HM Government

Mental Capacity Act 2005 Code of Practice

Including the Liberty Protection Safeguards

HM Government

Introduction

The Mental Capacity Act 2005 (‘the Act’) provides a statutory framework in England and Wales, for supporting people aged 16 and over to make their own decisions, alongside setting out the legal framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they may lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. The Act came into force in 2007.

The legal framework provided by the Act is supported by this Code of Practice (‘the Code’), which provides guidance and information about how the Act works in practice. Section 42 of the Act requires the Lord Chancellor to produce a Code of Practice for the guidance of a range of people with different duties and functions under the Act. Section 43 requires that the Lord Chancellor must have consulted the Welsh Government and such other persons as he considers appropriate, before the Code is prepared or revised. The Code is also subject to the approval of Parliament and must have been placed before both Houses of Parliament for a 40-day period without either House voting against it. This Code of Practice has been produced in accordance with these requirements.

The Act and Code are important parts of the UK’s commitment to the United Nations Convention on the Rights of Persons with Disabilities regarding promoting and protecting the rights and freedoms of people who may lack capacity to make decisions.

The Code has statutory force, which means that certain categories of people have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves. These categories of people are listed below.

How should the Code of Practice be used?

The Code of Practice provides guidance to anyone who is working with or caring for people who may lack capacity to make particular decisions. It describes how they should try to support people to make their own decision as far as possible, and their responsibilities when acting or making decisions on behalf of individuals if they lack the capacity to act or make these decisions for themselves.

The Code also provides guidance on the Liberty Protection Safeguards, which were introduced by the Mental Capacity (Amendment) Act 2019. The system authorises arrangements for care and treatment which constitute a deprivation of liberty for people who lack the relevant mental capacity to consent to these arrangements, and provides the necessary safeguards for the person in England and Wales.

Who is the Code of Practice for?

The Act does not impose a legal duty on anyone to 'comply' with the Code – it should be viewed as guidance rather than instruction. But if someone working with or caring for a person who lacks or may lack capacity has not followed relevant guidance contained in the Code, then they will be expected to give good reasons why they have departed from it.

Certain categories of people are legally required to 'have regard to' relevant guidance in the Code of Practice. That means they must be aware of the Code of Practice when supporting or making decisions on behalf of someone who lacks or may lack capacity to make a decision for themselves. They should follow the Code and be able to explain their reasons if they have not.

The categories of people that are required to have regard to the Code of Practice include anyone who is:

- a deputy appointed by the Court of Protection (see chapter 7)
- an attorney under a Lasting Power of Attorney (LPA) (see chapter 8)
- an Independent Mental Capacity Advocate (IMCA) (see chapter 10)
- carrying out research approved in accordance with the Act (see chapter 26)
- acting in a professional capacity for, or in relation to, a person who lacks capacity.
- being paid to carry out actions for or in relation to a person who lacks capacity.

The last two categories cover a wide range of people. People acting in a professional capacity may include:

- a variety of healthcare staff (doctors, dentists, nurses, therapists, radiologists, paramedics etc)
- social care staff (social workers, care managers, children's home staff etc)
- others who may occasionally be involved in the care of people who lack capacity to make the decision in question, such as paramedics, housing workers, or police officers.

People who are being paid to carry out actions for or in relation to a person who lacks capacity may include:

- care assistants in a care home
- care workers providing domiciliary care services,
- Shared Lives carers
- Supported living services
- personal assistants and support workers, and
- others who have been contracted to provide a service to people who lack capacity to consent to that service, for example staff at a day care centre or at an activity group.

However, the Act applies more generally to e*veryone* who works with, or cares for, someone who lacks or may lack capacity to make particular decisions for themselves. This includes family carers or other unpaid carers. The guidance given in the Code will help them to understand the Act and apply it. They should follow the guidance in the Code as far as possible.

What does 'lacks capacity' mean?

One of the most important terms in the Code is 'a person who lacks capacity'.

Whenever the term ‘a person who lacks capacity’ is used, it **means a person who lacks capacity to make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken.**

This reflects the fact that people may lack capacity to make some decisions for themselves but will have capacity to make other decisions. For example, they may have capacity to make small decisions about everyday issues such as what to wear or what to eat but lack capacity to make more complex decisions about financial matters.

It also reflects the fact that a person who lacks capacity to make a decision for themselves at a certain time may be able to make that decision at a later date. For example, they may have an illness or condition that means their capacity changes. Alternatively, it may be because at the time the decision needs to be made, they are unconscious or barely conscious, whether due to an accident or being under anaesthetic, or their ability to make a decision may be affected by the influence of alcohol or drugs.

Finally, it reflects the fact that while some people may always lack capacity to make some types of decisions – for example, due to a condition or severe learning disability that has affected them from birth – others may learn new skills that enable them to gain or regain capacity to make decisions for themselves.

Chapter 4 provides a full definition of what is meant by ‘lacks capacity’.

What does the Code of Practice actually cover?

The Code explains the Act and its key provisions.

- **Chapter 1** introduces the Mental Capacity Act 2005.
- **Chapter 2** sets out the five statutory principles behind the Act and the way they affect how it is put in practice.
- **Chapter 3** explains how the Act makes sure that people are supported to make their own decisions as far as possible. It also provides guidance on keeping the person at the centre of the Liberty Protection Safeguard system.
- **Chapter 4** explains how the Act defines ‘a person who lacks capacity to make a decision’ and sets out a clear test for assessing whether a person lacks capacity to make a particular decision at a particular time.
- **Chapter 5** explains what the Act means by acting in the best interests of someone lacking capacity to make a decision for themselves, and describes the checklist set out in the Act for working out what is in someone’s best interests.
- **Chapter 6** explains how the Act protects people who provide care or treatment for someone who lacks the capacity to consent to the action being taken.
- **Chapter 7** describes the role of the Court of Protection, established under the Act, to make decisions or declarations in cases where there is no other way of resolving a matter affecting a person who lacks capacity to make the decision in question. The chapter also provides guidance on the role of the court in the Liberty Protection Safeguards process.
- **Chapter 8** explains how people who wish to plan ahead for the possibility that they might lack the capacity to make particular decisions for themselves in the future are able to grant Lasting Powers of Attorney (LPAs) to named individuals to make certain decisions on their behalf, and how attorneys appointed under an LPA should act.

- **Chapter 9** describes the role of deputies appointed by the Court of Protection to act and make decisions on behalf of someone who lacks capacity to make those decisions and explains how they are supervised.
- **Chapter 10** describes the role of Independent Mental Capacity Advocates (IMCAs) appointed under the Act to help people who lack capacity to make certain significant decisions. It also sets out when they should be instructed. Chapter 10 also describes the role of IMCAs under the Liberty Protection Safeguards.
- **Chapter 11** explains the procedures that must be followed if someone wishes to make an advance decision to refuse medical treatment to come into effect when they lack capacity to refuse the specified treatment.
- **Chapter 12** introduced and explains the definition of a deprivation of liberty for the purposes of the Liberty Protection Safeguards. The Liberty Protection Safeguards can only be used to authorise arrangements that give rise to a deprivation of liberty.
- **Chapter 13** provides guidance on each step of the Liberty Protection Safeguard process.
- **Chapter 14** explains the role and responsibilities of the Responsible Body in the Liberty Protection Safeguard process and explains how the correct Responsible Body is identified.
- **Chapter 15** describes the role of the Appropriate Person under the Liberty Protection Safeguards, appointed to provide representation and support for the person throughout the process.
- **Chapter 16** describes the three assessments and determinations required by the Liberty Protection Safeguards. This chapter also provides guidance on who can carry out these assessments and determinations.
- **Chapter 17** describes the consultation in the Liberty Protection Safeguard process and sets out who should be consulted and at which stage consultation should take place.
- **Chapter 18** explains the role of the Approved Mental Capacity Professional (AMCPs) under the Liberty Protection Safeguards process. The AMCP is a specialist role that provides enhanced oversight for those people that need it most.
- **Chapter 19** gives guidance on section 4B of the Act, which provides the legal basis for decision makers to take steps to place restrictions on a person in exceptional circumstances, when it is necessary to make a decision to carry out life-sustaining treatment or a vital act to prevent a serious deterioration in the person's condition.
- **Chapter 20** provides information on how the Liberty Protection Safeguards system will be monitored by relevant monitoring bodies in England and Wales, who the monitoring bodies are, what data must be provided to them and the powers monitoring bodies may exercise to carry out their monitoring responsibilities.
- **Chapter 21** explains those parts of the Act which can apply to children and young people and how these relate to other laws affecting them. This chapter also explains how the Liberty Protection Safeguards system applies to 16- and 17-year olds.
- **Chapter 22** explains how the Act relates to the Mental Health Act 1983 and provides specific guidance on the interface between the Mental Health Act and the Liberty Protection Safeguards.
- **Chapter 23** describes the different agencies that exist to help make sure that adults who lack capacity to make a decision for themselves are protected from abuse and neglect.
- **Chapter 24** examines the various ways that disputes over decisions made under the Act or otherwise affecting people who lack capacity to make relevant decisions can be resolved. This chapter also provides guidance specific to challenging the Liberty Protection Safeguards process and, where applicable, authorisations.

- **Chapter 25** summarises how the laws about data protection and freedom of information relate to the provisions of the Act.
- **Chapter 26** provides guidance on how the Act sets out specific safeguards and controls for research involving, or in relation to, people lacking capacity to consent to their participation.

What is the legal status of the Code?

Where does it apply?

The Act and therefore this Code applies to everyone it concerns who resides or is present in England and Wales. However, it will also be possible for the Court of Protection to consider cases which involve persons who have assets or property outside this jurisdiction, or who live abroad but have assets or property in England or Wales.

What happens if people don't comply with it?

A failure to comply with the Code can be used in evidence before a court or tribunal in any civil or criminal proceedings, if the court or tribunal considers it to be relevant to those proceedings. If a court or tribunal believes that anyone making decisions for someone who lacks capacity has not acted in the best interests of that person, the court can use their failure to comply with the Code as evidence. That's why it is important that anyone working with, or caring for, a person who lacks or may lack capacity to make specific decisions should become familiar with the Code.

Where can I find out more?

The Code of Practice is not an exhaustive guide or complete statement of the law. Other materials have been produced by the Department of Health and Social Care, the Office of the Public Guardian and the Court of Protection to help explain aspects of the Act from different perspectives and for people in different situations. These include guides for family carers and other carers and basic information of interest to the general public. Many charities and third sector organisations have also produced factsheets and guides. Professional organisations may also produce specialist information and guidance for their members. Many workplaces now have policies and procedures on the MCA and the Code that staff should be aware of.

The Code also provides information on where to get more detailed guidance from other sources. (Further information appears in the footnotes to each chapter.) References made and any links provided to material or organisations do not form part of the Code and do not attract the same legal status. Signposts to further information are provided for assistance only and references made should not suggest that the Government endorses such material. Decision-makers should be aware that links provided in footnotes may not be to the latest version of regulations, and may wish to seek their own legal advice when considering the information provided in these references

Using the code

References in the Code of Practice

Throughout the Code of Practice, the Mental Capacity Act 2005 is referred to as 'the Act' and any sections quoted refer to this Act unless otherwise stated. References are shown as follows: section 4(1). This refers to the section of the Act. The subsection number is in brackets.

Where reference is made to provisions from other legislation, the full title of the relevant Act will be set out, for example ‘the Mental Health Act 1983’, unless otherwise stated. (For example, in chapter 13, the Mental Health Act 1983 is referred to as MHA and the Mental Capacity Act as MCA.) The Code of Practice is referred to as the Code.

Scenarios used in the Code of Practice

The Code includes many boxes within the text in which there are scenarios, using imaginary characters and situations. These are intended to help illustrate what is meant in the main text. The scenarios should not in any way be taken as templates for decisions that need to be made in similar situations.

Alternative formats and further information

The Code is also available in Welsh and easy read and can be made available in other formats on request.

Contents

1. What is the Mental Capacity Act 2005?

The Mental Capacity Act 2005 (the Act) provides the legal framework for supporting people aged 16+ to make their own decisions, alongside setting out the legal framework on how to make decisions on behalf of individuals who lack the mental capacity to do so for themselves. Everyone working with and/or caring for a person who may lack capacity to make a specific decision must comply with this Act when supporting or making a decision for that person. The same rules apply whether the decision is regarding a life-changing event or everyday situation.

The Act's starting point is that it should be assumed that a person has legal capacity to make a decision for themselves (the right to autonomy) unless it is established that they do not have capacity. A person will lack capacity if an assessment shows that they do not have capacity to make a decision at the time it needs to be made. The Act also states that people must be given all practicable help and support to enable them to make their own decision, or to maximise their participation in any decision-making process.

The underlying philosophy of the Act is to empower people to make their own decisions where possible and to ensure that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves is made in their best interests.

The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for them from being overly restrictive or controlling. But the Act also aims to balance an individual's right to make a decision for themselves with their right to be safeguarded from harm if they lack capacity to make a decision to protect themselves. The Act, with the Mental Capacity (Amendment) Act 2019, also sets out the provisions for the lawful deprivation of liberty of someone who lacks capacity.

The Act sets out core principles and framework for making decisions and carrying out actions in relation to a wide range of matters including personal welfare, healthcare and financial matters.

The Act contains several roles, bodies and powers, all of which support the Act's provisions. These include:

- Attorneys appointed under Lasting and Enduring Powers of Attorney (see chapter 8)
- The Office of the Public Guardian (OPG) (see particularly chapters 8 and 9)
- The Court of Protection (see chapter 7)
- Court-appointed deputies (see chapter 9)
- Independent Mental Capacity Advocates (see chapter 10)
- Responsible Body (see chapter 14)

- Approved Mental Capacity Professional (see chapter 18)
- Appropriate Person (see chapter 15)
- Monitoring Bodies (see chapter 20)

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

1.1 The Act applies to a very 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, what to buy when doing the weekly shopping, or routine medical treatment
- major life-changing events, such as whether the person should move into a care home or undergo major medical treatment

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

1.3 Sections 27 to 29 and section 62 of the Act set out the specific decisions which can never be made or actions which can never be carried out on behalf of a person who lacks capacity 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)

1.4 Section 27 of the Act specifically excludes decisions relating to 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
- giving consent under the Human Fertilisation and Embryology Act 2008

1.5 A capacity assessment should be undertaken if necessary, in order to establish whether the person lacks capacity to make a decision on one of these matters. See Chapter 4 on assessing capacity.

Mental Health Act matters (section 28)

1.6 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
- consent to the person being given treatment for mental disorder

1.7 Further guidance is given in chapter 22 of the Code.

Voting rights (section 29)

1.8 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. Nobody has to demonstrate they have the "mental capacity to vote".1

Unlawful killing or assisting suicide (section 62)

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

1.10 Although the Act does not allow anyone to make a decision about any of these matters on behalf of someone who lacks capacity, this does not prevent action being taken to safeguard a person at risk of abuse or exploitation. Where the person is unable to consent to such action, the action taken must be in their best interests and if necessary an application should be made to the High Court to consider the matter under its inherent jurisdiction (see paragraph 7.14).

How does the Act relate to other legislation?

1.11 The Mental Capacity Act 2005 applies in conjunction with other legislation affecting people who may lack capacity in relation to specific matters. This means that those acting under the Act should also be aware of their obligations under other legislation, including (but not limited to) the:

- Care Act 2014
- Social Service and Wellbeing (Wales) Act 2014
- Health and Social Care Act 2012
- Data Protection Act 2018
- Equality Act 2010
- Human Rights Act 1998

[1] Electoral Commission guidance on the electoral registration process for people who, for reasons of physical or mental incapacity, may need assistance in order to register details can be found at https://www.electoralcommission.org.uk/sites/default/files/pdf_file/IER-Guidance-on-assisted-applications-in-England-and-Wales.pdf

- Mental Health Act 1983
- Human Tissue Act 2004
- Additional Learning Needs and Education Tribunal (Wales) Act 2018
- Learning and Skills Act 2000
- Mental Health (Wales) Measure 2010
- Regulation and Inspection of Social Care (Wales) Act 2016
- Children and Families Act 2014
- Children Act 1989
- Health and Social Care (Safety and Quality) Act 2015
- United Nations Convention on Rights for Persons with Disabilities
- Fraud Act 2006
- Modern Slavery Act 2017
- Anti-social Behaviour, Crime and Policing Act 2014 (in relation to forced marriage)
- Counter-Terrorism and Security Act 2015

What does the Act say about the Code of Practice?

1.12 Section 42 of the Act sets out the purpose of the Code of Practice, which is to provide guidance for specific people in specific circumstances. Section 43 explains the procedures that have to be followed in preparing the Code and consulting on its contents, and for its consideration by Parliament. Section 42, subsections (4) and (5), set out the categories of people who are placed under a legal duty to 'have regard to' the Code and gives further information about the status of the Code. More details can be found in the Introduction, which explains the legal status of the Code.

2. What are the statutory principles and how should they be applied?

The Act intends to enable and support people aged 16 and over who may lack capacity, to maximise their ability to make decisions. It aims to protect the rights and interests of people who lack capacity to make particular decisions, and enable them to participate in decision-making, as far as they are able to do so.

Section 1 of the Act sets out the five 'statutory principles' – the values that underpin the legal requirements in the Act. This chapter provides guidance on how people should interpret and apply the statutory principles when using the Act.

In this chapter, as throughout the Code, a person's capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

Quick summary

- **Every person has the right to make their own decisions if they have the capacity to do so. Family carers and healthcare or social care staff must assume that a person has the capacity to make decisions, unless it is established that the person does not have capacity.**
- **Before concluding that an individual lacks capacity to make a particular decision, all practicable steps must have been taken to help them make their own decision.**
- **A person who makes a decision that others think is unwise should not automatically be considered as lacking the capacity to make the decision.**
- **Any act done for, or any decision made on behalf of, someone who lacks capacity must be in their best interests.**
- **Any act done for, or any decision made on behalf of, someone who lacks capacity should be an option that is the least restrictive of their basic rights and freedoms, as long as it is still in their best interests.**

What are the statutory principles?

2.1. The five statutory principles are the values that underpin the legal requirements in the Act. They are:

1. A person must be assumed to have capacity unless it is established that they lack capacity.

2. 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.

3. A person is not to be treated as unable to make a decision merely because they make an unwise decision.

4. 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.

5. Before the act is done, or the 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.

What is the purpose of the statutory principles

2.2. The statutory principles aim to:

- Empower people and encourage them to make their own decisions where possible, with support if needed,
- help people to take part, as much as practicable, in a decision that affects them and
- protect the rights and interests of people who lack capacity.

2.3. The principles aim to assist and support people who may lack capacity to make a particular decision, and not to restrict or control their lives. They aim to empower people and encourage supported decision-making as well as ensure that decisions made about a person accord as much as possible, within the law, with that person's wishes, values, beliefs and feelings[2].

2.4. The statutory principles apply to any act done or decision made under the Act. When followed and applied to the Act's decision-making framework, they will help people take appropriate action in individual cases. They will also help people find solutions in difficult or uncertain situations. Failure to observe the principles may leave organisations vulnerable to legal challenge3.

[2] Aintree Hospitals NHS Foundation Trust v James [2013] UKSC https://www.bailii.org/uk/cases/UKSC/2013/67.html

[3] *CH v A Metropolitan Council* [2017] EWCOP12 - https://www.bailii.org/ew/cases/EWCOP/2017/12.html

How should the statutory principles be applied?

