he can leave and whether he can be with JE. He stated:

*'The simple reality is that DE will be permitted to leave the institution in which [the local authority] has placed him and be released to the care of JE only as and when, – if ever; probably never, – [the local authority] considers it appropriate. [The local authority's] motives may be the purest, but in my judgment, [it] has been and is continuing to deprive DE of his liberty.'*

This means that even if a local authority decision is found to be in a person's best interests, it does not stop it being an unlawful deprivation of liberty.

## DoLS case study 2

The judge considered that there was no deprivation of liberty. The key factors in his decision included:

The care home was an ordinary care home where only ordinary restrictions of liberty applied.

The family were able to visit TG on a largely unrestricted basis and could take him out from the home for outings.

TG was personally compliant and expressed himself as happy in the care home.

The judge said:

*"Whilst I agree that the circumstances of the present case may be near the borderline between mere restrictions of liberty and Article 5 detention, I have come to the conclusion that, looked at as a whole and having regard to all the relevant circumstances, the placement of TG in (the care home) falls short of engaging Article 5."*



# Case study example

## Complex case for team training purposes

From the age of 13, M has had Type 1 insulin-dependent diabetes. She was able to manage that well and lived a normal life at home and at work for many years.

Unfortunately in her forties she began to suffer problems with her eyesight, and at the age of 53 one eye was removed, leaving her with just ten percent vision in the other. Since 2008 her health problems have multiplied. She required major surgery in 2009 and later that year she collapsed after what may have been a stroke. This marked a watershed in her ability to manage independently. She has become markedly inflexible in the level of support she wishes to accept, insisting on her own assessment of her diabetic management.

In 2011 that condition became unstable and she had five acute admissions to hospital, having become ill with diabetes ketoacidosis (DKA), a potentially fatal condition. She was discharged either home or to a nursing home. In 2012 there were two further admissions with high blood sugar. On the second occasion she was discharged to a residential home where she broke a hip. By April 2012 she was bedbound, incontinent and confused. In June 2012 she was admitted to the current care home.

M does not suffer from any major mental illness, though Dr Leonard considers she is currently mildly depressed. She takes antidepressants.

At the care home there has been a marked improvement in her diabetic control, nutrition, mobility, continence and cognition, though her diabetic control is still suboptimal because she is only partially compliant with her insulin regime and because she refuses to eat any food provided by the home. She is able to get around indoors and outdoors, but she is vulnerable to falls.

M has repeatedly and consistently said that she wishes to return home and has said that she will take her own life if this is not allowed to happen.

Between the 2nd and 4th of October M went to a residential rehabilitation unit to assess her ability to return home, but this failed as she was uncooperative and the unit did not feel able to manage her medical needs.



M has been multiply assessed by specialists of all descriptions whose statements appear in the papers. Their united view is that from the point of view of M's health she would be safer in the care home than at home. For example her current community mental health nurse says this:

*"From my past experience of the case and the unsuccessful period of residential rehab, I do not feel that reducing the risks within her home would be attainable and that 24-hour care is the most appropriate option of providing the care she requires and ensuring that this care is delivered."*

And later:

*"It is my opinion that [a return home] has been attempted extensively in the past and due to M's refusal to comply with the care plan there were multiple significant incidents when her life was threatened. Although she may report that she would be happier at home, there is a significant risk that she would come to serious harm should she return home."*

The manager of the care home says this:

*"I believe that as it is M's wish to return home, this could result in her being happier than the current situation. I also believe that her relationship with her partner is important to her and her expressed wish not to be separated from her partner would cause her less distress. However, it has been known that A has asked staff to make excuses for his leaving as her behaviour towards him has been stressful, and when in the home environment this facility may not be as easy. This could impact upon their relationship."*

*I also believe that she would be more comfortable within her own surroundings as she frequently expresses her displeasure about not sleeping in a double bed and not having her own possessions around her. In her views expressed to myself her home is her security as she can be on her own, of which is her preference as she has always been a solitary character. However, it is this opinion that has impacted upon her diabetes management when being at home in the past. Her refusal to accept support within her own home has been identified by the district nurses and care agencies. This could have devastating consequences on her health should she refuse the access to care services and that is highly likely."*

*I believe that M would be able to have more control over her life which she desperately wants, and in turn this will make her happier. However, the way that she takes control of her diabetes is inappropriate and could result in further admissions or deterioration in her health that could result in fatality."*



In relation to the management of M's diabetes, Miss L, a senior specialist nurse, clearly explained the processes involved the nature of the medication regime, and the range of consequences arising from non-compliance of different kinds. Her evidence establishes that if there is a default in the insulin supply that M receives there will undoubtedly be a deterioration in her physical health. The probability is that this would be picked up, but the length of time that would be available to take action would be limited with the likeliest scenario being a situation that had to be resolved within a certain number of hours or a few days; however the possibility of a more urgent and possibly fatal event cannot be discounted.