Principle 1: 'A person must be assumed to have capacity unless it is established that he lacks capacity.' (section1(2))

2.5. This principle recognises that every adult has the right to make their own decisions – unless it is established that they lack the capacity to make a particular decision when it needs to be made.

2.6. It is important to balance people's right to make a decision with their right to safety and protection. The starting assumption is always that an individual has the capacity, until it is established that they do not. Chapter 4 explains the Act's definition of 'lack of capacity' and the processes involved in assessing capacity. Assuming capacity should not be used as a reason for not assessing capacity in relation to a decision. There should always be a proper assessment where there are doubts about a person's capacity to make a decision. The onus is on the person intending to carry out the intervention to have properly established that capacity is really lacking in the individual concerned. It is not for the individual to prove that they have the capacity to make the decision.

Scenario: Assessing a person's capacity to make decisions

When planning for her retirement, Ms A made and registered a Lasting Power of Attorney (LPA – see chapter 8) – a legal process to allow her son to help her with or act on her behalf in financial matters whilst she has capacity, with her consent; and in the future if she loses capacity to manage them herself. She has now been diagnosed with dementia, and her son is worried that she is becoming confused about money.

Her son must assume that his mother has capacity to manage her affairs. He must consider each of Ms A's financial decisions as she makes them, giving her any help and support she needs to make these decisions herself.

Ms A's son goes shopping with her, and he sees she is capable of finding goods and making sure she gets the correct change. But when she needs to make decisions about her investments, Ms A gets confused – even though she has made such decisions in the past. She still doesn't understand after her son explains the different options.

Her son concludes that she has capacity to deal with everyday financial matters but not more complex affairs. Therefore, he uses the LPA for the difficult financial decisions his mother can't make, whilst still involving her in the decision and considering her wishes and feelings, beliefs and

values. Ms A continues to deal with her other affairs for as long as she has capacity to do so.

2.7. Some people may need help to be able to make a decision or to communicate their decision. However, this does not necessarily mean that they cannot make that decision – unless there is evidence that they do lack the capacity to do so. Anyone who believes that a person lacks capacity should be able to demonstrate why. Chapter 4 explains the standard of evidence required.

Principle 2: 'A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.' (section1(3))

2.8. It is important to do everything practicable to help a person make a decision for themselves before concluding that they lack capacity to do so. People with an illness or disability affecting their ability to make a decision should be supported to help them make as many decisions as they can.

2.9. This principle aims to stop people being wrongly labelled as lacking capacity to make particular decisions, without evidence. Because it encourages individuals to make decisions for themselves, it also helps prevent unnecessary interference in their lives.

2.10. The kind of support people might need to help them make a decision varies. It depends on personal circumstances, the kind of decision that has to be made (there should be clarity about what precisely the decision is) and the time available to make the decision. It might include:

- using a different form of communication (for example, non-verbal communication) providing information in a more accessible form (for example, photographs, drawings, or films)
- considering where and when a decision is made - for some people it may be better that they make a decision at a particular time of day, or in a familiar setting
- treating a medical condition which may be affecting the person's capacity
- having a structured programme to improve a person's capacity to make particular decisions (for example, helping a person with learning disabilities to acquire new skills)
- involving an advocate or a trusted friend (who can advise, or support the person) or
- ensuring the person is spoken to in their preferred language.

2.11. Chapter 3 gives more information on ways to help people make decisions for themselves.

Scenario: Taking steps to help people make decisions for themselves

Ms S has Down's syndrome and is in the last year at her local special school. She communicates using Makaton signing, saying some single words and an assistive communication app on her tablet computer. She also enjoys using her tablet computer to take photos and play games.

She has to decide on her next educational placement. In preparation for making the decision school staff talk with Ms S as well as assisting her to use her tablet computer to take photos of key staff and relevant places in the local further education college. In addition, school staff use Ms S's tablet computer to make videos of her doing various activities in college.

With Ms S's permission, school staff talk with her parents about taking photos and videos when they accompany Ms S on visits to the other colleges she is considering. This enables Ms S to access the information when she wants to look at and for school staff and her parents to talk with her about it to support her making her decision.

When she makes the decision, she will be able to use the photos and videos to assist her.

2.12. Anyone supporting a person who may lack capacity should not use excessive persuasion or allow their support to become pressure. This might include behaving in a manner which is overbearing or dominating, or seeking to influence the person's decision, and could push a person into making a decision they might not otherwise have made. It is important, however, to provide appropriate advice and information, outlining the choices a person has and the implications of making or not making a decision.

Scenario: Giving appropriate advice and support

Mr S has a diagnosis of depression. He does not feel that his current medication is working very well and is also causing him to put on weight. He has told his Community Psychiatric Nurse (CPN) that he wishes to stop taking his medication.

Mr S's CPN has thought about the relevant information that he believes Mr S needs to consider when making this decision. As such he provides Mr S with information about the possible risks of stopping his medication as well as alternatives that he could try. He also knows that Mr S's first language is not English, so he ensures that he provides all the information in Mr S's first language as well as in English.

Using this information Mr S decides to try an alternative medication to see if that makes a difference before stopping medication altogether.

2.13. In some situations, decisions cannot be delayed while a person gets support to make a decision. This can happen in emergency vital act situations or when an urgent decision is required (for example, immediate medical treatment). In these situations, the only practicable and appropriate steps might be to keep a person informed of what is happening and why.

Principle 3: 'A person is not to be treated as unable to make a decision merely because he makes an unwise decision.' (section 1(4))

2.14. Everybody has their own values, beliefs, preferences and attitudes. A person should not be assumed to lack the capacity to make a decision just because other people think their decision is unwise. This applies even if family members, friends, healthcare or social care staff are unhappy with a decision. The Act focuses on the ability of a person to make a decision, not on the outcome of the decision itself [4].

[4] Kings College Hospital Foundation Trust and C and V [2015] EWCOP 80 - https://www.bailii.org/ew/cases/EWCOP/2015/80.html

Scenario: Allowing people to make decisions that others think are unwise

Ms M was involved in a car accident several years ago. At the time she was assessed as lacking capacity to manage her property and financial affairs and a deputy was appointed to manage them for her.

Ms M now believes she has regained capacity to manage her property and financial affairs. Her deputy expresses concern that Ms M is impulsive and reckless with money, and is concerned that Ms M will spend all of her compensation money and have nothing left for her care.

A capacity assessor looks at Ms M's pre-accident history and discovers that thirty years ago Ms M inherited £500,000. At that time, it took Ms M two weeks to spend the money – she bought a sports car and a 5-star round the world trip. Her view on money was 'easy come, easy go' and that she would rather have the instant gratification of spending the money than any delayed gratification that she may not live to appreciate.

It was evident that Ms M's poor money management was not related to her brain injury, rather to her longstanding, pre-accident belief about money.

2.15. There may be cause for concern if somebody:

- repeatedly makes decisions that appear unwise and put them at significant risk of harm or exploitation or
- makes a particular unwise decision that is obviously irrational or out of character.

2.16. These circumstances do not necessarily mean that somebody lacks capacity, as we have a right to make decisions that others may feel are unwise. But there might be a need for further investigation, taking into account the person's past decisions and choices. For example, have they developed a medical condition or disorder that is affecting their capacity to make particular decisions? Are they easily influenced by undue pressure? Or do they need more information or support to help them understand the consequences of the decision they are facing? If there is a proper reason to doubt that the person has capacity to make the decision, it will be necessary to assess their capacity by applying the test in the Act.

Scenario: Decisions that cause concern

Mr R has an acquired brain injury following a car accident. Before the accident Mr R was very good at managing his finances and he believes, post-accident he has retained the ability to manage his property and financial affairs. However, there are concerns from those that know him that he may not have the capacity to do so as he appears unable to keep to a budget.

A capacity assessor asks Mr R if he knows what a budget is, and he replies that it is a set amount of money that he has to spend on a certain items or a project. The assessor asks Mr R about the dangers of overspending and he talks knowledgably about debt.

The assessor notes that each month Mr R overspends his monthly allowance of £2000 and asks him about this. Mr R's response is that he needs more money as what he has is not enough. The assessor explores what Mr R spends his money on and finds that Mr R believes that spending £350 each month on a pair of trainers is reasonable, as is spending £750 per month on taking his friends out to dinner.

Talking to Mr R shows that he is not able to apply the ideas of budgeting and the risk of debt to his own circumstances. While he may appear to be able to weigh up the necessary information in theory, he is not able to apply it in practice.

Principle 4: '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 his best interests.' (section 1(5))

2.17. A person's best interests must be the basis for all decisions made and actions carried out on their behalf in situations where they lack capacity to make those particular decisions for themselves. Exceptions to this are around research (see chapter 26), advance decisions to refuse treatment (see chapter 11), Liberty Protection Safeguards (see chapter 13) and needs assessments under other legislation, where other safeguards apply.

2.18. It is impossible to give a single description of what 'best interests' are, because they depend on individual circumstances. However, section 4 of the Act sets out a checklist of steps to follow in order to determine what is in the best interests of a person who lacks capacity to make the decision in question. See chapter 5 for detailed guidance and examples.

2.19. Best interests decisions should consider the issues from the person's own point of view, taking into account their wishes and feelings, involving them in the decision wherever possible, and including wider considerations than their 'medical' or

'financial' interests[5]. Decision makers must, wherever practicable and appropriate, consult others involved in caring for the person or with an interest in their welfare.

2.20. If the individual has capacity to make a decision, a best interests decision cannot be made for them even if someone believes they have a 'duty of care' towards the person.

Principle 5: 'Before the act is done, or the 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.' (section 1(6))

2.21. Before somebody makes a decision or acts on behalf of a person who lacks capacity to make that decision or consent to the act, they must always question if they can do something else that would interfere less with the person's basic rights and freedoms.

2.22. Where there is more than one option, it is important to explore ways that would be less restrictive or allow the most freedom for a person who lacks capacity to make the decision in question. However, the final decision must always allow the original purpose of the decision or act to be achieved.

2.23. Any decision or action must still be in the best interests of the person who lacks capacity. So sometimes it may be necessary to choose an option that is not the least restrictive alternative if that option is in the person's best interests. In practice, the process of choosing a less restrictive option and deciding what is in the person's best interests will be combined. But both principles must be applied each time a decision or action may be taken on behalf of a person who lacks capacity to make the relevant decision.

Scenario: Finding a less restrictive option

Ms J is in a rehabilitation hospital six months after experiencing a traumatic brain injury. She has some movement in her left hand and very little other movement. A friend has bought her a soft cuddly toy with a long tail which she is just about able to grip.

Ms J has no language yet and little purposeful activity. She enjoys holding the toy moving it across her face for stimulation.

When her parents arrive to visit her one morning, they find she is wearing a 'boxing glove' on her left hand. This prevents her from making any movement. The nurses' rationale is that this is in her best interests as they feared her putting the toy in her mouth and possibly choking.

[5] Aintree Hospitals NHS Foundation Trust v James [2013] UKSC 67. https://www.bailii.org/uk/cases/UKSC/2013/67.html

Ms J's parents point out that a less restrictive option would be to remove the soft toy when she is not monitored, which would keep her safe but would not restrict the only physical movement she has.

3. How should people be helped to make their own decisions?

All practicable steps must be taken to help someone to make their own decisions before it can be concluded that they lack capacity to make that decision themselves (see statutory principle 2, see chapter 2). In addition, as section 3(2) of the Act underlines, these steps (such as helping individuals to communicate) must be taken in a way which reflects the person's individual circumstances and meets their particular needs. This chapter provides practical guidance on how to support people to make decisions for themselves, or to play as big a role as possible in decision-making. This chapter also offers practical guidance on how to ensure that the person is kept at the centre of the LPS process.

In this chapter, as throughout the Code, a person's capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

Quick summary

To help someone make a decision for themselves, check the following points:

- Providing information
- Does the person have all the information they need to make a particular decision?
- If they have a choice, have they been given information on all the alternatives, including not making a decision, right away, or at all?

Communicating in an appropriate way

- Could anyone else help with communication (for example, a family member, support worker, interpreter, speech and language therapist or advocate)?
- Could information be explained or presented in a way that is easier for the person to understand (for example, by using simple language or visual aids)?
- Have different methods of communication been explored if required, including non-verbal communication?

Making the person feel at ease

- Are there particular locations where they may feel more at ease?
- Are there particular times of day when the person's understanding is better?
- Could the decision be put off to see whether the person can make the decision at a later time when circumstances are right for them?

Supporting the person

- Can anyone else help or support the person to make the decision?

How is the person kept at the centre of the LPS process?

- There are a number of decisions that need to be taken during the LPS process, including; on the person's care or treatment, on the arrangements surrounding the care or treatment, on whether they wish to be supported by an Appropriate Person or IMCA.
- The person should always be supported to make those decisions as far as possible. Even if the person lacks the capacity to make one decision, they may still be able to make another.

What information does the person and their Appropriate Person or IMCA have the right to?

- The Responsible Body has a duty to publish certain information, and to ensure that the person and their Appropriate Person (where relevant) understands the information. All information must be accessible.
- The Responsible Body must also ensure that the person and their Appropriate Person understands certain information.

How can someone be helped to make a decision?

3.1 There are several ways in which people can be helped and supported to make a decision for themselves. These will vary depending on the decision to be made, the timescale for making the decision, and the individual circumstances of the person making it.

3.2 The Act applies to a wide range of people with different conditions that may affect their capacity to make particular decisions. So the appropriate steps to take will depend on:

- a person's individual circumstances (for example, somebody with learning difficulties may need a different approach to somebody with dementia)
- the decision the person has to make, and
- the length of time they have to make it

3.3 Significant, one-off decisions (such as moving house) will require different considerations from day-to-day decisions about a person's care and welfare. However, the same general processes should apply to each decision.

3.4 The purpose of support is to enable the person to make their own decision. The person giving support may think a specific decision is best. But they should not pressure the person they are supporting into choosing that specific decision. This is particularly important where the person's life experiences mean that they have only very limited experience of being allowed to make their own decisions.

3.5 Providing appropriate support with decision-making should be a core part of a person-centred approach to the care and support planning process.

What happens in emergency situations?

3.6 Clearly in emergency situations (for example, where a person collapses and is brought unconscious into a hospital), urgent decisions will have to be made and immediate action taken in the person's best interests. In these situations, it may not be practicable or appropriate to delay the decision while trying to help the person make their own decisions or to consult with any known attorneys or deputies. However, even in emergency situations, health and social care staff should try to find out what they can about the person's wishes and feelings, (by asking other people if necessary), and should communicate with the person and keep them informed of what is happening.

What information should be provided to people and how should it be provided?

3.7 It is important to provide information that will help the person to make decisions and to tailor that information to the individual's needs and abilities. Information must also be in the easiest and most appropriate form of communication for the person concerned. For example, some people respond better when given information verbally, others may like to read a leaflet before they decide. Some may also require support from a carer or friend who may know how best to communicate with the person, or their preferred way to receive information.

3.8 What information should be provided to the person will depend on the nature of the decision. For example, if the decision concerns medical treatment, the doctor must explain the purpose and effect of the course of treatment and the likely consequences of accepting or refusing treatment.

3.9 Anyone helping someone to make a decision for themselves should follow these steps:

- Take time to explain anything that might help the person make a decision. It is important that they have access to all the information they need to make an informed decision, including the nature of the decision and why it needs to be made.
- Try not to give more detail than the person needs as this might confuse them. In some cases, a simple, broad explanation will be enough. But it must not miss out important relevant information.
- What are the risks and benefits? Describe any foreseeable consequences of making the decision, and of not making any decision now or at all.
- Explain the effects the decision might have on the person and those close to them – including anyone involved in their care.
- If they have a choice, give them the information for each of the options, in a balanced way.
- For some types of decisions, it may be important to give access to advice from elsewhere. This may be independent or specialist advice (for example, from a medical practitioner or a financial or legal adviser). But it might simply be advice from trusted friends or relatives.
- It may be helpful to make a record of the information provided and the steps taken to communicate it.

Communication – general guidance

3.10 To help someone make a decision for themselves, all possible and appropriate means of communication should be tried:

- The first step should be to ask the person if they would like any help, or if there is anyone who they would like to be there with them, for example, relatives, friends, a GP, social worker, religious community member, any attorneys appointed under a Lasting Power of Attorney, or deputies appointed by the Court of Protection.
- Ask people who know the person well about the best form of communication (try speaking to family members, carers, day centre staff or support workers). They may also know somebody the person can communicate with easily, or the time when it is best to communicate with them.
- Use appropriate language. Where appropriate, use pictures, objects or illustrations to demonstrate ideas.

- Speak at the right volume and speed, with appropriate words and sentence structure. It may be helpful to pause to check understanding, to ask open questions that check understanding, or show that a choice is available.
- Break down difficult information into smaller points that are easy to understand. Allow the person time to consider and understand each point before continuing.
- It may be necessary to repeat information or go back over a point several times, in order to enable the individual to retain the information long enough to make an effective decision.
- Be aware of cultural, ethnic or religious factors that may influence a person's way of thinking, behaviour or communication. For example, some people may be used to involving members of their community in decision-making. Someone's religious beliefs may influence their approach to medical treatment decisions. Awareness of cultural considerations should be balanced with awareness of other relevant considerations such as undue pressure or coercion, and safeguarding duties.

Scenario: Providing relevant information in an appropriate way

Mr T has some physical disabilities and had a traumatic brain injury 5 years ago. His personal injury claim has been settled and his parents have been appointed as his finance and health and welfare deputies.

A care team now needs to be appointed to support Mr T in his own home. While his parents have the authority to make the decision, their aim is to support Mr T to make the decision himself.

In discussion with Mr T, they identify the things that are most important in his life. These are presented in a visual job advert and posted online. Mr T, his parents and case manager together consider and agree who to interview.

The interview is in an informal setting at a local restaurant. Firstly, everyone socialises over lunch, then the candidates are involved in a group discussion and finally a 1:1 interview. Photos are taken of the candidates so that Mr T has a visual record.

After the interview Mr T, his parents and his case manager discuss who to appoint. They all come to same conclusion about two people. Mr T is able to say simply why he preferred these two, the case manager has a

professional perspective, and Mr T's parents are happy that they do not need to use their decision-making power as deputies.

Scenario: Helping people with complex communication needs

Ms C is 18 and attends her local special school. Ms C has profound and multiple learning difficulties, and vocalises but has no recognisable speech. On Friday afternoons, students choose between time in the ball pool or the sensory room. Throughout the school all school staff use the

same objects of reference for each activity, the ball pool is represented by one of the balls and the sensory room by a scented cushion.

Therefore, Ms C has become familiar with the activities and associated objects of reference. On Friday afternoons the classroom is scented with mandarin to help the students distinguish it from other days of the week. The teacher or support assistant works with each student individually to support them making their choice at the beginning of the afternoon session. The student is given both the ball and cushion to touch and smell and then asked to choose.

The school staff are aware that Ms C likes both activities, but possibly prefers the ball pool, as she seems to be willing to stay longer and uses the vocalisation staff know indicates she is happier in the ball pool than the sensory room. When she is asked to choose the staff observe which object of reference she reaches for first. To confirm whether she is making a real choice the staff swap the objects of reference to check her decision. If she does not make the decision, the staff have already ascertained from her parents, via the home school book, which activity they believe she would like to do.

Whether she makes the decision, or her parents do, Ms C is given the object of reference for the chosen activity and it is explained to her this is what she is going to do and is then taken to the activity.

Helping people with specific communication or cognitive problems

3.11 Where people have specific communication or cognitive problems, the following steps can help:

- Find out how the person is used to communicating. Do they use picture boards or Makaton (signs and symbols for people with communication or learning difficulties) or do they have a way of communicating that is only known to those close to them?
- If the person has hearing difficulties, use their preferred method of communication (for example, British Sign Language, visual aids, written messages or sign language). Where appropriate, use a qualified interpreter.
- Is assistive communication technology such as voice synthesisers, keyboards or other computer equipment available to help?
- If the person does not use verbal communication skills, allow more time to communicate effectively.
- For people who use non-verbal methods of communication, their behaviour (in particular, changes in behaviour or distress) can provide indications of their feelings.

- Some people may prefer to use non-verbal means of communication and can communicate most effectively in written form using computers or other communication technologies. This is particularly true for those with autistic spectrum disorders.
- For people with specific communication difficulties, it may be appropriate to seek advice or support from a professional, for example, a speech and language therapist or an expert in clinical neuropsychology.

Scenario: Making the most of technology

Mr A has a mild learning disability and cerebral palsy. He uses very little verbal communication and relies on assistive technology to communicate effectively. He was admitted to hospital and a surgical intervention was proposed by the medical team. Mr A's communication difficulties and learning disability raised concerns about his capacity to consent to this procedure.

The hospital speech and language team, along with other members of hospital staff, spent time with Mr A explaining the intervention to him in a way that he could understand after liaising with his family and community speech and language therapist. Easy read written information is provided for him to peruse in his own time. The speech and language therapists involved in Mr A's care create a plan to help him communicate his wishes during the mental capacity assessment.
Mr A's assistive technology device is brought to the hospital and he is supported to practise using this, but alternative methods of communication are also planned in case he does not feel confident using it as, due to his illness he has not used it in some time. Flashcards with "Yes" and "No" are used as a supplementary communication tool. The mental capacity assessment was also broken down into parts that could be answered using "yes" and "no" answers.

Using a mixture of the above, the hospital team demonstrates that Mr A has capacity to consent to the medical investigation. He communicates his wishes regarding his health and wellbeing.

The medical procedure was undertaken successfully. Similar steps are taken to discuss with Mr A how to manage the findings of the investigation.

What steps should be taken to put a person at ease?

3.12 To help put someone at ease and so improve their ability to make a decision, careful consideration should be given to both location and timing.

Location

3.13 In terms of location, consider the following:

- Where possible, choose a location where the person feels most at ease. For example, people are usually more comfortable in their own home than at a doctor's surgery.
- Would the person find it easier to make their decision in a relevant location? For example, could you help them decide about medical treatment by taking them to hospital to see what is involved?
- Choose a quiet location where the discussion will not be easily interrupted.
- Try to eliminate any background noise or distractions (for example, the television or radio, or people talking).
- Choose a location where the person's privacy and dignity can be properly respected, and the person is free from influence so can make their own decision.

Timing

3.14 In terms of timing, consider the following:

- Try to choose the time of day when the person is most receptive – some people are better in the mornings, others are more alert in the afternoon or early evening. It may be necessary to meet several times before a decision can be made.
- If the person's capacity is likely to improve in the foreseeable future, wait until it has done so – if practicable and appropriate. For example, this might be the case after treatment for depression or a psychotic episode. This may not be practicable and appropriate if the decision is urgent.
- Some medication can affect a person's capacity (for example, medication which causes drowsiness or affects memory). Can the decision be delayed until side effects have subsided?
- Take one decision at a time – be careful to avoid making the person tired or confused.
- Don't rush – allow the person time to think things over or ask for clarification, where that is possible and appropriate.
- Avoid or challenge time limits that are unnecessary if the decision is not urgent. Delaying the decision may enable further steps to be taken to assist people to make the decision for themselves.

Scenario: Putting a person at ease

Ms K has moderate learning disabilities and needs a diagnostic scan. She finds hospital environments daunting and says that she sometimes doesn't understand verbal instructions, finding visual information easier than spoken and written information.

She meets with her consultant, support worker and Learning Disabilities Clinical Nurse Specialist to consider the scan. The medical team want to ensure she has capacity to consent to the procedure if possible. The consultant explains the risks and benefits of the procedure to her, in simple language, allowing time for her to process the information. Ms K is also offered a tour of the scanning department.

In this way Ms K is able to understand and retain the information and communicate this to the consultant. She says she is happy to have the scan and signs the consent form.

During the procedure Ms K is supported by a member of the Learning Disabilities team. She completes the scan successfully.

Support from other people

3.15 In many cases, ensuring that a person has someone else there to support them will enable them to make their own decision (and therefore supports principle 2). This may be because this will put them at their ease and reduce anxiety. It may also be because the person can help interpret the way in which they communicate. Often the person can provide information on who would help them make a decision (or, in some cases, who would not help them). Such information from the person must be taken seriously and given appropriate weight.

3.16 It is important to make sure that the person is happy to receive support and that they trust the person who is supporting them. All practicable steps should be taken to avoid the risk of coercion or undue influence.

3.17 If there are no significant trusted people, or no-one willing to provide support then it may be appropriate to consider an advocate.

3.18 A professional who has to decide whether the person has the capacity to make the decision in question should watch the interaction between the individual and the person providing them with support. If the professional feels that the supporter is not seeking to enable the person to make their own decision or is trying to get the

person to make the decision that the supporter wishes, they may have to ask the supporter to leave.

3.19 Professionals who are involving others should be aware of the confidentiality requirements and responsibilities under the common law duty of confidentiality and as set out in the UK General Data Protection Regulation (GDPR) and the Data Protection Act 2018 (see chapter 25). This limits what can be shared with others. If the person has capacity in relation to information sharing, under the common law duty of confidentiality no confidential information can be shared without their consent [unless there is an overriding public interest in disclosing or legal duty or authorisation to disclose]. Any disclosure of personal data will also need to meet one of the lawful grounds in Article 6 of the UK GDPR. If the information is special category data for the purposes of the UK GDPR it will also need to meet one of the conditions in Article 9 of the UK GDPR or Schedule 1 to the Data Protection Act 2018. Professionals should refer to professional and employers' guidance for further information.

Scenario: Concerns about undue influence

Ms T has dementia and lives in her own home. She has recently experienced a couple of falls, the latest of which left her hospitalised. She temporarily agrees to move to a care home until fit enough to return home. As her agreed time at the care home comes to an end, staff considered her need to stay at the care home as she has experienced another fall there.

Ms T's son has lasting power of attorney (LPA) for health and welfare and raises concerns about her frailty and occasional moments of confusion about where she is. He says Ms T needs to continue her stay at the care home. Ms T agrees on this occasion, which conflicts with the view she had previously consistently expressed, which was to return home as soon as possible.

A member of staff at the care home has concerns about the distress Ms T appears to be in and the influence the son may have had on the change in Ms T's response. She assesses Ms T's capacity to make this decision, speaking to her about her concerns when the son is not present. This uncovers Ms T's fear of being a burden on her son as this could increase the amount of care support he may need to provide her with.

The member of staff assesses that Ms T has retained and used the relevant information and therefore has capacity to make the decision to return home with a care package to support her. Although Ms T's son has

an LPA, it does not apply as she has capacity to make this decision about her care.

What other ways are there to enable decision-making?

3.20 There are other ways to help someone make a decision for themselves.

- Many people find it helpful to talk things over with people they trust or people who have been in a similar situation or faced similar dilemmas. For example, people with learning difficulties may benefit from the help of a designated support worker or being part of a support network.
- If someone is very distressed (for example, following a death of someone close) or where there are long-standing problems that affect someone's ability to understand an issue, it may be possible to delay a decision so that the person can have psychological therapy, if needed.
- Some organisations have produced materials to help people who need support to make decisions and for those who support them. Some of this material is designed to help people with specific conditions, such as Alzheimer's disease or profound learning disability.
- In some situations – for example, when considering sexual relationships - tailored training courses may help to the person to understand what they need to in order to make a decision.

Scenario: Getting support from other people

Ms R has learning disabilities and recently told staff at the care home where she lives that she wants to have sex with her boyfriend. After speaking to Ms R about this, staff are clear that Ms R does not understand that she could get pregnant if she has sex, or how babies are made.

Staff assess Ms R as lacking the capacity to consent to sex. They understand that this means that they will have to stop her from having sex with her boyfriend, which will upset her.

Staff devise a tailored plan that includes providing Ms R with sex education over the course of the next month. They will reassess her capacity at the end of the course with a view to undertaking more training if she still lacks capacity to decide to have a sexual relationship.

How is the person involved in the Liberty Protection Safeguards process?

3.21 The Liberty Protection Safeguards (LPS) offer protections for people who need to have arrangements put in place, for their care or treatment, which amount may to a deprivation of their liberty but who lack or may lack the relevant mental capacity to consent to those arrangements. It must never be assumed that a person lacks the capacity to consent to the arrangements. There are, therefore, a number of steps decision-makers should take before triggering, and during, the LPS process.

3.22 There are also a number of decisions to be made by the person themselves during the LPS process, such as making a request to be represented and supported by an IMCA (Independent Mental Capacity Advocate) and applying to the Court of Protection. Each of these decisions should be treated individually. It should not be assumed that the person does not have the capacity to make one decision, purely because they lacked the capacity to make a different one. Professionals and other staff who work with the person should ensure that the person, and the IMCA or Appropriate Person, have the relevant information available to them to help them make any such decisions. Whether or not the person has the relevant capacity, the decision maker must always ensure they are involved in decision as far as possible. Information should be made available about the Liberty Protection Safeguards overall and also about the particulars of individual cases.

Key decisions that are relevant to support the person in the LPS process

3.23 There are a number of decisions that may be required at different stages: prior to the process being triggered, during the assessments stage, or once an authorisation is in place. The person should be supported to make each of these decisions as far as possible. Full details of the LPS process are provided in chapter 13.

3.24 Prior to the LPS process a decision will need to be made regarding the person's care and treatment. The person should be supported to make their own decision as far as possible. However, if they lack capacity to consent to that care or treatment a 'best interests' decision may be needed. Please see chapter 5 for more information on best interests decisions.

3.25 If a best interests decision has been made regarding the care or treatment, a further decision about the arrangements enabling the person's care or treatment may be needed. The person should be supported as far as possible to make the decisions

regarding their care and treatment, or the arrangements enabling it, before the LPS process is triggered.

3.26 Depending on the circumstances of the case, the person could be supported to understand the following sort of information about the arrangements:

- Where are the arrangements taking place? Has the person had to move to a new place to receive the care or treatment?
- How long will the arrangements be in place for? How long they may be treated or cared for in the new accommodation?
- Is the accommodation near activities that the person enjoys and are they still able to access those activities under the new arrangements?
- Will the person be able to see their friends and family under the new arrangements?
- Who lives in the accommodation(s) and who delivers care to the person? Are they people that the person gets on with or is close to? Does the person feel supported at that place?
- Will the person be allowed to spend time on their own or will they need to be supervised at all times?
- Will the person be free to spend the day how they wish or will they have to follow a certain schedule?
- Will the person be able to decide to live or receive care or treatment somewhere else?

3.27 These questions do not constitute a test of capacity. However, in appropriate cases, they may help the person express their wishes and feelings about the arrangements, and in turn help decision-makers to determine whether they have capacity to consent to them. In order to support the person to consent to the arrangements, decisions-makers should:

- ensure that the person has all the relevant information to understand the proposed arrangements;
- explain the consequences of the arrangements, to help the person best understand how they will affect their life;
- use the best communications method for the person (please see paragraphs 3.11 above for more information).
- Decision makers should also consider this alongside the advice set out in chapter 12, regarding the test of capacity required for different settings.

3.28 Even though it may be determined that the person does not have the capacity to make a decision about the arrangements that amount to a deprivation of liberty, the person may still be able to express their wishes and feelings about these arrangements, for example, through things that they say or their behaviour. The

Responsible Body should take into account the views and wishes of the person when deciding whether to authorise the arrangements. The Responsible Body must also carry out a consultation process to determine the person's wishes and feelings about the arrangements. Please see chapter 14 for more information.

3.29 The person should be supported where appropriate through the LPS process. It is therefore key in most cases that someone is there to represent and support them in interactions with the Responsible Body and, where relevant, in the court. In the LPS process, the person may be supported and represented by an Independent Mental Capacity Advocate (IMCA) or an Appropriate Person. The person should be supported to be involved in the appointment of their representation and support, as far as possible. this should involve, as far as possible, supporting the person to understand the differences between an IMCA and an Appropriate Person and make a decision about which form of representation is best for them. The person may request the support of an IMCA, if they have the capacity to do so. Please see chapter 10 for more information on IMCAs.

3.30 Alternatively, if there is a potentially suitable individual who could be appointed as the Appropriate Person, the person would need to consent to the appointment, if they have the capacity to do so. The person should be supported to make this decision as far as possible. In most cases, where the person does not want an Appropriate Person appointed – irrespective of whether they have the relevant capacity - this will normally mean that individual should not be appointed. But there will be some cases where nevertheless the Responsible Body will still consider it is in the person's best interests for the Appropriate Person to be appointed. If an Appropriate Person should not be appointed, the Responsible Body will need to consider if the legal criteria for the appointment of an IMCA applies. Please see more information on the Appropriate Person in chapter 15.

3.31 Once an authorisation is in place, the person may wish to challenge the arrangements, or request a review of the arrangements. If the person is unhappy with the arrangements, their IMCA or Appropriate Person should support them to decide what they would like to do next. Please see chapter 10 and 15 for more information.

The person's information rights

3.32 The Responsible Body must publish information about the LPS process that is accessible and appropriate to the needs of the person and the Appropriate Person. The information that the Responsible Body must publish is:

- the effect of an LPS authorisation including, assessments and determinations, consultation, and pre-authorisation reviews,
- the process for authorising arrangements,
- the circumstances in which an IMCA should be appointed,

- the role of the Appropriate Person,
- when a case will be considered by an AMCP at pre-authorisation review stage,
- the person's right to challenge the arrangements and authorisation in the Court of Protection, and how they bring such a challenge, and,
- how reviews will be carried out, and the circumstances leading to reviews.

Please see chapter 14 for more information on the Responsible Body and what each of these headings should include.

3.33 The Responsible Body must also take practical steps to ensure that the person who is going through the LPS process, and their Appropriate Person understand certain matters. This includes the matters listed in paragraph 14.68, and how they apply to the person's case, and the nature of the proposed arrangements. If the person or their Appropriate Person or IMCA has a specific communication need, the Responsible Body should consider providing assistance and respond to all reasonable requests for communication methods.

3.34 In addition to this, the person, or their Appropriate Person or IMCA may seek the following information from the relevant Responsible Body:

- How section 4B of the Act applies before a decision about an authorisation is made, and how the person may challenge any deprivation of liberty that is being justified under this power. Section 4B enables decision makers to take steps to deprive a person of their liberty without an LPS authorisation in place, where certain conditions are met. Please see chapter 19 for more information on section 4B.
- How and when the person and their Appropriate Person or IMCA can access other relevant information about the LPS process e.g. how to access a copy of their records.
- Information about renewals of LPS authorisations.
- How to suggest someone for the Appropriate Person role, or how the Appropriate Person may step down from the role, if they wish to.
- How the LPS process interacts with other health and care legal frameworks (for example, under the Care Act 2014 or Children Act 1989), and how this may impact the person.
- How to raise complaints about the LPS process with the Responsible Body.

3.35 The person has a right to information about their case at any time, this includes the assessments and determinations or consultation. Where an authorisation is given, the person must also be sent their authorisation record within 72 hours. If it is not already shown on the record, the person or their Appropriate Person or IMCA can request to see if there was any disagreement between the Responsible Body and the individual carrying out the pre-authorisation review. This may be most relevant

where the Approved Mental Capacity Professional has carried out the pre-authorisation review. This also applies after a renewal is given.

4. How does the Act define a person's capacity to make a decision and how should capacity be assessed?

This chapter explains what the Act means by 'capacity' and 'lack of capacity'. It provides guidance on how to assess whether someone has the capacity to make a decision, and suggests when professionals should be involved in the assessment.

In this chapter, as throughout the Code, a person's capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

Quick summary

Presuming someone has capacity

- There is a presumption that people have the capacity to make their own decisions. If there is a proper reason to doubt that the person has capacity to make the decision, it is necessary to assess their capacity.

Understanding what is meant by capacity and lack of capacity

- A person's capacity must be assessed specifically in terms of their capacity to make a particular decision at the time it needs to be made.
- It is important to take all possible steps to try to help people to make a decision for themselves (see chapter 2, principle 2 and chapter 3).

Assessing capacity

- Anyone assessing someone's capacity to make a decision will need to apply the test in the Act. It can be broken down into three questions:
    - Is the person able to make the decision (with support if required)?

- **If they are unable, is there an impairment or disturbance in the functioning of their mind or brain?**
- **Is the person's inability to make the decision because of the impairment or disturbance?**

- A person is unable to make a decision if they cannot:

  - **understand information about the decision to be made (the Act calls this 'relevant information'),**
  - **retain that information in their mind (long enough to make the decision),**
  - **use or weigh that information as part of the decision-making process, or**
  - **communicate their decision (by any means).**

- For complex or major decisions, a more thorough assessment involving a professional may be required.

What is mental capacity?

4.1 Mental capacity is the ability to make a decision, with support as necessary. This includes the ability to make a decision that affects daily life – such as when to get up, what to wear or whether to go to the doctor when feeling ill. It also refers to the ability to make more serious or significant decisions, including those that may have legal consequences – for the person or others. This includes, for example, agreeing to have medical treatment, deciding where to live or buying goods.

4.2 Assessing capacity correctly is vitally important to everyone affected by the Act. Someone who is incorrectly assessed as lacking capacity may be denied their right to make a specific decision – particularly if others think that the decision would not be in their best interests or could cause harm. If however, a person lacks the capacity to make specific decisions, that person might make a decision they do not really understand, which could cause harm or put the person at risk.

4.3 It can be particularly difficult for people caring for the person if they consider their decision to be unwise. It is important to carry out an assessment to understand whether the person has capacity to make that decision. It is also important that the person who does an assessment can justify their conclusion as to whether the person has capacity. Many organisations provide specific professional guidance on assessing capacity for members of their profession6.

4.4 Some people may need help to be able to make or communicate a decision (see chapter 3). But this does not necessarily mean that they lack capacity to do so. What matters is their ability to carry out the processes involved in making the decision, rather than the outcome.

When should capacity be considered?

4.5 There is a presumption that people have the capacity to make their own decisions. However, it may be necessary to consider whether a person has capacity to make a specific decision if:

- The decision the person is proposing to take is significantly out of character;
- The decision the person is proposing to take appears to be unwise, especially if they are putting either themselves or others at risk;
- It has already been shown that the person lacks capacity to make other decisions in their life as a result of an impairment or disturbance that affects the way their mind or brain works;
- A deprivation of the person's liberty is necessary for the person's care or treatment (see chapter 12).