Dr Leonard has met M three times and liaised with many of the other key professionals including a diabetic consultant. I find him to be a careful, balanced and realistic witness and I accept his evidence. I take these points from it. He says that this is not an easy decision and M's circumstances are really uncommon in that she lacks capacity on the crucial issue of her care needs, but in other respects has a clear understanding of her immediate environment.

He regards the current situation as not necessarily being stable because of the strength of M's feelings and in particular the situation that she would be in if, having brought these proceedings, she regarded them as having failed. Her views are consistent and unchanged; indeed Dr Leonard regards them as being unchangeable in all probability. Her negative view of her circumstances is eloquently expressed, and her threats of self-harm are taken seriously by Dr Leonard, who considers them a significant risk.

Dr Leonard considers that M has an unrealistically optimistic view of the situation that would exist if she returns home. He advised that her response following a return could not be predicted. She might appreciate that she was more likely to stay at home if she cooperated with support services, but this could by no means be guaranteed. As to the prospects for success, the impression given by Dr Leonard throughout his evidence is that these are guarded, but by no means unattainable. As to M's current quality of life he described it as being significantly adversely affected by her current deprivation of liberty. He referred to the unsuitable, from M's point of view, group of other inhabitants of the home, many of whom are much older and suffering from advanced dementia. He pointed to her objections about lack of privacy, inability to come and go and alienation from her home environment and her possessions. It is also the case that a recent occupational therapy report confirms that M's needs are not, in that regard, being met.



Dr Leonard further describes a refusal of this application as being seen by M as final and says that the message that she would take would be that she was neither going home now nor, in all probability, at any time in the future.

As to the best interests decision, Dr Leonard describes it as not being an easy one. He says that risks exist, whichever course is taken, and that any plan will need close monitoring. His ultimate conclusion appears in the summary and opinion of his report:

*“In addition to the interaction of different factors that make up her overall best interests, their consideration is very dependent upon the weight given to these different aspects of her best interests. There then remains the uncertainty surrounding any particular course of action and that some variables, for example the quality and availability of care staff in the community, along with whether or not they form a positive relationship with M, can be positively influenced but not completely controlled. In contrast, the nature of her experience and health within residential care from 2012 is more clearly known, nonetheless I have also indicated that I do not think this can be assumed to be a stable situation.”*

*“My own conclusion is that a successful return home would be in her best interests and that all options to achieve this have not been fully explored. I am aware of the situation during 2011 and concerns that this pattern of deteriorating health could be repeated, but an acceptance of more limited aims for her diabetic management, emphasis to her of the very limited options for enabling a return home, predetermined arrangements for access, and the improvement in her general health during the past year may represent conditions from which it could be achieved.”*

As to M's wishes and feelings, these are very clear and entirely consistent regardless of who she is speaking to or where the conversation is taking place. M hates it at the care home; she hates the people, she hates the noise, the impersonality, the lack of privacy and the absence of her own surroundings. She said this in parting to the District Judge: “I want to be out of here quick or be dead.” Whether or not her threats to kill herself represent a real physical threat, they undoubtedly represent an expression of the strength of her feelings.

M's partner, A, gave as his view that although he is concerned about M's compliance, in particular with carers, such has been the good work of the care home, that she could do with a trial of being at home with a care package. He described the areas in which M would need help from carers. They fall into the category of support services in and outside the home rather than intimate care. He described how he and M used to share a bedroom in the past and would hope to do so in future if this was possible.



## Judicial decision reached

Reviewing these matters, I do not consider that M will recover capacity in relation to the matter in question. I do consider that so far as practicable she has been permitted and encouraged to participate in these proceedings by means of her litigation friend and IMCA and by the visit of the Judge to her at the care home. I do not, in evaluating this matter, in any way approach matters out of a desire to bring about M's death. On the contrary, I approach that matter with great caution, accepting the submission on behalf of the CCG that the administration of diabetes in this case might be regarded as life-sustaining treatment as defined in subparagraph 10.