4.6 Considering a person's capacity is not the same as assessing their capacity. It is asking whether there is a proper reason to doubt that the person has the capacity to make the decision in question. Failure to consider this can be just as harmful for the person as an overly hasty decision that they lack capacity to make the decision.

4.7 When considering a person's capacity, it is important that steps are taken to try and support the person to make their own decision. As explained more fully in Chapter 3, this includes asking the following questions:

- Does the person have all the relevant information they need to make the decision?

[6] See for example: British Medical Association & Law Society, *Assessment of Mental Capacity: Guidance for Doctors and Lawyers* (Fourth edition) (London: Law Society, 2015); the Joint Royal Colleges Ambulance Service Liaison Committee Clinical Practice Guidelines (JRCALC), available online at: https://aace.org.uk/clinical-practice-guidelines/ and British Psychological Society, *Guidelines on assessing capacity* (BPS, 2019), available online at: https://www.bps.org.uk/news-and-policy/what-makes-good-assessment-capacity.

- If they are making a decision that involves choosing between alternatives, do they have information on all the different options?
- Would the person have a better understanding if information was explained or presented in another way?
- Are there times of day when the person's understanding is better?
- Are there locations where they may feel more at ease?
- Can the decision be put off until the circumstances are different and the person concerned may be able to make the decision?
- Can anyone else help the person to make choices or express a view (for example, a family member or carer, an advocate or someone to help with communication)?

When should capacity be assessed?

4.8 If there is a proper reason to doubt that the person has capacity to make the decision, it is necessary to assess their capacity by applying the test in the Act. An assessment is not the same as a conclusion that the person lacks capacity to make the decision. When provided with appropriate support (see chapter 3), the conclusion of a capacity assessment may be that the person does have capacity to make the decision.

4.9 Capacity assessments should be reviewed if circumstances which may affect the person's decision-making capacity change.

When should a record be made of a capacity assessment?

4.10 Wherever there has been reason to assess a person's capacity, a record of the assessment should be made. It can be just as important to record a conclusion that the person does have capacity to make a decision as it is to record that they do not, particularly if:

- Concluding that the person has capacity is likely to expose them to particular risks; or
- The person has fluctuating decision-making capacity and there may be doubt in future about whether they had the capacity to make a decision, such as granting a power of attorney or making an advance decision to refuse treatment[7].

[7] A, B and C v X and Z [2012] EWHC 2400 (COP), B and C v X and Z [2012] EWHC 2400 (COP) A, B and C v X and Z [2012] EWHC 2400 (COP), available at: https://www.mentalhealthlaw.co.uk/media/A,_B_and_C_v_X,_Y_and_Z_(2012)_EWHC_2400_(COP),_(2012)_MHLO_112.pdf

What does the Act mean by 'lack of capacity'?

4.11 Section 2(1) of the Act states:

> *'For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.'*

4.12 This can be broken down into three questions:

1. Is the person able to make the decision (with support if required)?
2. If they cannot, is there an impairment or disturbance in the functioning of their mind or brain?
3. Is the person's inability to make the decision because of the impairment or disturbance?

4.13 An assessment of a person's capacity must be based on their ability to make a specific decision at the time it needs to be made (with support if necessary), and not their ability to make decisions in general. A person may be able to make decisions about some issues but not about others. For example, a person may be able to manage a small financial allowance to cover their day to day expenditure but not be able to make more complex decisions about their financial affairs. Section 3 of the Act defines what it means to be unable to make a decision (this is explained in paragraph 4.20 below).

Scenario: Assessing capacity is decision-specific

Ms A has diabetes and a learning disability. Her local authority needs to determine whether she can make decisions regarding her health and welfare. She manages her diabetes independently without difficulty.

However, she is a vulnerable adult because historically she has put herself at risk by allowing strangers into her home which they have used as a base to sell drugs from. Ms A does not understand the risk associated with inviting these strangers into her home.

If a capacity assessor were to assess Ms A generally regarding 'health and welfare' she would fail because of her inability to understand the risk associated with inviting the strangers into her home.

However, a capacity assessment about the specific health and welfare decisions regarding managing her diabetes demonstrates she has capacity to make these decisions.

4.14 Section 2(2) states that the impairment or disturbance does not have to be permanent. A person can lack capacity to make a decision at the time it needs to be made even if:

- the loss of capacity is temporary
- their capacity changes over time

What safeguards does the Act provide around assessing someone's capacity?

4.15 An assessment that a person lacks capacity to make a decision must never be based simply on:

- their age
- their appearance
- assumptions about their condition, or
- any aspect of their behaviour (section 2(3))

4.16 The Act deliberately uses the word 'appearance', because it covers all aspects of the way people look. So, for example, it includes the physical characteristics of certain conditions (for example, scars, features linked to Down's syndrome or muscle spasms caused by cerebral palsy) as well as aspects of appearance like skin colour, tattoos and body piercings, or the way people dress (including religious dress).

4.17 The word 'condition' is also wide-ranging. It includes physical disabilities, learning difficulties and disabilities, illness related to age, and temporary conditions (for example, drunkenness or unconsciousness).

4.18 Aspects of behaviour might include extrovert (for example, shouting or gesticulating), withdrawn behaviour (for example, talking to yourself or avoiding eye contact), or differences in behaviour, including regarding decision-making, related to the person's cultural background.

Scenario: Not making assumptions about someone's ability to make a decision

Mr F has a diagnosis of paranoid schizophrenia. He wants to make a Will.

Despite some delusional beliefs, for instance that his neighbours listen to him through the electrical sockets in his home, Mr F demonstrates that he is able to understand the nature and purpose of a Will, what he has to give away, those that might expect to inherit, as well as who he wants to give his estate to and how he wishes to divide it up.

Despite his delusional beliefs, Mr F meets the criteria for capacity to make a Will.

What proof of lack of capacity does the Act require?

4.19 Anybody who is asked to show in court that an individual lacks capacity to make the decision at the time it needs to be made will need to establish this on the balance of probabilities (section 2(4)). Strictly speaking, this standard does not apply to the other areas where the Act requires people to consider capacity. For instance, the Act requires a person providing care and treatment to have a reasonable belief that the individual lacks capacity to agree to the steps being taken (see Chapter 6 – [para 6.54-6.62)). If appropriate steps have been taken to consider the individual's capacity, then a belief that it is more likely than not that they lack capacity will be reasonable. The same will apply when considering whether the person has capacity to consent to arrangements for enabling their care and treatment which are being considered under the LPS. In all situations, and whether or not in court, it is never for the individual themselves to 'prove' that they have capacity.

What is the test of capacity?

4.20 The Act defines what it means to lack capacity to make a particular decision for purposes of the Act in section 2 and what it means to be unable to make a decision in section 3. Assessment of a person's capacity against these definitions is often known as the 'capacity test'. It is not a medical test, but rather a legal test.

4.21 To apply the test, it can be broken down into three questions:

1. Is the person able to make their own decision (with support if required)?

2. If not, is there an impairment or disturbance in the functioning of their mind or brain?
3. Is the person's inability to make the decision because of the impairment or disturbance?

4.22 Further information relating to these questions is set out below.

4.23 A conclusion that a person lacks capacity to make a particular decision must be based upon this test, and not on any other test a health or social care professional may use for other tasks. For instance:

- A doctor may feel a person lacks insight into their condition, but this does not in itself mean the person lacks capacity to make a specific decision.
- A Mini-Mental State Examination may aid in assessing whether a person has dementia, but a particular score does not itself mean that the person has or lacks capacity to make a specific decision.

Scenario: Assessing whether an impairment or disturbance is affecting someone's ability to make a decision

Ms J suffers a stroke which weakens one side of her body and causes her communication difficulties. Her home has been the family home for years. Her son invites her to live with him, a decision which would mean selling the family home.

Her daughter does not want the family home to be sold and questions whether Ms J has capacity to make the decision to sell her house and move in with her son.

Ms J's hospital consultant is asked to assess her capacity to make the decision to sell her home.

The consultant ascertains that, after her stroke, Ms J retains the capacity to make that decision.

What does the Act mean by 'inability to make a decision'?

4.24 A person is unable to make a decision if they cannot:

1. **understand** information about the decision to be made (the Act calls this 'relevant information'),
2. **retain** that information in their mind (long enough to make the decision),
3. **use or weigh** that information as part of the decision-making process, or

4. **communicate** their decision (by any means). See section 3(1).

4.25 These four points are explained in more detail below. The first three should be applied together. If a person cannot do any of these three things, they will be assessed as unable to make the decision. The fourth only applies in situations where people cannot communicate their decision in *any way*.

Understanding information about the decision to be made

4.26 It is important not to assess someone's understanding before they have been given relevant information about a decision. Every effort must be made to provide information in a way that is most appropriate to help the person to understand. Quick or partial explanations are not acceptable unless the situation is urgent (see chapter 3 for some practical steps).

4.27 Relevant information includes:

- the nature of the decision,
- the reason why the decision is needed, and
- the likely effects of deciding one way or another, or making no decision at all.

4.28 The courts have made decisions in a number of cases which help to show what information is relevant in particular circumstances, for example:

- Medical treatment[8]
- Residence[9]
- Care[10]
- Contact[11]

4.29 The courts have emphasised that these guidelines need to be tailored to the facts of each individual case12.

4.30 Section 3(2) outlines the need to present information in a way that is appropriate to meet the individual's needs and circumstances. It also stresses the importance of explaining information using the most effective form of communication for that

[8]Heart of England NHS Foundation Trust v JB [2014] EWHC 342 (COP), available at:https://www.bailii.org/ew/cases/EWHC/COP/2014/342.html.

[9] LBX v K, L and M [2013] EWHC 3230 (Fam), available at: https://www.bailii.org/ew/cases/EWHC/Fam/2013/3230.html.

[10] LBX v K, L and M [2013] EWHC 3230 (Fam), available at: https://www.bailii.org/ew/cases/EWHC/Fam/2013/3230.html.

[11] LBX v K, L and M [2013] EWHC 3230 (Fam), available at: https://www.bailii.org/ew/cases/EWHC/Fam/2013/3230.html.

[12] B v A Local Authority [2019] EWCA Civ 913, available at: https://www.bailii.org/ew/cases/EWCA/Civ/2019/913.html.

person (such as simple language, sign language, visual representations, computer support or any other means). It may be appropriate to seek advice or support from a speech and language specialist.

4.31 For example:

- A person with a learning disability may need somebody to read written information to them. They might also need illustrations to help them to understand. Or they might stop the reader to ask what things mean. It might also be helpful for them to discuss information with an advocate.
- A person with anxiety or depression may find it difficult to reach a decision about treatment in a group meeting with professionals. They may prefer to read the relevant documents in private. This way they can come to a conclusion alone, asking for help if necessary.
- Someone who has an acquired brain injury might need to be given information several times. It will be necessary to check that the person understands the information. If they have difficulty understanding, it might be useful to present the information in a different way (for example using different forms of words, pictures or diagrams). Written information, voice recordings, videos and posters can help people remember important facts.
- A person's family structure or cultural background may mean that a particular decision would normally be made by, or with the agreement of their family or community, but It should not be assumed that the person's background means they will make a decision in a particular way.

4.32 Relevant information must include what the likely consequences of a decision would be (the possible effects of deciding one way or another) – and also the likely consequences of making no decision at all (section 3(4)). In some cases, it may be enough to give a broad explanation using simple language. But a person might need more detailed information or access to advice, depending on the decision that needs to be made.

4.33 It is important to ask questions to check that the person has understood the information. If a decision could have serious consequences, it is even more important that a person understands the information relevant to that decision. The

4.34 person should be able to give some form of explanation of the information that has been explained to demonstrate that they have understood.

Scenario: Providing relevant information in an appropriate format

Mr L has learning disabilities and has developed an irregular heartbeat. He has been prescribed medication for this, but is anxious about having regular blood tests to check his medication levels. His doctor gives him a leaflet to explain:

- the reason for the tests,
- what a blood test involves,
- the risks in having or not having the tests, and
- that he has the right to decide whether or not to have the test.

The leaflet uses simple language and photographs to explain these things. Mr L's carer helps him read the leaflet over the next few days, and checks that he understands it.

Mr L goes back to tell the doctor that, even though he is scared of needles, he will agree to the blood tests so that he can get the right medication. He is able to pick out the equipment needed to do the blood test.

The doctor concludes that Mr L can understand, retain and use the relevant information and therefore has the capacity to make the decision to have the test.

Retaining information

4.35 Section 3(3) states that people who can only retain information for a short while must not automatically be assumed to lack the capacity to decide – it depends on what is necessary for the decision in question. However, the person must be able to hold the information in their mind long enough to use it to make an effective decision. Items such as notebooks, computers, photographs, posters, videos and voice recorders can help people record and retain information. It may be helpful at the end of the decision-making process to check that the person has retained the information they need.

Scenario: Assessing a person's ability to retain information

Mr R has early on-set dementia. He wishes to make a lasting power of attorney (LPA). He suffers with poor short term memory and struggles to retain new information for more than about an hour.

A solicitor meets with Mr R to discuss an making an LPA. Mr R is unable to tell the solicitor what an LPA is. The solicitor explains to Mr R the nature and purpose of an LPA, as well as the role of an attorney and any risks that might arise.

For the next hour, Mr R is able to retain the relevant information relating to his LPA. He demonstrates that he has capacity to make decisions in order to make the LPA, and signs the document.

Using or weighing information as part of the decision-making process

4.36 For someone to have capacity, they must have the ability to weigh up information and use it to arrive at a decision. Sometimes people can understand information, but an impairment or disturbance stops them using it. In other cases, the impairment or disturbance leads to a person making a specific decision without understanding or using the information they have been given[13].

Scenario: Using and weighing information

A social worker visits Mr E who has a learning disability and very limited communication. A decision is required regarding Mr E walking out of doors without support, as well as other care-related issues.

The social worker spends time sharing all the relevant information with Mr E in a way that is suited to his understanding. He appears to understand the information, and the social worker considers how to test his ability to

[13] An important case to consider using and weighing is Kings College Hospital NHS Foundation Trust v C & Anor [2015] EWCOP 80, available at: https://www.bailii.org/ew/cases/EWCOP/2015/80.html

use and weigh it. She decides it is best to observe him several times on walks outdoors with staff.

The social worker follows close behind Mr E and his support staff. It is clear that he is unable to use the information about road safety, as he lurches into the road several times. Even when he is standing with the support worker at the crossing, he presses the buttons and then starts to walk without waiting for the green sign.

The social worker concludes that Mr E lacks capacity to make decisions to walk outside safely alone. This is consistent with the views of his support staff.

4.37 For example, a person with the eating disorder anorexia nervosa may understand information about the consequences of not eating14. But their compulsion to not eat might be too strong for them to ignore. Some people who have a brain injury might make impulsive decisions regardless of information they have been given or their understanding of it, which may indicate that they are not able to use or weigh the information.

4.38 Another common area of difficulty is where a person with an acquired brain injury gives coherent answers to questions, but it is clear from their actions that they are unable to give effect to their decision. This is sometimes called an impairment in their executive function. If the person cannot understand (and/or use and weigh) the fact that there is a mismatch between what they say and what they do when required to act, it can be said that they lack capacity to make the decision in question. However, this conclusion can only properly be reached when there is clear evidence of repeated mismatch between what the person says and what they do. This means that in practice it is unlikely to be possible to conclude that the person lacks capacity as a result of their impairment on the basis of one single assessment.

4.39 A person who makes a decision which others consider to be unwise should not be presumed to lack capacity. However, a series of unwise decisions may indicate an inability to use or weigh information.

[14] Re E (Medical treatment: Anorexia) [2012] EWCOP 1639, available at:http://www.bailii.org/ew/cases/EWHC/COP/2012/1639.html.

Scenario: Executive functioning impairment

Ms L had a brain injury three years ago. She has impulsivity arising from this injury and finds it hard to control issues relating to basic needs such as food and sex. She is overweight and this is beginning to affect her mobility and general health.

During any discussion with her carer she is competent and gives measured answers to questions about why it is important that she follows a restricted diet. However shortly afterwards she purchases and eats multiple bars of chocolate from a vending machine or shop.

In a capacity assessment interview around the question of control of her diet Ms L is able to understand all the information she is given. She also appears to be able to use and weigh that information.

However, the capacity assessment goes broader than the interview, establishing that when Ms L is in the presence of food that she should not eat, there is a pattern of her impulsivity taking over so that she invariably eats the food. Immediately after each incident Ms L is able to describe why she shouldn't have eaten it.

The capacity assessment demonstrates a repeated mismatch between what Ms L says and what she does when she encounters food, and that she lacks the capacity to make decisions about her diet.

Inability to communicate a decision in any way

4.40 Sometimes there is no way for a person to communicate. This will apply to very few people, but it does include:

- people who are unconscious or in a coma, or
- those with the very rare condition sometimes known as 'locked-in syndrome', who are conscious but cannot speak or move at all.

4.41 If a person cannot communicate their decision in any way at all, the Act says they should be treated as if they are unable to make that decision.

4.42 Before deciding that someone falls into this category, it is important to make all practicable and appropriate efforts to help them communicate. This might call for the involvement of speech and language therapists, specialists in non-verbal communication or other professionals. Chapter 3 gives advice for communicating with people who have specific disabilities or cognitive problems.

4.43 Communication by simple muscle movements can show that somebody can communicate and may have capacity to make a decision15. For example, a person might blink an eye or squeeze a hand to say 'yes' or 'no'. In these cases, assessment must use the first three points listed in paragraph 4.24, which are explained in more depth in paragraphs 4.26–4.38.

4.44 Very few people have capacity to make a decision but not be able to communicate it to anyone else. If other people consider that the person cannot do one of the things required to make a decision (i.e. to understand, retain, use and weigh the relevant information) but they are trying to communicate something, any record of the consideration of the person's capacity should not say that they are unable to communicate their decision. This is because they have not made a decision that they can communicate. The record should show what the person is communicating, for the purpose of working out their best interests.

Impairment or disturbance in the functioning of the mind or brain

4.45 If it is established that a person is unable to make a particular decision, it is then necessary to show that the person has an impairment or the mind or brain, or some sort of disturbance that affects the way their mind or brain works, and that this has caused them to be unable to make the decision. If the person does not have an impairment or disturbance in the functioning of the person's mind or brain, then they cannot lack decision-making capacity for purposes of the Act.

4.46 Examples of an impairment or disturbance in the functioning of the mind or brain may include the following:

- Conditions associated with some forms of mental illness
- Dementia
- Significant learning disabilities
- The long-term effects of an acquired brain injury
- Physical or medical conditions that cause confusion, drowsiness or loss of consciousness
- Delirium
- Concussion following a head injury, and
- The symptoms of alcohol or drug use

4.47 It is easier to establish that a person has an impairment or disturbance in the functioning of their mind or brain if they have a formal diagnosis of a particular condition. However, a formal diagnosis is not necessary for the purposes of the

[15] The X Primary Care Trust v XB & Anor - The X Primary Care Trust v XB & Anor [2012] EWHC 1390 (Fam) (01 May 2012), available at: https://www.bailii.org/ew/cases/EWHC/Fam/2012/1390.html

Act. It is also not necessary for the impairment or disturbance to fit into a recognised clinical diagnosis (for example in a psychiatric manual). However, the person claiming that an individual lacks capacity must be able to show a proper basis for considering that they have an impairment or disturbance.

Scenario: Using and weighing information – internet usage

Ms W has a learning disability and experienced trauma in her childhood resulting in what is described as 'an emerging personality disorder' She has known attachment issues and can latch on to men and become convinced they are going to marry her. She is desperate for a baby.

Recently Ms W's internet use has become extremely worrying. She lives with her mother, who now feels unable to support her. Ms W is making contact with numerous men, including known sex offenders, and is being sexually explicit in text and photographs online.

A social worker assesses Ms W's capacity for internet usage. At first, he feels that she has capacity as she gives a good account of the risks and internet safety and appears to understand everything he talks to her about. Ms W is less clear in demonstrating her understanding that someone may not be who they say they are, but she still says that people might say they are your friend when they aren't, or their online photograph may be of another person.

Ms W tells the social worker that her boyfriend is coming to collect her tonight. He is buying her a ring and a puppy, and they are going to get married. The social worker asks her about her boyfriend and she shows him some of their conversations, and says she met her boyfriend a week ago on a dating site, has sent very explicit photographs and has agreed to have sex with his sons when he collects her.

The social worker tries to discuss how Ms W knows her boyfriend is genuine and whether it is safe to run away with him so soon. All that Ms W says is that he is going to marry her and buy her a ring and a puppy.

The social worker concludes that Ms W's learning disability and the impact on that of an attachment disorder and a personality disorder mean that she is unable to use and weigh the necessary information to keep safe on the internet.

Is the person's inability to make the decision caused by the impairment or disturbance in the functioning of their mind or brain?

4.48 In all cases, it is necessary to ask whether the inability of the person to make the decision is because of the impairment or disturbance in the functioning of their mind or brain. This will mean explaining (for instance) how a person's dementia means that they cannot use and weigh the information relevant to the decision in question. The impairment or disturbance must not merely impair their ability to make the decision but render them unable to make the decision.

4.49 There will be some cases where it is not easy to identify whether a person is unable to make their own decisions because of an impairment or disturbance or because of the influence of a third party. So long as the impairment or disturbance can be demonstrated to be a cause of the person's inability to make the decision, then they will lack capacity for purposes of the Act.

4.50 However, if the reason a person cannot make a decision is not because of an impairment or disturbance in the functioning of their mind or brain, then they do not lack capacity for the purposes of the Act. It may be that the real reason is the influence of someone else, threat, coercion or fear of the consequences of a decision. If this is the case and there are concerns about the person's safety or wellbeing, then safeguarding procedures should be followed. In some circumstances it may be appropriate for an application to be made to the High Court to consider the matter under its inherent jurisdiction (see paragraph 7.14).

People with fluctuating capacity or capacity affected by a temporary factor

4.51 It is important to recognise that an assessment that a person lacks capacity to make a particular decision at a particular time does not mean that they lack capacity for all decisions at all times. Some people's ability to make decisions fluctuates because of the nature of a condition that they have. This fluctuation can take place either over a matter of days or weeks (for instance where a person has bipolar disorder) or over the course of the day (for instance a person with dementia, whose cognitive abilities may be significantly less impaired at the start of the day than they are towards the end). Temporary factors, such as acute illness, severe pain, a urinary tract infection, medication or bereavement may also affect someone's ability to make decisions. How to approach the situation will depend upon the nature of the decision.

Isolated decisions

4.52 If it is an isolated decision that needs to be made, it may be possible to delay the decision until the person has the capacity to make it for themselves. The person's

decision should then be clearly recorded, and evidence recorded to show that they had capacity to make it.

4.53 It may also be helpful to discuss and record what the person would want if they lost capacity to make similar decisions in future. This means that, if further decisions then need to be taken in their best interests, the decision-maker can take the person's wishes and feelings into consideration (see chapter 5).

4.54 If it is not possible to delay the decision, the minimum action necessary should be taken until the person regains decision-making capacity.

Repeated decisions

4.55 Some decisions are not one-off and need to be repeated over a period of time, for example the day to day management of a person's finances, or management of a condition such as diabetes. While capacity is time-specific, for repeated decisions it may be appropriate to consider the broader time over which the decisions need to be made. If a person is only able to make the decisions at limited periods of the time over which they need to be made, it may be appropriate to proceed on the basis that they lack capacity.[16] This is especially so if the consequences of the decisions are serious and the person only has capacity to make them for a very small part of the time.

4.56 It will be necessary to keep the person's capacity under review and reassess their capacity if it becomes apparent that they have the capacity to make the decisions more often than not.

Scenario: Fluctuating capacity

Mr J has long term complex alcohol misuse and mental health issues. He is living in a specialist alcohol rehabilitation service, undertaking a gradual alcohol reduction programme.

Mr J has a history of exceeding his agreed daily alcohol intake, becoming intoxicated. On these occasions, he forgets to eat and has accessed a shared computer at the service to participate in online gambling, which has resulted in him losing substantial amounts of money.

[16] *Cheshire West and Chester Council v PWK* [2019] EWCOP 57, available at: https://www.bailii.org/ew/cases/EWCOP/2019/57.html.

Where there are instances of Mr J appearing to be intoxicated which could result in him having impaired judgement, staff carry out a mental capacity assessment to understand whether he has the capacity to make a decision to pay large sums of money in the hope of a jackpot win.

Staff assess whether he can weigh up the risks versus benefits of continuing to gamble and make a decision about whether to go on spending the money. Where he is unable to weigh up the risks, his access to the shared computer is restricted using a best interests decision, as agreed as part of his care planning, including the use of an advanced statement made whilst Mr J has capacity.

Fluctuating capacity and the Liberty Protection Safeguards

4.57 For the particular approach to take to fluctuating capacity in the context of the Liberty Protection Safeguards, see chapter 16 (para 16.28-16.32).

Ongoing conditions that may affect capacity

4.58 Generally, capacity assessments should be related to a specific decision. But there may be people with an ongoing condition that affects their ability to make certain decisions or that may affect other decisions in their life. One decision on its own may make sense but may give cause for concern when considered alongside others.

4.59 Again, it is important to review capacity from time to time, as people can improve their decision-making capabilities. In particular, someone with an ongoing condition may become able to make some, if not all, decisions. Some people (for example, people with learning disabilities) will learn new skills throughout their life, improving their capacity to make certain decisions. Conversely, some people (for example, people with dementia) may become less able to make decisions as time passes and their condition progresses. So assessments should be reviewed from time to time.

4.60 Capacity should always be reviewed:

- whenever a care and support plan is being developed or reviewed
- at other relevant stages of the care planning process, and
- as particular new decisions need to be made.

Scenario: Ongoing conditions

Mr P had an accident at work and suffered severe head injuries. His partner applied to the Court of Protection to be his property and finance deputy as it became clear that Mr P would be awarded compensation to pay for care he would need throughout his life as a result of his head injury. Mr P objected as he believed he could manage his life and wanted to decide how to spend his money.

As part of his capacity assessment Mr P wrote a list of what he intended to spend his money on. This included luxury items, which would not leave enough money to cover the costs of his care in future years. It was explained to Mr P how much such items would cost and what that would leave him with for his care needs.

The court judged that Mr P had capacity to make day-to-day financial decisions, but he did not understand why he had received compensation, or how spending it as he wished could affect his future care. The court therefore decided Mr P lacked capacity to manage large amounts of money and appointed his partner as his deputy to make ongoing financial decisions relating to his care. But it gave Mr P access to enough funds to cover his every day needs and occasional treats.

Who should assess capacity?

4.61 The person who assesses an individual's capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made. This means that different people will be involved in assessing someone's capacity to make different decisions at different times.

4.62 For most day-to-day decisions, this will be the person caring for them at the time a decision must be made. For example, a care worker might need to assess if the person can agree to being bathed. Then a district nurse might assess if the person can consent to have a dressing changed.

4.63 For acts of care or treatment (see chapter 6), the assessor must have a 'reasonable belief' that the person lacks capacity to agree to the action or decision to be taken before making a decision or taking an action in their best interests.

4.64 [This paragraph has been deleted as it had been inserted in error.]

4.65 If a doctor or healthcare professional proposes a course of action (for example, treatment or an examination), they must be alert to signs that the person may lack capacity to consent, and give them all reasonable help and support to make a

decision. Assessment of capacity is a core clinical skill. In settings such as a hospital, assessment of capacity may involve the multi-disciplinary team (a team of people from different professional backgrounds who share responsibility for a patient). But ultimately, it is for the professional responsible for the person's treatment to make sure that capacity has been assessed17.

4.66 If a person chooses to instruct a legal practitioner for a legal transaction (for example making a will or selling a house), the legal practitioner must be satisfied that the person has capacity to instruct them. They should also consider whether the client has the capacity to satisfy any relevant legal test for the transaction. If the legal practitioner thinks the client may not have this capacity, they should advise them of their concerns and of the implications if they are found to lack capacity. It may be necessary to advise the client that an opinion on their capacity should be obtained from a professional with the relevant expertise[18].

4.67 There may be circumstances where an education provider needs to assess whether a young person has the capacity to make a particular decision, such as whether to participate in a course. As with adults, it is up to the person responsible for the young person's care at the time the decision needs to be made to assess whether they have the capacity to make the decision. Where the young person has an Education, Health and Care plan (England) or an equivalent Welsh education plan19 in place, those responsible for the young person's care should refer to it when supporting the young person to make a decision. Education providers would not be expected to assess a young person's capacity to make major or complex decisions. In those circumstances, it is likely that a professional opinion (from a GP or psychologist, for example) will be needed.

- More complex decisions are likely to need more formal assessments (see paragraph 4.69 below). A professional opinion on the person's capacity might be necessary. This could be, for example, from a psychiatrist, psychologist, a speech and language therapist, occupational therapist or social worker. But the

[17] General Medical Council - Decision making and consent guidance, available at: https://www.gmc-uk.org/-/media/documents/gmc-guidance-for-doctors---decision-making-and-consent-english_pdf-84191055.pdf.

- [18] The Law Society and Solicitors Regulation Authority also provide guidance as to solicitors' professional obligations in this area, available at: https://www.lawsociety.org.uk/en/topics/regulation/sra-standards-and-regulations
- https://www.sra.org.uk/solicitors/

[19] Until the Additional Learning Needs and Education Tribunal (Wales) Act 2018 comes into force, part IV of the Education Act 1996 (and the Special Educational Needs Code of Practice for Wales) provides for the provision of statements of special educational needs in Wales, available at: https://gov.wales/sites/default/files/publications/2018-02/additional-learning-needs-and-education-tribunal-wales-act-2018-explanatory-notes.pdf.

final decision about a person's capacity must be made by the person intending to make the decision or carry out the action on behalf of the person who lacks capacity – not the professional, who is there to advise.

- Any assessor should have the skills and ability to communicate effectively with the person (see chapter 3). If necessary, they should get professional help to communicate with the person. In all cases, the person carrying out the assessment must be careful not to allow their own view of the decision to bias their assessment.

Scenario: Who should assess capacity?

Following a stroke Ms B was found collapsed at home by paramedics, who reported signs of severe neglect. During the discharge planning process, the hospital clinical and social care team proposed an interim care home to enable social services to clean Ms B's house and put in safety measures. Ms B refused and threatened to sue the hospital for interfering with her private life.

Hospital Multi-Disciplinary Team (MDT) capacity assessments suggested Ms B had capacity to decline care. Following a discussion with her daughter, a more comprehensive capacity assessment was done regarding her discharge because of concerns that she was not aware of how her self-neglect would affect her health.

The social worker, neurology consultant and occupational therapist discussed with Ms B her home setting, with the help of photographs taken by her daughter. Ms B could describe the layout of her house but not for instance how the clutter had caused her various falls, why she had not had a wash in months or why the food in her fridge was unsafe. She was upset about the assessment and said she was being unlawfully detained and her rights were infringed. She said that she would not consent to going to a care home but could not explain this in detail. She eventually agreed to a care package and social services helping her declutter her home.

The MDT team concluded on the balance of probabilities that Ms B's neurological condition meant she lacked capacity to understand the risks of her hazardous living conditions. Although she was able to communicate her wishes, she was unable to recall the concerns and reasons for the discussion.

Despite collectively agreeing that Ms B lacked the capacity to make the decision to return home, the team decided to respect her wishes. They accepted that a less restrictive option would be a discharge home, with a

full package of care and protective measures in place. They would review the situation regularly with the help of Ms B's daughter.

What is 'reasonable belief' of lack of capacity?

4.68 Carers (whether family carers or other carers) and care workers do not have to be experts in assessing capacity in relation to day to day decisions. But to have protection from liability when providing care or treatment (see chapter 6), they must have a 'reasonable belief' that the person they care for lacks capacity to make relevant decisions about their care or treatment (section 5 (1)). To have this reasonable belief, they must have taken 'reasonable' steps to establish that that the person lacks capacity to make a decision or consent to an act at the time the decision or consent is needed. This includes providing support to enable the person to make their own decision. They must also establish that the act or decision is in the person's best interests (see chapter 5).

4.69 Everyday decisions do not usually need to follow formal processes, such as involving a professional to make an assessment. However, if somebody challenges their assessment (see paragraph 4.97), the carer must be able to describe the steps they have taken. They must also have objective reasons for believing the person lacks capacity to make the decision in question.

4.70 The steps that are accepted as 'reasonable' will depend on individual circumstances and the urgency of the decision. Professionals, who are qualified in their particular field, are normally expected to undertake a fuller assessment, reflecting their higher degree of knowledge and experience, than family members or other carers who have no formal qualifications. See paragraph 4.81 for a list of points to consider when assessing someone's capacity. The following may also be helpful:

- Start by assuming the person has capacity to make the specific decision. Is there anything to suggest otherwise?
- Are there any relevant cultural considerations about how the person usually makes specific decisions, for instance collectively as part of a family unit? However also be aware of any signs of coercion.
- Does the person have a previous diagnosis of disability or mental disorder? Does that condition now affect their capacity to make this decision? If there has been no previous diagnosis, it may be best to get a medical opinion.
- Make every effort to communicate with the person to explain what is happening.
- Make every effort to try to help the person make the decision in question.
- See if there is a way to explain or present information about the decision in a way that makes it easier to understand. If the person has a choice, do they have information about all the options?

- Can the decision be delayed to take time to help the person make the decision, or to give the person time to regain the capacity to make the decision for themselves?
- Does the person understand what decision they need to make and why they need to make it?
- Can they understand information about the decision? Can they retain it, use it and weigh it to make the decision?
- Be aware that the fact that a person agrees with you or assents to what is proposed does not necessarily mean that they have capacity to make the decision.

When should professionals be involved?

4.71 Anyone assessing someone's capacity may need to get a professional opinion when assessing a person's capacity to make complex or major decisions. In some cases this may involve contacting the person's doctor. If the person has a particular condition or disorder, it may be appropriate to contact a specialist (for example, consultant psychiatrist, psychologist or other professional with experience of caring for patients with that condition). A speech and language therapist might be able to help if there are communication difficulties. Other professionals such as nurses, social workers, occupational therapists and others may be able to provide the professional skills necessary. In some cases, a multi-disciplinary approach is best, or it may be necessary to seek an experienced capacity assessor. In some cases a fee may be charged for providing this service.

4.72 Professionals should never express an opinion without carrying out a proper examination and assessment of the person's capacity to make the decision. They must apply the appropriate test of capacity. In some cases, they will need to meet the person more than once – particularly if the person has communication difficulties. Professionals can get background information from a person's family and carers. But the personal views of these people about what they want for the person who lacks capacity must not influence the outcome of that assessment.

4.73 Professional involvement might be needed if:

- the decision that needs to be made is complicated or has serious consequences
- an assessor concludes a person lacks capacity, and the person challenges the finding
- family members, carers and/or professionals disagree about a person's capacity
- there is a conflict of interest between the assessor and the person being assessed

- the person being assessed is expressing different views to different people – they may be trying to please everyone or telling people what they think they want to hear
- somebody might challenge the person's capacity to make the decision – either at the time of the decision or later (for example, a family member might challenge a will after a person has died on the basis that the person lacked capacity when they made the will)
- somebody has been accused of abusing a vulnerable adult who may lack capacity to make decisions that protect them
- a person repeatedly makes decisions that put them at risk or could result in suffering or damage.

Scenario: Getting a professional opinion

Ms M has a history of schizophrenia including time in a long stay psychiatric hospital. She has no living family and lives alone. Her care worker visits once daily and she has a community psychiatric nurse (CPN) who has regular contact.

She is diagnosed with a stage 4 maxillary sinus cancer and is supported by her CPN but refuses treatment. Her oncology team determine that she had capacity for this decision. The tumour progresses and causes Ms M pain, and she takes low dose morphine.

Ms M has a fall and her GP and community palliative care consultant advise admission to the local hospice, but she refuses.

The doctors assess Ms M's mental capacity to decide not to go to the hospice. They are unsure how much morphine Ms M has taken, and the extent of the tumour. With the support of Ms M's care worker, they explain their concerns, and the benefits and downsides of admission to the hospice. Ms M shows no memory deficit but cannot explain why she does not want to go to the hospice.

The consultant's view is that, on balance, Ms M does not have capacity to make this decision because she does not appear to be using and weighing information. The GP decides that Ms M's behaviour is consistent with her previous behaviour and that, on balance, Ms M has capacity to choose to stay at home despite the apparently unwise nature of the decision. The care worker agrees with the GP, but the consultant is concerned that the care worker is not a clinician and that this is a complex decision.

The two doctors are unable to reach agreement and contact the CPN, who confirms the GP's account of Ms M's usual manner of communication and her consistently expressed wish to stay at home. The GP and consultant

agree that, on balance, Ms M has capacity to choose to remain at home, despite the risks.

With the help of Ms M's social worker, and with her agreement, they increase the care worker visits to three times per day and the GP agrees to visit again the following day. Two days later Ms M has another fall. The tumour has eroded through the skin overlying her cheek, and she agrees to admission to a hospice.

4.74 In some cases, it may be a legal requirement, or good professional practice, to undertake a formal assessment of capacity. These cases include:

- where a person's capacity to sign a legal document (for example, a will), could later be challenged[20],
- to establish whether a person who might be involved in a legal case needs the assistance of the Official Solicitor or other litigation friend (somebody to represent their views to a court and give instructions to their legal representative) and there is doubt about the person's capacity to instruct a solicitor or take part in the case[21]
- whenever the Court of Protection has to decide if a person lacks capacity in a certain matter
- if the courts are required to make a decision about a person's capacity in other legal proceedings[22]
- if there may be legal consequences of a finding of capacity (for example, deciding on financial compensation following a claim for personal injury)
- if consideration is being given to depriving the person of their liberty

What other legal tests of capacity are there?

4.75 The Act states that the definition of 'lack of capacity' and the test for capacity set out in the Act are 'for the purposes of this Act'. This means that the definition and test are to be used in situations covered by the Act. Schedule 6 of the Act also amends existing laws to ensure that the definition and test are used in other areas of law not covered directly by the Act.

[20] *Kenward v Adams*, The Times, 29 November 1975

[21] Civil Procedure Rules 1998, r 21.1, Family Procedure Rules 2010 15.1. See also Hinduja v Hinduja & Ors [2020] EWHC 1533 (Ch) which covers medical evidence of capacity, available at: https://www.bailii.org/ew/cases/EWHC/Ch/2020/1533.html.