When coming to consider the core questions that arise under subparagraph 6 as being amongst the circumstances of the case, it is worth noting that so far as I can tell there is no information that is seriously in dispute in this matter. The facts are broadly as set out above and are not contested by the parties, it is the weight to be given to them that is in issue.

I place considerable weight on M's wishes, bearing in mind that the domain in which she is incapacitated does not extend over all areas of her life. As Mr Stockwell, on her behalf, put it, the essential justification for the deprivation of liberty is the prevention of DKA.

M's views are quite understandable bearing in mind the restricted and impoverished quality of her life in the home. This is no fault at all of the home itself, but it is in most ways not a suitable place for her. What it does offer is the best available quality of care for her diabetes management, but at what cost? That question is pithily answered by Mr Butler in his position statement in which he says that at the care home there is almost complete certainty of physical safety at the cost of the happiness of M, even if that might somewhat overstate what can be achieved at the home.

Turning to M's beliefs and values, both before and after her illness, M is described by A as being a private and independent person. They cohabited part time, with each of them feeling happy to keep their own homes. The impact of group living on M is in consequence more difficult than it would be for many others. Another of M's characteristics is that she has always been a determined person, but since her illness this has developed into a habit of inflexibility. She is acknowledged to be a particularly difficult person to help. This is likely to continue wherever she lives.



In relation to the views of others, I have taken account of the views of all those referred to above. I am in no doubt that everyone concerned has thought hard about what is in M's best interests. It is not surprising that witnesses called by the CCG are by vocation highly motivated by their responsibility to keep her safe. I also place substantial weight upon the judgement of A, who knows M and her situation extremely well.

Ultimately the court must balance these factors:

- M's wishes, feelings and values which point towards a return home.
- the best possible control of her diabetes, which points towards her remaining in the care home.
- the risks to her health that exist in the care home, both by way of a possible deterioration in her physical and mental state consequent upon her being made to stay there, and by way of her threats of self-harm.
- the risks to her health that would exist following a return home, as described by Miss L.

Having weighed these matters up I have reached the clear conclusion that the case for a continued deprivation of M's liberty has not been made out. I accept that there are many uncertainties in a return home, indeed more uncertainties both of a good and a bad kind than in maintenance of the status quo. Negatively these include a possible deterioration in her physical and mental state as a result of non-cooperation. The deterioration may be gradual, but might also be sudden, occurring in a matter of a few hours, and may even, though perhaps less likely, be instantly life-threatening. Any decision that M returns home must accept the real possibility that the attempt will fail and the possibility in the worst case that she may die as a result of a sudden deterioration in her condition. Like Dr Leonard, I do not however accept the view that failure is inevitable.

The above disadvantages are, in my view, outweighed by the following considerations.

- the possibility that cannot be ignored that M will cause herself serious physical harm if she is told that she is not going home.
- the real possibility that her enjoyment of life might to some degree be recovered following a return home even if it does not fully meet her expectations.



In the end, if M remains confined in a home she is entitled to ask “What for?” The only answer that could be provided at the moment is “To keep you alive as long as possible.” In my view that is not a sufficient answer. The right to life and the state’s obligation to protect it is not absolute and the court must surely have regard to the person’s own assessment of her quality of life. In M’s case there is little to be said for a solution that attempts, without any guarantee of success, to preserve for her a daily life without meaning or happiness and which she, with some justification, regards as insupportable.

Finally, and on a separate matter, in closing submissions Mr Stockwell raised an entirely new issue about whether proceedings of this kind adequately protect the Article 5 rights of a person in M’s position at all. I could not detect anything of practical or legal substance in this argument, which has not been prefigured in the proceedings and was not developed further. Accordingly I do not take account of it.

Before parting from the case, I would add two things.

Firstly, my decision implies no criticism whatever of any of the witnesses from the local authority or by the CCG. I understand the position taken and the reasons for it; indeed it would be difficult for them to have taken a different view on the facts of the case. There are risks either way and it is perfectly appropriate that responsibility for the outcome should fall on the shoulders of the court and not on the shoulders of the parties.

Secondly, I have already noted the visit made by the District Judge to M in the care home about a month before this hearing. A careful written record was made and placed with the papers. The visit has therefore had the dual purpose of informing the court of M’s views and of making M feel connected to the proceedings without putting her into the stressful position of having to come to court in person. I commend this as an approach that may be of value in other cases of this kind.