[22] Masterman-Lister v Brutton & Co and Jewell & Home Counties Dairies [2002] EWCA Civ 1889, CA at 54, available at: https://www.bailii.org/ew/cases/EWCA/Civ/2002/1889.html.

4.76 For example, Schedule 6, paragraph 20 disqualifies a person from jury service if they lack the capacity (using this Act's definition) to carry out a juror's tasks.

4.77 Before the Act was introduced, judges in court cases had developed tests of capacity to cover specific situations (known as common law tests)23. These covered:

- capacity to make a will[24]
- capacity to make a gift[25]
- capacity to enter into a contract[26]
- capacity to litigate (take part in legal cases)[27]
- capacity to enter into marriage[28]

4.78 The first edition of the Code published in 2007 stated that the Act's definition of capacity is in line with the existing common law tests, and the Act did not replace them. It also stated that when cases came before the court on the above issues, judges could adopt the definition set out in the Act if they thought it was appropriate to do so. Since then it has been made clear that the Act's test of capacity applies to most situations including:

- capacity to litigate (take part in legal cases)[29]
- capacity to enter into a marriage[30]

4.79 However, in a limited number of situations judges have held that the existing common law test of capacity differs from the test set out in the Act and that the common law test should continue to apply in preference to the test set out in the Act. This is the case in relation to:

- capacity to make a will[31]

[23] For details, see British Medical Association & Law Society, *Assessment of Mental Capacity: Guidance for Doctors and Lawyers* (Fourth edition) (London: Law Society, 2015)

[24] *Banks v Goodfellow* (1870) LR 5 QB 549 - https://www.lexiswebinars.co.uk/legal/hot-topics/vulnerable-clients/supporting-materials/Banks-v-Goodfellow.PD.

[25] Case: *Re Beaney (deceased)* [1978] 2 All ER 595.

[26] Case: *Re Boughton v Knight* (1873) LR 3 PD 64.

[27] *Masterman-Lister v Brutton & Co and Jewell & Home Counties Dairies* [2003] 3 All ER 162 (CA) - Masterman-Lister v Brutton & Co [2002] EWCA Civ 1889 (19 December 2002), available at: https://www.bailii.org/ew/cases/EWCA/Civ/2002/1889.html

[28] *Sheffield City Council v E & S* [2005] 1 FLR 965, available at:https://www.bailii.org/ew/cases/EWHC/Fam/2004/2808.html

[29] Civil Procedure Rules 1998 Part 21.1, available at: https://www.legislation.gov.uk/uksi/1998/3132/part/21

[30] *PBM v TGT* [2019] EWCOP 6, available at: https://www.bailii.org/ew/cases/EWCOP/2019/6.html

[31] *Re Clitheroe* [2021] EWHC 1102 (Ch) Clitheroe, Re Probate [2021] EWHC 1102 (Ch) (04 May 2021), available at: https://www.bailii.org/ew/cases/EWHC/Ch/2021/1102.html.

- capacity to make a gift[32]

4.80 The law in this area is not yet entirely clear as the question of whether a common law test of capacity should apply, even where it differs from the test set out in the Act, has not yet been considered by an appeal court.

What steps should be taken when assessing capacity?

4.81 Capacity assessments should be criteria-focussed, evidence-based, person-centred and non-judgemental. Chapter 3 describes steps which should be taken to support the person to make their own decision. This should not stop when the person's capacity is being assessed. Indeed, trying to support the person to make their own decision will also help the assessor in gathering information to be able to assess whether the person has the capacity to make the decision.

4.82 Anyone assessing someone's capacity will need to decide which of these steps are relevant to their situation.

- They should ensure all practicable steps have been taken and continue to be taken to try and support the person to make the decision for themselves.
- They should make sure that they understand the nature and effect of the decision to be made themselves.
- They may need access to relevant documents and background information (for example, details of the person's finances if assessing capacity to manage affairs, or of their cultural background). See chapter 25 for details on access to information.
- They may need other relevant information to support the assessment (for example, healthcare records or the views of staff involved in the person's care).
- Family members and close friends may be able to provide valuable background information (for example, the person's past behaviour and abilities and the types of decisions they can currently make). But their personal views and wishes about what they would want for the person must not influence the assessment.
- They should ensure they are assessing the person when they are in the best state to make the decision, if possible. Many of the practical steps suggested in chapter 3 will help to create the best environment for assessing capacity.
- They should again explain to the person all the information relevant to the decision. The explanation must be in the most appropriate and effective form of communication for that person.

[32] *Kicks v Lee [2014] EWHC 3926 (Ch)*, available at: https://www.bailii.org/ew/cases/EWHC/Ch/2014/3926.html

- Check the person's understanding after a few minutes. The person should be able to give a rough explanation of the information that was explained. There are different methods for people who use non-verbal means of communication (for example, observing behaviour or their ability to recognise objects or pictures).
- Avoid questions that need only a 'yes' or 'no' answer (for example, 'Did you understand what I just said?'). They are not enough to assess the person's capacity to make a decision. There may be no alternative in cases where there is major communication difficulties, and in these cases, check the response by asking questions again in a different way.
- Repeating these steps can help confirm the result.
- Skills and behaviour do not necessarily reflect the person's capacity to make specific decisions. The fact that someone has good social or language skills, polite behaviour or good manners doesn't necessarily mean they understand the information or are able to weigh it up.

4.83 Capacity assessments should take place with the person – it is not normally appropriate to make assessments based on papers or reports33 (see paragraph 4.87 regarding action where an assessment is not possible). In some circumstances, it may be appropriate to carry out an assessment remotely via video conference if:

- it is not possible to visit the person and there is reason to doubt their capacity
- doing is a practicable step to support the person's capacity, perhaps due to the nature of their condition or situation.

4.84 An explanation of why it has not been possible to carry out the assessment in person should be recorded.

4.85 It will be important for the assessor to be aware that people may make decisions in different ways. For example, in some cultures decisions are generally taken individually, whereas in others decisions may be made using a more collective approach with others in the family or community. A person's wish to defer decisions to others could wrongly be taken as indication that they lack capacity, when in fact it is usual for them to make decisions this way. It will therefore be important for the assessor to use the information they have gathered as part of the assessment to develop a good understanding of the person, including how they make decisions usually, to help them consider and assess whether they have capacity.

[33] Wandsworth Clinical Commissioning Group v IA (By the Official Solicitor As His Litigation Friend) [2014] EWCOP 990 (03 April 2014) (bailii.org), available at:https://www.bailii.org/ew/cases/EWHC/COP/2014/990.html

Are assessment processes confidential?

4.86 People involved in assessing capacity will need to share information about a person's circumstances. But there are ethical codes and laws that require professionals to keep personal information confidential. As a general rule, professionals must ask their patients or clients if they can reveal information to somebody else – even close relatives. But sometimes information may be disclosed without the consent of the person who the information concerns (for example, to protect the person or prevent harm to other people)[34].

4.87 Anyone assessing someone's capacity needs accurate information concerning the person being assessed that is relevant to the decision the person has to make. So professionals should, where possible, make relevant information available. They should make every effort to get the person's permission to reveal relevant information. They should give a full explanation of why this is necessary, and they should tell the person about the risks and consequences of revealing, and not revealing information. If the person is unable to give permission, the professional might still be allowed to provide information that will help make an accurate assessment of the person's capacity to make the specific decision. Chapter 25 has more detail on how to access information.

What if capacity assessment is not possible?

4.88 If it is not possible to carry out a capacity assessment, it is important to consider the reasons why assessment is not possible and what steps should follow. Where assessment is not possible and there are reasons to doubt the person's capacity, the reasons and any evidence of them should be recorded. In some cases, it may be appropriate to make an application to the Court of Protection to consider the person's capacity to make the decision in question.

4.89 There may be circumstances in which a person whose capacity is in doubt refuses to undergo an assessment of capacity or refuses to be examined by a doctor or other professional. In these circumstances, it might help to explain to someone refusing an assessment why it is needed and what the consequences of refusal are. Consideration should also to be given as to what other steps might help the person engage, as part of the requirement to support their decision-making[35]. Threats or attempts to force the person to agree to an assessment are not acceptable.

[34] For example, see cases in the circumstances discussed in W v Egdell and others [1990] 1 All ER 835 at 848 - https://www.bailii.org/ew/cases/EWCA/Civ/1989/13.html and S v Plymouth City Council and C, [2002] EWCA Civ 388) at 49 - https://www.bailii.org/ew/cases/EWCA/Civ/2002/388.html.

[35] AMDC v AG & Anor [2020] EWCOP 58 AMDC v AG & Anor [2020] EWCOP 58 (18 November 2020), available at: https://www.bailii.org/ew/cases/EWCOP/2020/58.html.

4.90 If the person lacks capacity to agree or refuse, the assessment can normally go ahead, as long as the person does not object to the assessment, and it is in their best interests (see chapter 5).

4.91 Nobody can be forced to undergo an assessment of capacity. If someone refuses to open the door to their home, it cannot be forced. If there are serious worries about the person's mental health, it may be possible to get a warrant to force entry and assess the person for treatment in hospital – but the situation must meet the requirements of the Mental Health Act 1983 (section 135). But simply refusing an assessment of capacity is in no way sufficient grounds for an assessment under the Mental Health Act 1983 (see chapter 22).

4.92 If the reason for the person refusing appears to be that they are being coerced by someone else (for instance a family member or a carer), then it may be possible to get an order from the High Court under its inherent jurisdiction ordering the other person to allow a professional to speak to the person in private. In Wales, it may be possible for an officer authorised by a local authority to make an application to a justice of the peace for an adult support and protection order under section 127 Social Services and Well-Being (Wales) Act 2014.

Who should keep a record of assessments?

4.93 Assessments of capacity to take day-to-day decisions or consent to care require no formal procedures or recorded documentation. Paragraphs [4.67-4.69 above explain the steps to take to reach a 'reasonable belief' that someone lacks capacity to make a particular decision. It is good practice for paid care workers to keep a record of the steps they take when caring for the person concerned, including steps to establish capacity.

Professional records

4.94 It is good practice for professionals to carry out a proper assessment of a person's capacity to make particular decisions and to record the process of the capacity assessment in the relevant professional records to demonstrate how the conclusion that the person has or does not have capacity was reached (see paragraph 4.80).

4.95 Solicitors should assess a client's capacity to give instructions or carry out a legal transaction (obtaining a medical or other professional opinion, if necessary) and record it on the client's file.

4.96 An assessment of a person's capacity to consent or agree to the provision of services will be part of the care planning processes for health and social care needs and should be recorded in the relevant documentation.

Formal records of capacity

4.97 In some cases, a more detailed report of capacity may be required. Regulations, Rules or Orders made under the Mental Capacity Act or other statutes may require findings to be recorded in a specific way. For example, the Court of Protection will require the completion of a COP3 (Assessment of Capacity) form.

How can someone challenge a finding of lack of capacity?

4.98 There are likely to be occasions when someone may wish to challenge the results of an assessment of capacity. The first step is to raise the matter with the person who carried out the assessment. If the challenge comes from the individual who is said to lack capacity, they might need support from family, friends or an advocate. Ask the assessor to:

- give reasons why they believe the person lacks capacity to make the decision, and
- provide objective evidence to support that belief.

4.99 The assessor must show they have applied the principles of the Mental Capacity Act (see chapter 2). Attorneys, deputies and professionals will need to show that they have also followed guidance in this chapter.

4.100 It might be possible to get a second opinion from an independent professional or another expert in assessing capacity. Chapter 24 has other suggestions for dealing with disagreements. But if a disagreement cannot be resolved, the person who is challenging the assessment may be able to apply to the Court of Protection. The Court of Protection can rule on whether a person has capacity to make the decision covered by the assessment (see chapter 7).

Retrospective assessments

4.101 In some circumstances there may be doubt about whether a person had capacity to make a decision at a point of time in the past. It may not always be necessary to try and determine whether they had capacity if it is possible to support them to make the decision now. For example, if there are doubts about the person's capacity to make an advance decision to refuse treatment, it may be possible for them to make a new one if it can be established that they have the capacity to make it now.

4.102 In many situations, it is good practice to keep a record of the conclusion of a capacity assessment (see paragraphs 4.92 – 4.96) . This means it will be much easier to address any doubt about the person's capacity afterwards.

4.103 However, in some cases it will be necessary to reach a conclusion about whether a person had capacity to make a decision in the past without any record of assessment. These are likely to be situations where a court is involved and are likely to involve questions about whether a particular document should be seen as having legal effect. For example:

- where a person's capacity to have made their will is questioned after their death. The High Court would have to resolve the dispute;
- where a person's capacity to have granted a lasting power of attorney is questioned, and it is clear they no longer have capacity to grant a new power. The Court of Protection would be required to consider whether the person had capacity at the point they granted the power of attorney;
- where a person's capacity to have made an advance decision to refuse treatment is questioned, and it is clear they no longer have capacity to make a new advance decision or to make decisions about medical treatment. The Court of Protection would be required to consider whether the person had capacity to make the advance decision when it was made.

4.104 Where a person's capacity to make a decision is being assessed retrospectively, the approach to be taken is different to assessing capacity 'in real time'. For example, it is clearly not now possible to seek to support the person to make the decision. It will be necessary to gather as much evidence as possible from surrounding documents and circumstances to establish whether or not the person had capacity at the time.

4.105 Importantly, the presumption of capacity works differently where the person's capacity is being determined retrospectively. Where proper reasons are put forward to suggest the person did not have capacity, anyone who relies on the fact the person did have capacity will need to be able to show, on the balance of probabilities, that this was the case. Who might need to show this depends on the circumstances. It might be the attorney where a power of attorney is questioned. It might also be the person themselves (or someone acting on their behalf) where an advance decision to refuse treatment is questioned.

5. What does the Act mean when it talks about 'best interests'?

As set out in earlier chapters, when someone has capacity to make a decision the person should make that decision for him/herself, with support if needed.

When someone lacks capacity to make the decision, however, the Act says that any act done for, or any decision made on the person's behalf, must be done, or made, in that person's best interests. This chapter explains what the Act means by 'best interests', the things that should be considered when trying to work out what is in someone's best interests and how best interests decisions should be recorded. It also highlights some of the difficulties that might come up in working out what the best interests of a person who lacks capacity to make the decision actually are.

In this chapter, as throughout the Code, a person's capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

Quick summary

A decision-maker trying to work out the best interests of a person who lacks capacity to make a particular decision ('lacks capacity') should:

- Identify the available options
- Consider the factors in the checklist set out in the Act including:
  - Avoiding discrimination by not making assumptions about someone's best interests simply on the basis of their age, appearance, condition or behaviour.
  - Identifying all relevant circumstances that the person who lacks capacity would take into account if they were making the decision or acting for themselves.
  - Assessing whether the person might regain capacity and if so, deciding whether the decision can wait until then.
  - Encouraging and enabling the person to participate in the decision-making process as much as possible.

- If the decision concerns life-sustaining treatment, not being motivated in any way by a desire to bring about the person's death.
- Finding out the person's views, including their past and present wishes and feelings, beliefs, values and cultural background and any other factors they would be likely to consider if they were making the decision for themselves.
- Consulting others who are close to the person, involved in their care or treatment or acting as attorney or deputy for their views about the person's best interests and to see if they have any relevant information about the persons wishes and feelings, beliefs, values and cultural background.

- Avoid restricting the person's rights by seeing if there are other options that may be less restrictive of the person's rights and explaining reasoning if the least restrictive option is not pursued.
- Weigh up all of these factors in order to work out what is in the person's best interests.
- Consider whether a record of the decision needs to be made.

What is the best interests principle and who does it apply to?

5.1 As chapter 2 explained, the Act's first principle is that people must be assumed to have capacity to make a decision or act for themselves unless it is established that they lack it. People with capacity are able to decide for themselves what they want to do. When they do this, they might choose an option that other people don't think is in their best interests. That is their choice and does not in itself mean that they lack capacity to make those decisions. However, there may be indications of a lack of capacity if the decision is uncharacteristic or exposes the person to risk or danger. Deciding a person's best interests is therefore only relevant after all practicable steps have been taken without success to support the person to make the decision in question or give consent to an act being done.

5.2 The best interests principle is set out in section 1(5) of the Act:

'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 his best interests.'

5.3 Section 1(5) of the Act confirms that the principle applies to any act done, or any decision made, on behalf of someone where there is reasonable belief that the person lacks capacity under the Act. This covers informal day-to-day decisions and actions as well as decisions made by the courts.

5.4 This principle covers all aspects of financial, personal welfare and healthcare decision-making and actions, whether the decision is a minor issue – like what to wear – or a major issue, like whether to provide particular healthcare.

5.5 It applies to anyone making decisions for a person who lacks capacity or acting under the provisions of the Act, including:

- family carers, other carers and care workers
- parents (see chapter 21)
- healthcare and social care staff
- attorneys appointed under a Lasting Power of Attorney or Enduring Power of Attorney
- deputies appointed by the court to make decisions on behalf of someone who lacks capacity, and
- the Court of Protection.

5.6 As long as these acts or decisions are in the best interests of the person who lacks capacity to make the decision for themselves, or to consent to acts concerned with their care or treatment, then the decision-maker or carer will be protected from liability (see chapter 6).

Exceptions to the best interests principle

5.7 There are three key circumstances where the Mental Capacity Act applies but where the best interests principle will not apply.

- The first is where an adult has previously made a valid and applicable advance decision to refuse medical treatment while they had the capacity to do so. Their advance decision should be respected when they lack capacity, even if others think that the decision to refuse treatment is not in their best interests (guidance on advance decisions is in chapter 11).
- The second concerns arrangements made under the Liberty Protection Safeguards. All decisions about care or treatment of a person who lacks capacity must be made using the best interests principle. However, sometimes the arrangements around the care or treatment may amount to a deprivation of liberty. Where this is the case, these arrangements must be authorised under the Liberty Protection Safeguards to ensure they are necessary and proportionate (see chapter 13).
- The third concerns the involvement in research, in certain circumstances, of someone lacking capacity to consent (see chapter 26).

5.8 The best interests principle also does not apply to decisions made about assessing and meeting needs under other relevant legislation outside of the Act, for example the Care Act 2014 and the Social Services and Wellbeing (Wales) Act 2014, or (in relation to children and young people), the Children and Families Act 2014/the Additional Learning Needs and Education Tribunal (Wales) Act 2018. This is because each of those legislative frameworks provide their own, specific, ways in

which to ensure that the interests of the person are taken into account, including where they cannot participate in the decision-making process.

5.9 Other than in these circumstances, the underpinning principle of the Act is that all acts and decisions should be made in the best interests of the person without capacity.

What does the Act mean by best interests?

5.10 The term 'best interests' is not defined in the Act, but it can best be thought of representing the decision or action that is right for that particular person as an individual at the time that the decision needs to be made or action taken. It does not mean doing what the decision-maker would do. 'Best interests' encompasses not just a person's medical interests, but also their social, cultural and psychological interests[36].

5.11 The Act does not prescribe what is in a person's best interests but sets down a process to follow that requires specific questions to be asked, steps to be followed, and matters to be considered. That process is designed to recognise, in particular, that a conclusion that the person is not able to make their own decision is not an 'off-switch' for their rights and freedoms[37].

5.12 Acting or deciding in a person's best interests is not the same as doing the best thing that could theoretically be done. If a particular option is not available then no determination can be reached that this would be in the person's best interests. This is discussed further at paragraph 5.74 below.

5.13 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 (see paragraph 5.27), 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, but must instead consider the person's wishes, feelings, values and beliefs.

5.14 Working out what is in someone else's best interests may be difficult, and the Act requires people to follow certain steps to help them work out whether a particular act or decision is in a person's best interests. In some cases, there may be disagreement about what someone's best interests really are. As long as the person who acts or makes the decision has followed the steps to establish whether a person has capacity, and, if the person lacks capacity, have done everything they reasonably can to work out what someone's best interests are, the law should protect them.

[36] See Aintree University Hospitals NHS Foundation Trust v James [2013] UKSC 67 - https://www.bailii.org/uk/cases/UKSC/2013/67.html

[37] See Wye Valley NHS Trust v B [2015] EWCOP 60, available at: https://www.bailii.org/ew/cases/EWCOP/2015/60.html.

Scenario: Whose best interests?

Mr P has a severe learning disability and lives in a care home. He has dental problems which cause him a lot of pain but refuses to open his mouth for his teeth to be cleaned.

The staff suggest that it would be a good idea to give Mr P an occasional general anaesthetic so that a dentist can clean his teeth and fill any cavities. Mr P lacks the capacity to consent to this. His mother is worried about the effects of an anaesthetic, but she hates to see him distressed and suggests instead that he should be given strong painkillers when needed.

While the views of Mr P's mother and carers are important in working out what course of action would be in his best interests, the decision must not be based on what would be less stressful for them. Instead, it must focus on Mr P's best interests.

Having talked to others, the dentist involves Mr P in the decision, with the help of his key worker and an advocate, to find out the cause and location of the problem and to explain to him that they are trying to stop the pain. The dentist ascertains whether any other forms of dental care would be better, such as a mouthwash or dental gum.

The dentist concludes that it would be in Mr P's best interests for:

- a proper investigation to be carried out under anaesthetic so that immediate treatment can be provided
- options for his future dental care to be reviewed by the care team, involving Mr P as far as possible

Who is the decision-maker?

5.15 In the Code, and in everyday use, the term "decision-maker" is frequently used. However, in general, it is important to understand that the Act does not identify any formal decision-makers. The exceptions are:

- If a Lasting Power of Attorney or Enduring Power of Attorney has been made and registered, or a deputy has been appointed under a court order, then the attorney or deputy will be the decision-maker for decisions within the scope of their authority;
- Where the Court of Protection makes the decision on behalf of the person (see Chapter 7)

5.16 In every other case, the Act does not say that any specific person or type of person is the decision-maker. Wherever appropriate, a decision as to what is in the best interests of a person unable to take the relevant decision should be reached informally and collaboratively between those involved in their care or interested in their welfare, whether paid/professional or unpaid. This means that:

- The fact that someone is seen as the person's next of kin does not mean that they have any legal right to make any decision on their behalf; but also that
- A professional does not have a right to make the decision on behalf of the person simply because they occupy a particular position.

5.17 However, it still makes sense to think of a "decision-maker" because of the way in which the Act works.

5.18 Anyone who wants out to carry an act in connection with the care or treatment of another will only be protected from criminal and civil liability if they reasonably believe that the person lacks capacity to make the relevant decision and that the action to be taken is in the person's best interests (see chapter 6).

5.19 In some cases, the person who is going to carry out the act could be thought of as "the decision-maker" because they are having to decide whether they have the necessary reasonable belief to be able to benefit from the protection from liability. For instance:

- A GP taking a blood sample from a patient who they reasonably believe to lack capacity to consent would be the decision-maker as to whether taking that blood is in their patient's best interests.
- The paid care worker who has to decide whether to step in to intervene to prevent a person with dementia from injuring themselves will have to decide there and then whether they reasonably believe that the person lacks capacity and that the step is in their best interests (and, if it amounts to restraint, whether the additional conditions discussed in chapter 6 are met).

5.20 In other cases, the person actually carrying out the act will be acting on the direction or under the supervision of another, or subject to a plan drawn up by someone else. In each case, the person will themselves have to be satisfied that they are acting in the best interests of the individual before carrying out the act, but are likely to being relying upon the views set down in the plan. In that case, it will be the person who is responsible for the plan who could be thought of as "the decision-maker." In the hospital context, for instance, the consultant in charge of the patient's care should usually be thought of as the decision-maker.

5.21 In any such situation, especially if there are different staff involved in the person's care from different organisations, it is important that there is one person who is identified as having the responsibility for the coordination of the process to determine what is in the individual's best interests. This may be the person who can be seen as the "decision-maker" in the way set out above, but in some cases, it could be more appropriate for that person to delegate this task to someone who has

the right set of skills to facilitate the process of considering all the matters set out under the Act.

5.22 In all cases involving an organisation there must, however, ultimately be one person who is prepared to take responsibility on behalf of that organisation for the conclusion that the step being taken is in the best interests of the individual concerned. That does not mean that they have the right to take that decision, but simply that they are accountable for it.

5.23 It is important that everyone involved in the best interests decision-making process knows and agrees who the decision-maker is, and that, no matter who is making the decision, the most important thing is that the decision-maker tries to work out what would be in the best interests of the person who lacks capacity. The decision-maker should try to identify any of their own unconscious biases to ensure they do not influence the best interests decision.

Scenario: Coming to a joint decision

Ms D has severe autism and learning disabilities and receives nutrition through a feeding tube. She has quickly lost weight and needs to undergo investigative medical procedures under anaesthetic.

Ms D does not like to be touched and previously suffered extreme distress when police officers restrained her for transfer by ambulance in an emergency. A mental capacity assessment by her GP confirms that she lacks capacity with respect to medical treatment decisions.

The hospital convenes a meeting, attended by members of the medical team including the anaesthetist and hospital safeguarding team, Ms D's father and sister, and her GP. An IMCA is not required because Ms D family speaks of her wishes and beliefs.

Decisions made in the meeting enable the medical team to create a detailed care and support plan based on Ms D's best interests: Her family will encourage her to be voluntarily secured on a stretcher for transfer to hospital. The anaesthetist will prescribe a small dose of pre-medication the night before to relieve her anxieties. Her mother will accompany her in the ambulance. Ms D will be first on the hospital morning list as this is less disruptive for her.

On the day of the procedure, Ms D is calm and her family support her to get in the ambulance with a minimum of distress. She goes straight to the CT suite with the anaesthetist, where she is anaesthetised for the scan, with CT and endoscopic procedures conducted consecutively to avoid unnecessary trips to hospital and unnecessary further use of chemical restraint. This positive experience gives Ms D reassurance about future procedures.

What must be taken into account when trying to work out someone's best interests?

Available options

5.24 Most best interests decisions will involve a choice, either between a person doing something and not doing something (for instance carrying out a medical procedure), or making a choice on behalf of the individual between two or more options (for instance where they might live). Where the choice is being made on behalf of the individual, that choice can only be between options which are actually available to them[38].

5.25 The process of best interests decision-making therefore needs to start with identification of what options are available. In some cases, this may appear very clear. In other cases, it may be necessary to make this identification on a provisional basis if not all information is yet available. In every case, it may be that a further option becomes clear during the process of considering the person's best interests. For instance, it might become apparent that it is so important to them that they remain at home that they would be prepared to tolerate a higher degree of risk to them than professionals might previously have considered acceptable. If so, the option of them remaining at home might therefore become available in a way that it

Scenario: A less restrictive option

A best interests assessor visits Ms K who has a learning disability.

Ms K is independently mobile and sociable with good communication skills. She needs prompting from care staff with all aspects of her care, as well as emotional support for anxiety issues.

The best interests assessor discovers that Ms K lives with three male residents, all of whom are non-verbal. Ms K is also supervised one on one and sometimes segregated to her own room, not because of her own behaviour but because of potential aggression from another resident.

The best interests assessor concludes that less restrictive options should be considered for Ms K. A social care review is carried out and an alternative placement is found for her with another female resident. This means Ms K no longer needs one on one support and does not ever need to be segregated to parts of her home.

[38] N v ACCG [2017] UKSC 22, available at: https://www.bailii.org/uk/cases/UKSC/2017/22.html.

had not previously done before. It is therefore important to consider the options available throughout the process and revisit them if required.

5.26 When considering the available options, the decision-maker must consider whether the purpose can be as effectively achieved in a way that is less restrictive of the person's rights and freedom (see paragraphs 2.21-2.23).

Best Interests Checklist

5.27 Because every case – and every decision – is different, the law can't set out all the factors that will need to be taken into account in working out someone's best interests. But section 4 of the Act sets out some common factors that must always be considered when trying to work out someone's best interests. These factors are summarised in the checklist here:

- Working out what is in someone's best interests cannot be based simply on someone's age, appearance, condition or behaviour (paragraphs 5.31-5.32)).
- All relevant circumstances should be considered when working out someone's best interests (paragraphs 5.33-5.36).
- If there is a chance that the person will regain the capacity to make a particular decision, then it may be possible to put off the decision until later if it is not urgent (paragraphs 5.44–5.48).
- Every effort should be made to enable and encourage the person who lacks capacity to take part in making the decision (paragraphs 5.37-5.43
- Special considerations apply to decisions about life-sustaining treatment (paragraphs 5.49–5.60).
- The person's past and present wishes and feelings, beliefs, values and any relevant cultural factors should be taken into account (paragraphs 5.61-5.80).
- The views of other people who are close to the person who lacks capacity, or a person involved in their care or treatment, should be considered, as well as the views of an attorney or deputy, in particular their views of what that person wanted (paragraphs 5.84-5.96)

5.28 It is important not to take shortcuts in working out best interests, and a proper and objective assessment must be carried out. If the decision is urgent, there may not be time to examine all possible factors, but the decision must still be made in the best interests of the person who lacks capacity.

5.29 Even though they must always be considered, not all the factors in the checklist will be relevant to all types of decisions or actions, and in many cases other factors will have to be considered as well, even though some of them may then not be found to be relevant. For example, an important factor might be the promotion of independence, preservation of dignity or considering the impact on the person of significant change in circumstances[39].

[39] *Newcastle-upon-Tyne City Council v TP and FW* [2016] EWCOP 61, available at: https://www.bailii.org/ew/cases/EWCOP/2016/61.html.

5.30 What is in a person's best interests may well change over time. This means that even where similar actions need to be taken repeatedly in connection with the person's care or treatment, the person's best interests should be regularly reviewed. Likewise, where a particular medical treatment has been started because it is in their best interests at that point in time, the decision should be reviewed on a regular basis to ensure that that remains the case.

Scenario: Following the checklist

Ms M has dementia and is beginning to neglect her personal hygiene and has several times been found wandering in the street unable to find her way home. Ms M's carers are concerned that she no longer has capacity to make appropriate decisions about her daily care. Her daughter is her personal welfare attorney and believes the time has come to act under the Lasting Power of Attorney (LPA).

She initially assumes it would be best for Ms M to move into a care home, since the staff would be able to help her wash and dress and prevent her from wandering. However, it cannot be assumed simply on the basis of her age, condition, appearance or behaviour either that Ms M lacks capacity to make such a decision or that such a move would be in her best interests.

Ms M's daughter must assess Ms M's capacity to make the decision and she consults Ms M's GP about this. The GP assesses Ms M as lacking the capacity to make this decision. Ms M's daughter then considers all the relevant factors in the best interests' checklist to decide what would be in her best interests.

Her daughter therefore considers:

- Ms M's past and present wishes and feelings
- the views of the people involved in her care
- any alternative ways of meeting her care needs effectively which might be less restrictive of Ms M's rights and freedoms, such as increased provision of home care or attendance at a day centre.

By following this process, Ms M's daughter reaches the decision that it would be in Ms M's best interests to explore finding a suitable care home for her.

Ms M's daughter follows the best interest checklist regarding other matters that fall under the authority of the LPA.

What safeguards does the Act provide around working out someone's best interests?

5.31 Section 4(1) states that anyone working out someone's best interests must not make unjustified assumptions about what their best interests might be simply on the basis of the person's age, appearance, condition or any aspect of their behaviour. In this way, the Act ensures that people who lack capacity to make decisions for themselves are not subject to discrimination or treated any less favourably than anyone else.

5.32 'Appearance' is a broad term and refers to all aspects of physical appearance, including skin colour, mode of dress and any visible medical problems, disfiguring scars or other disabilities. A person's 'condition' also covers a range of factors including physical disabilities, learning difficulties or disabilities, age-related illness or temporary conditions (such as drunkenness or unconsciousness). 'Behaviour' refers to behaviour that might seem unusual to others, such as talking too loudly or laughing inappropriately. It may also relate to the person's cultural background.

How does a decision-maker work out what 'all relevant circumstances' are?

5.33 When trying to work out someone's best interests, the decision-maker should try to identify all the issues that would be most relevant to the individual who lacks capacity and to the particular decision, as well as those in the 'checklist'. Clearly, it is not always possible or practicable to investigate in depth every issue which may have some relevance to the person who lacks capacity or the decision in question. So relevant circumstances are defined in section 4(11) of the Act as those:

a) of which the person making the determination is aware, and

b) which it would be reasonable to regard as relevant.

5.34 The relevant circumstances will of course vary from case to case. They may include both short-term and long-term implications. For example, when making a decision about major medical treatment, a doctor would need to consider the clinical needs of the patient, the potential benefits and burdens of the treatment on the person's health and life expectancy and any other factors relevant to making a professional judgement. But it would not be reasonable to consider issues such as life expectancy when working out whether it would be in someone's best interests to be given medication for a minor problem.

5.35 Financial decisions are another area where the relevant circumstances will vary. For example, if a person has received a substantial sum of money as compensation for an accident resulting in an acquired brain injury, the decision-maker would have to consider a wide range of circumstances when making decisions about how the money is spent or invested, such as:

- whether the person's condition is likely to change,

- whether the person needs professional care, and
- whether the person needs to live somewhere else to make life easier for them.

5.36 These kinds of issues can only be decided on a case-by-case basis.

How should the person who lacks capacity be involved in working out their best interests?

5.37 The decision-maker should make sure that all practicable means are used to enable and encourage the person to understand and participate as fully as possible in the decision-making process and any action taken as a result, or to help the person improve their ability to participate (section 4(4)). This may include taking into account any relevant collective decision-making processes in the person's family or wider cultural background.

5.38 Even if the person lacks capacity to make the decision, they may have wishes and feelings on matters affecting the decision, and on what outcome would be preferred. These should be ascertained where possible (see paragraph 5.61).. Their involvement can help work out what would be in their best interests. When finding out these views, the decision-maker should also consider the circumstances under which they were expressed to ensure the person's wishes and feelings are not a result of coercion by other people[40].

5.39 Consulting the person who lacks capacity will involve taking time to explain what is happening and why a decision needs to be made. Chapter 3 includes a number of practical steps to assist and enable decision-making which may be also be helpful in encouraging greater participation. These include:

- using simple language or communication aids such as pictures or assistive technology to help the person understand the options
- asking them about the decision at a time and location where the person feels most relaxed and at ease
- breaking the information down into easy-to-understand points
- using specialists such as interpreters, signers or speech and language therapists, to communicate with the person
- seeking the support of an advocate where relevant, who may have built up an understanding of the person's wishes and feelings over time.

5.40 This may mean that other people are required to communicate with the person to establish their views. For example, a trusted relative or friend, a full-time carer or an advocate may be able to help the person to express wishes or aspirations or to indicate a preference between different options.

[40] See ADS v DSM [2017] EWCOP 8, available at: https://www.bailii.org/ew/cases/EWCOP/2017/8.html.

5.41 More information on all of these steps can be found in chapter 3.

5.42 Taking steps to enable and encourage the person to participate in the decision may lead to a rethinking about whether they lack capacity to make the decision with the support available. If this is the case, it is important to go back and reassess their capacity to determine whether the person is able to make the decision for themselves.

5.43 The person who lacks capacity should also be informed of the outcome of the decision, unless there is a good reason for them not to be informed. Where it is decided not to inform them, the reason for this should be recorded.

Scenario: Involving someone in working out their best interests

Mr O has severe learning difficulties and Is taking a life skills course at his local further education college. He has an Education, Health and Care Plan (EHCP) held by the college and local authority.

At college, Mr O has the options of attending experience in a variety of placements including animal care or horticulture work. A capacity assessment concludes that, on the balance of probabilities, Mr O lacks capacity to make his own decision about a placement due to his inability to retain information. His college arranges a meeting, with invites extended to those involved in Mr O's EHCP, including Mr O and his parents. The meeting aims to inform a decision about where his work experience placement would be.

During the meeting Mr O says he likes looking after animals and has a cat and a rabbit at home. He said he does not like to see animals being hurt. His parents explained that Mr O will become upset if he sees animals being hurt on the television at home. His parents agree that the animal care option would be good for him but add that they worry his fear of seeing animals in pain means that a work experience placement at a vet's surgery for instance would be inappropriate. The meeting concludes it would be in Mr O's best interest to find a placement in animal care, which does not involve seeing animals being hurt.

The college for Mr O's animal care work experience to be in an animal sanctuary where he will not see animals undergoing surgical procedures. The EHCP contains details of Mr O's needs which enables the college to put in place adjustments required for Mr O to undertake the work placement.

How do the chances of someone regaining and developing capacity affect working out what is in their best interests?

5.44 There are some situations where decisions may be deferred if someone who currently lacks capacity may regain the capacity to make the decision for themselves. Section 4(3) of the Act requires the decision-maker to consider:

- whether the individual concerned is likely to regain the capacity to make that particular decision in the future, and
- if so, when that is likely to be

5.45 It may then be possible to put off the decision until the person can make it for themselves.

5.46 In emergency situations – such as when urgent medical treatment is needed – it may not be possible to wait to see if the person may regain capacity so they can decide for themselves whether or not to have the urgent treatment.

5.47 Where a person currently lacks capacity to make a decision relating to their day-to-day care, the person may – over time and with the right support – be able to develop the skills to do so. Though others may need to make the decision at that particular moment in time, all possible support should be given to that person to enable them to develop the skills so that they can make the decision for themselves in the future.

Scenario: Short term decisions for someone who may regain capacity

Mr F has had a stroke and as a result is unable to speak. Within days, he shows signs of improvement, and his medical team believe that with treatment he will recover over time. However at present his wife and the hospital staff find it difficult to communicate with him in order to ascertain his capacity and wishes regarding various decisions.

Mr F has always looked after the family finances, and his wife has no access to his personal bank account to provide the family with money to live on or pay the bills. These financial decisions cannot be delayed until Mr F's condition improves.

His wife therefore makes an application to the Court of Protection for an order that allows her to access Mr F's bank account in order to pay the bills and manage the immediate household expenses.

Decisions about longer-term arrangements are delayed until the extent of Mr F's recovery is better known.

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

- the cause of the lack of capacity can be treated, either by medication or some other form of treatment or therapy
- the lack of capacity is likely to decrease with time (for example, where it is caused by the effects of medication or alcohol, or following a traumatic event)
- a person with learning disabilities may learn new skills or be subject to new experiences which increase their understanding and ability to make certain decisions
- the person may have a condition which causes capacity to come and go at various times (such as some forms of mental illness)
- a person previously unable to communicate may learn a new form of communication (see chapter 3).