Nearest relative as defined by the MHA	Lasting power of attorney (LPA)	Independent mental capacity advocate (IMCA)	Court-appointed deputy
<p>Not chosen by service user and is one person only; nearest relative may or may not hold the LPA (if there is one); often the person's main carer.</p>	<p>Chosen by service user and may be more than one person; LPA may or may not be held by the nearest relative.</p>	<p>For people without family or friends or contacts outside of the care team.</p>	<p>For people without LPA who lack capacity and where major decisions have to be made.</p>
<p>Functions can be delegated On limited grounds, nearest relative may be displaced (and an acting nearest relative appointed) by the County Court.</p>	<p>Role cannot be delegated.</p>	<p>Instructed by the local authority or NHS body.</p>	<p>Appointed by the Court of Protection.</p>
<p>No automatic right to personal information.</p>	<p>Has right to access personal information needed to carry out the role.</p>	<p>Has right to access personal information needed to carry out the role.</p>	<p>Has right to access personal information needed to carry out the role.</p>
<p>Has powers to:</p> <ul style="list-style-type: none"> <li>• seek assessment by an ASW with a view to an application for detention</li> <li>• object to admission for treatment (Section 3 guardianship)</li> <li>• make application for admission</li> <li>• order discharge (subject to certain limitations).</li> </ul>	<p>May be involved in decisions about:</p> <ul style="list-style-type: none"> <li>• personal welfare including health care</li> <li>• property and affairs</li> </ul> <p>Is a decision maker.</p>	<p>Consult widely when major decisions are needed about:</p> <ul style="list-style-type: none"> <li>• serious medical treatment</li> <li>• transfer of accommodation</li> <li>• reviews of accommodation</li> <li>• abuse cases, including when family of friends implicated</li> </ul> <p>Is not a decision maker.</p>	<p>Is appointed by the Court for specific decisions, such as medical treatment and financial matters</p> <p>Is a decision maker.</p>



# Glossary

## **Advance decision**

Allows an adult with capacity to set out a refusal of specified medical treatment in advance of the time when they might lack the capacity to refuse it at the time it is proposed. If life-sustaining treatment is being refused, the advance decision has to be in writing, signed and witnessed, and has to include a statement saying that it applies even if life is at risk.

## **Attorney**

The person an individual chooses to manage their assets or make decisions under a Lasting Power of Attorney or Enduring Power of Attorney.

## **Best interests**

The duty of decision makers to have regard to a wide range of factors when reaching a decision or carrying out an act on behalf of a person who lacks capacity.

## **Capacity**

The ability to make a decision.

## **Contemporaneous**

At the same time. Any person with capacity can refuse treatment at the time it is offered. An advance decision means accepting what the person wanted some time ago is what they want now.

## **Court of Protection**

Where there is a dispute or challenge to a decision under the Mental Capacity Act 2005, this Court decides on such matters as whether a person has capacity in relation to a particular decision, whether a proposed act would be lawful, and the meaning or effect of a Lasting Power of Attorney or Enduring Power of Attorney.

## **Court-appointed deputy**

An individual or trust corporation appointed by the Court of Protection to make best interests decisions on behalf of an adult who lacks capacity to make particular decisions.

## **Decision maker**

Someone working in health or social care or a family member or unpaid carer who decides whether to provide care or treatment for someone who cannot consent; or an attorney or deputy who has the legal authority to make best interests decisions on behalf of someone who lacks the capacity to do so.



### **Donor**

The person who makes a Lasting Power of Attorney to appoint a person to manage their assets or to make personal welfare decisions.

### **Enduring Power of Attorney (EPA)**

A power of attorney to deal with property and financial affairs established by previous legislation. No new EPAs can be made after the Mental Capacity Act 2005 is implemented, but existing EPAs continue to be valid.

### **Independent mental capacity advocate (IMCA)**

An advocate who has to be instructed when a person who lacks capacity to make specific decisions has no one else who can speak for them. They do not make decisions for people who lack capacity, but support and represent them and ensure that major decisions regarding people who lack capacity are made appropriately and in accordance with the Mental Capacity Act 2005.

### **Lasting Power of Attorney (LPA)**

A power under the Mental Capacity Act 2005 which allows an individual to appoint another person to act on their behalf in relation to certain decisions regarding their financial, welfare and healthcare matters.

### **Public Guardian**

This official body registers Lasting Powers of Attorney and court-appointed deputies and investigates complaints about how an attorney under a Lasting Power of Attorney or a deputy is exercising their powers.



# Notes