How should someone's best interests be worked out when making decisions about life-sustaining treatment?

5.49 A special factor in the checklist applies to decisions about treatment which is necessary to keep the person alive ('life-sustaining treatment') and this is set out in section 4(5) of the Act. The fundamental rule is that anyone who is deciding whether

or not life-sustaining treatment is in the best interests of someone who lacks capacity to consent to or refuse such treatment must not be motivated by a desire to bring about the person's death.

5.50 Whether a treatment is 'life-sustaining' depends not only on the type of treatment, but also on the particular circumstances in which it may be prescribed. For example, in some situations giving antibiotics may be life-sustaining, whereas in other circumstances antibiotics are used to treat a non-life-threatening condition. It is for the doctor or healthcare professional providing treatment to assess whether the treatment is life-sustaining in each particular situation.

5.51 It is also for the doctor or healthcare professional in each situation to decide whether the life-sustaining treatment in question is a treatment it would be reasonable to give in the circumstances. For example:

- Some treatments may provide no realistic prospect of success: for instance, it might be that CPR (cardio-pulmonary resuscitation) could not restart the person's heart and breathing.
- Some treatments cannot be provided for clinical reasons: for instance, it might not be practicable to reinsert a feeding tube for a person being fed by clinically assisted nutrition and hydration.
- Some treatments may be covered by specific policies: for instance, a hospital may have a policy that antibiotics cannot be given in certain situations because of the risk of antibiotic resistance. Or a particular drug may not be available to use because it does not meet national commissioning criteria.

5.52 In deciding whether it is reasonable to give a particular treatment to a particular patient, the treating doctor should take into account any statement in advance made by the patient in the same way as a request made by the patient who has capacity to make such decisions.

5.53 If the treatment is not one that is reasonable to give, the treating doctor cannot be required by the Act to provide it. A person lacking capacity cannot be in a better position than a person with capacity. If the option would not be available for the person if they had capacity and were requesting it, there is no requirement that this be offered as part of a best interests decision[41]. There may be other routes to resolve any dispute that may arise in consequence of the decision not to offer the treatment, but they fall outside the scope of this Act, and cannot be resolved by the Court of Protection.

5.54 If the treatment is, in principle, one that is both reasonable and available to give, then the decision will need to be made as to whether it is in the patient's best interests to give it.

[41] Aintree University Hospitals NHS Foundation Trust v James [2013] UKSC 67, available at: https://www.bailii.org/uk/cases/UKSC/2013/67.html.

5.55 Alongside the guidance in this Code, doctors and other staff should refer to relevant professional guidance for the process of making the decision, including the need (for instance) for a second opinion[42].

5.56 In making a best interests decision about giving or continuing life-sustaining treatment, there is always a strong presumption that it will be in the patient's best interests to attempt to prolong his or her life, and the decision-maker **must not be motivated by a desire to bring about the person's death for whatever reason, even if this is from a sense of compassion.**

5.57 However, the strong presumption in favour of attempting to prolong life can be displaced (not followed) where:

- There is clear evidence that the person would not want the treatment in question in the circumstances;
- The treatment itself would be overly burdensome for the patient, in particular, by reference to what is known about whether it is more important to the patient to be kept alive at all costs or to be kept comfortable;
- There is no prospect that the treatment will return the patient to a state of a quality of life that the patient would regard as worthwhile. The important viewpoint is that of the patient, not of the doctors or healthcare professionals.

5.58 If at the end of the process there is agreement that it is not in the patient's best interests to give or continue the treatment, the life-sustaining treatment should either be withheld or stopped, as to do otherwise would be to act unlawfully. There is no need in such a case to obtain the authorisation of the Court of Protection before doing so.

5.59 However, if at the end of the process, it is apparent that the way forward is finely balanced, or there is a difference of medical opinion, or a lack of agreement to a proposed course of action from those with an interest in the patient's welfare (for instance between clinicians and the person's family), an application must be made to the Court of Protection (see chapter 7)43. An application to the Court of Protection is also very likely to be required if there is a potential conflict of interest which cannot be appropriately managed, so that the medical professionals involved can properly say that they reasonably believe that they are acting in the best interests of the person.

[42] For instance, the British Medical Association has best interests decision-making guidance regarding clinically assisted nutrition and hydration, available at: https://www.bma.org.uk/advice-and-support/ethics/adults-who-lack-capacity/clinically-assisted-nutrition-and-hydration.

The Royal College of Physicians has guidance relating to decisions in respect of those in Prolonged Disorders of Consciousness, available at: https://www.rcplondon.ac.uk/news/prolonged-disorders-consciousness-new-guidelines-help-doctors-and-families.

The Resuscitation Council (UK) has guidance on decisions about whether or not to provide CPR, available at: https://www.resus.org.uk/library/publications/publication-decisions-relating-cardiopulmonary.

[43] NHS Trust v Y [2018] UKSC 46, available at: https://www.bailii.org/uk/cases/UKSC/2018/46.html

5.60 Decisions in relation to life-sustaining treatment should be kept under review. The fact that the decision was taken to start a life-sustaining treatment because this was in the patient's best interests does not mean that it will continue indefinitely to be in their best interests. How often the review will be required will depend on the nature of the patient's case. See 6.25-6.31 for more on major healthcare decisions including 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) decisions.

How do a person's wishes and feelings, beliefs and values affect working out what is in their best interests?

5.61 Section 4(6) of the Act requires the decision-maker to consider, as far as they are 'reasonably ascertainable':

a) 'the person's past and present wishes and feelings (and in particular, any relevant written statements made by him when he had capacity),

b) the beliefs and values that would be likely to influence his decision if he had capacity, and

c) the other factors that he would be likely to consider if he were able to do so.'

5.62 Paragraphs 5.24-5.30 above give further guidance on each of these factors.

5.63 Asking what is in a person's best interests is not the same as asking 'what would the person have done?'[44]. The final decision must be based entirely on what is in the person's best interests.

5.64 However, the courts have made clear that a person's past and present wishes and feelings must be taken into consideration and can be the deciding factor in best interests decision-making[45].

5.65 In every case, the decision-maker must take the steps set out at paragraph 5.27 – i.e. participation of person, consultation, wishes and feelings, especially identification of written statements, thinking about beliefs and values]. In many – but not all – cases, carrying out this process means that the decision-maker will then have a clear view as to what the person would have done if they were able to make the decision themselves.

5.66 In many situations, this will, in turn, give the answer as to what is in the person's best interests. This may be particularly so in relation to decisions about medical treatment (see further 5.74-5.77). Good social care and clinical practice also

[44] Briggs v Briggs (No 2) [2016] EWCOP 53, available at: https://www.bailii.org/ew/cases/EWCOP/2016/53.html

[45] Re AB [2019] EWCA Civ 1215, available at: https://www.bailii.org/ew/cases/EWCA/Civ/2019/1215.html

provide that care should, as far as possible, be delivered in line with the person's known wishes and feelings, beliefs and values.

5.67 In other cases, taking into account all the relevant circumstances (as required by section 4) means that a different decision is taken to that the person would have taken. Examples of where this may be appropriate might include:

- Where giving effect to the person's wishes would be to expose the person to a level of risk that the person is unable to take into account for themselves, such as an elderly person with dementia who wishes to continue to live at home but is no longer able to safely care for themselves.
- Where the person is unable to understand or weigh up the information relevant to a decision, such as a person who has received compensation to pay for specialist care that they need following an accident, but who wants to spend the money on a luxury item.

5.68 In any case where the decision-maker reaches a conclusion that the decision or action that is in the person's best interests is not that which the person would have taken, the decision-maker should be prepared to justify their decision. The greater the departure from what the decision maker considers that the person would themselves have done, the clearer the justification the decision-maker should be able to give. See also 5.102-5.108 for how to record best interests decisions.

What is 'reasonably ascertainable'?

5.69 How much a decision-maker can learn about a person's past and present views will depend on the decision, circumstances and the time available. The decision-maker is under a duty to take all practicable steps to obtain and consider as much relevant information as possible, usually by talking to the person or those who know them, in the time available. What is available in an emergency will be different to what is available in a non-emergency. But even in an emergency, there may still be an opportunity to try to communicate with the person or his friends, family or carers (see chapter 3 for guidance on helping communication)[46].

What role do a person's past and present wishes and feelings play?

5.70 The Act requires the decision-maker to consider the person's past and present wishes and feelings. This means considering both what the person is currently doing or saying and what they may have said in the past. If wishes and feelings expressed now appear to contradict with wishes and feelings expressed in the past, the decision-maker will need to consider the contradiction very carefully in the context of the particular circumstances to help determine what is in the person's best interests.

[46] See Winspear v City Hospitals Sunderland NHS Foundation Trust [2015] EWHC 3250 (QB), available at: https://www.bailii.org/ew/cases/EWHC/QB/2015/3250.html

5.71 The person may have held strong views in the past which could have a bearing on the decision to be made now. All reasonable efforts must be made to find out whether the person has expressed views in the past that should inform the decision to be made. This could have been through oral or written communication, behaviour or habits, or recorded in any other way (for example, videos or voice recordings or posts on social media). When finding out these views, the decision-maker should also consider the circumstances under which they were expressed to ensure the person's wishes and feelings were not influenced by other people's views[47].

5.72 Section 4(6)(a) places special emphasis on formal or informal written statements or instructions (such as an LPA) the person might have made before losing capacity[48]. These could provide a lot of information about a person's wishes. For example, these statements could include information about the type of medical treatment they would want in the case of future illness, where they would prefer to live, or how they wish to be cared for. The person may have made specific advance statements setting out their preferences about any aspect of care, accommodation or lifestyle should they lose capacity.

5.73 The decision-maker should consider written statements carefully. If their decision does not follow something a person has put in writing, they should record the reasons why. They should be able to justify their reasons if someone challenges their decision.

5.74 A doctor should take written statements made by a person before losing capacity which request specific treatments as seriously as those made by people who currently have capacity to make treatment decisions. But, just as with a request made by a person who has capacity, the doctor would not have to follow a written request if they think the specific treatment would be clinically unnecessary or not appropriate for the person's condition. If a treatment is not available, then it would not fall to be considered as part of best interests decision-making.

5.75 It is important to note the distinction between a written statement expressing treatment preferences and a statement which constitutes an advance decision to refuse treatment. This is covered by section 24 of the Act, and it has a different status in law. Doctors cannot disregard a valid and applicable advance decision to refuse treatment made by an adult. An advance decision to refuse treatment must be followed if it meets the Act's requirements and applies to the person's circumstances. In these cases, the treatment must not be given (see chapter 11 for more information). If there is not a valid and applicable advance decision, treatment should be provided based on the person's best interests. If there is an advance decision but it is not valid and applicable, the doctor must still consider it as part of the assessment of the person's best interests if they have reasonable grounds to think it is a true expression of the person's wishes or values.

[47] See *ADS v DSM* [2017] EWCOP 8, available at: https://www.bailii.org/ew/cases/EWCOP/2017/8.html

[48] See paragraph 58 of *Re BM* [2014] EWCOP B20, available at: - https://www.bailii.org/ew/cases/EWCOP/2014/B20.html

5.76 People who cannot express their current wishes and feelings in words may express themselves through their behaviour. In some cases, an advocate could help the person make choices and express their views. Expressions of pleasure or distress and emotional responses will also be relevant in working out what is in their best interests. Finally, just because a person cannot express a clear and consistent wish, it does not mean that they do not have feelings which have to be taken into account[49].

5.77 In many situations, the healthcare team and the person may have worked together to produce an Advance Care and Support Plan to record their treatment and care wishes[50]. The plan will help guide decision-making at a point when the person does not have capacity to make their own decisions. This plan may contain details of any relevant written statements and advance decisions, together with the names of anyone appointed to act as the person's health and welfare attorney. See paragraphs 5.90 and 5.91 for more detail.

[49] Re AB (Termination of Pregnancy) [2019] EWCA Civ 1215, available at: https://www.bailii.org/ew/cases/EWCA/Civ/2019/1215.html

[50] NICE Decision-making and mental capacity guideline Overview | Decision-making and mental capacity | Guidance | NICE, available at: https://www.nice.org.uk/guidance/ng108

Scenario: Using a future care and support plan

Ms G has advanced Alzheimer's dementia and lives in a nursing home. In the last 2 months she has been admitted to hospital twice because she became feverish and stopped eating. She was very distressed and agitated in hospital, which her daughters felt was due to the change in her environment.

The GP and nursing home manager meet with one of Ms G's daughters who says that she does not think that her mother should be admitted to hospital if this should happen again. The GP assesses Ms G as lacking capacity to make decisions about her treatment and participate in discussions, with no realistic chance of recovery of capacity.

A formal meeting is held to agree a future care and support plan for Ms G. Careful consideration is given as to who should be consulted. Ms G is a widow with three daughters, one of whom lives a long way away. The home manager speaks with her by telephone. The daughters identify Ms G's long-term close friend as someone who should be consulted.

The nursing home manager, friend and 2 daughters meet. Everyone involved agrees that if Ms G developed another chest infection it would be in her best interests to remain in the nursing home with good symptom control, and not to receive antibiotics to prolong her life.

The nursing home manager confirms the outcome of meeting to the other daughter who agrees with the care and support plan. A future care and support plan document is completed recording these recommendations, confirming how the principles of best interests decision-making have been followed.

One month later, Ms G becomes very unwell. An out of hours GP is called and assessment Ms G as having signs of a chest infection which could be fatal if she is not treated with intravenous antibiotics, and that she may die even with treatment because of her underlying conditions. The agency nurses on duty at the home do not know Ms G well, but show the future care and support plan to the out of hours GP. He unsuccessfully attempts to contact the daughters by phone.

The GP can see from the future care and support plan that a robust process has been followed which follows the principles of the Mental Capacity Act best interests decision-making. Informed largely by the future care and support plan, the GP is able to make a best interests decision to prescribe medicine to keep Ms G comfortable in the nursing home, and she dies the next day.

What role do beliefs and values play?

5.78 Everybody's values and beliefs influence the decisions they make. They may become especially important for someone who lacks capacity to make a decision because of a progressive illness such as dementia, for example. Evidence of a person's beliefs and values can be found in things like their:

- cultural background
- religious beliefs
- political convictions, or
- past behaviour or habits.

5.79 Some people set out their values and beliefs in a written statement while they still have capacity. Others may never have had capacity to make a decision or may never have had the ability to express their wishes and feelings.

5.80 The values of the family or community in which the person is brought up may be relevant. A best interests decision may need to take into account the effect it would have on how the person is viewed by their community. However, this should be approached with caution, especially if the act might cause the person themselves distress51.

[51]See for example IH (Observance of Muslim Practice) [2017] EWCOP 9, available at: https://www.bailii.org/ew/cases/EWCOP/2017/9.html

Scenario: Considering beliefs and values

Ms A worked for an overseas charity until she was involved in a car accident and suffered an acquired brain injury. She now lacks capacity to make complex financial decisions and the Court of Protection has appointed her father as deputy to invest the compensation she received. As the decision-maker regarding managing her compensation he must think about her wishes, beliefs and values, as well as her care needs, before deciding how to invest the money.

Ms A's father talks to her friends and former colleagues. They tell him how deeply Ms A's political beliefs shaped not just her approach to work but also her wishes, feelings and beliefs regarding all aspects of managing her life.

Ms A's father decides not to invest in the bonds that a financial adviser had recommended as having the best return, because they are from companies Ms A would not have approved of. Instead, he employs an ethical investment adviser who choose investments which are in line with her wishes, feelings and beliefs.

What other factors should a decision-maker consider?

5.81 Section 4(6)(c) of the Act requires decision-makers to consider any other factors the person who lacks capacity would consider if they were able to do so. This might include the effect of the decision on other people, obligations to dependants or the duties of a responsible citizen[52].

5.82 The Act allows actions that benefit other people, as long as they are in the best interests of the person who lacks capacity to make the decision. For example, having considered all the circumstances of the particular case, a decision might be made to take a blood sample from a person who lacks capacity to consent, to check for a genetic link to cancer within the family, because this might benefit someone else in the family. But it might still be in the best interests of the person who lacks capacity[53].

5.83 'Best interests' also goes beyond the person's medical interests[54]. For example, courts have previously ruled that possible wider benefits to a person who lacks

[52] The Secretary of State for the Home Department v Skripal [2018] EWCOP 6 (22 March 2018), available at:https://www.bailii.org/ew/cases/EWCOP/2018/6.html

[53] NHS Foundation Trust v MC [2020] EWCOP 33 A NHS Foundation Trust v MC [2020] EWCOP 33, available at: https://www.bailii.org/ew/cases/EWCOP/2020/33.html

[54] See *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, available at:https://www.bailii.org/uk/cases/UKSC/2013/67.html

capacity to consent, such as providing or gaining emotional support from close relationships, are important factors in working out the person's own best interests[55]. If it is likely that the person who lacks capacity would have considered these factors themselves, they can be seen as part of the person's best interests.

Who should be consulted when working out someone's best interests?

5.84 The Act places a duty on the decision-maker to consult other people close to a person who lacks capacity, where practicable and appropriate, on what decision they think would be in the person's best interests. The primary purpose of consultation is to understand what the person's decision would be if they could take it for themselves[56].

5.85 The duty applies to those involved in caring for the person and interested in the person's welfare, and it may be appropriate to seek the views of more people for more serious decisions (whilst respecting patient confidentiality). Under section 4(7), the decision-maker has a duty to take into account the views of the following people, where it is practicable and appropriate to do so:

- anyone the person has previously named as someone they want to be consulted,
- anyone involved in caring for the person (including care workers and medical professionals),
- anyone interested in their welfare (for example, parents or other family carers, other close relatives, an advocate already working with the person, or education staff where appropriate),
- an attorney appointed by the person under a Lasting Power of Attorney (who may be the decision maker on behalf of the person, depending on the nature of the LPA), and
- a deputy appointed for that person by the Court of Protection (whose deputyship may give them authority to make a decision on behalf of the person).

5.86 If there is no-one to speak to about the person's best interests, the person may qualify for an Independent Mental Capacity Advocate (IMCA). When an IMCA has been instructed, they should be involved in the process until a decision has been made and implemented fully. For more information on IMCAs, see chapter 10.

[55] See for example *G (TJ)* [2010] EWCOP 3005, available at: - https://www.bailii.org/ew/cases/EWCOP/2010/3005.html

[56] *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67 at paragraph 39, available at: https://www.bailii.org/uk/cases/UKSC/2013/67.html.

5.87 Any decision-maker must show they have thought carefully about whom to speak to. If it is practicable and appropriate to speak to the above people, they must do so and must take their views into account.

5.88 The decision-maker must be able to explain why they did not speak to a particular person when it would appear objectively that that person would be someone to consult. It is good practice to have a clear record of their reasons. A failure to consult with someone properly interested in the person's welfare when it is practicable and appropriate to do so will mean that the decision-maker cannot rely upon the defence in section 5 of the Act[57].

5.89 The decision-maker should try to find out:

- what the people consulted think is in the person's best interests in this matter, and
- if they can give information on the person's wishes and feelings, beliefs and values (for instance about how the person has lived their life; what has been important to them; what they think the person would say now).

5.90 This information may be available from somebody the person named before they lost capacity as someone they wish to be consulted. People who are close to the person who lacks capacity, such as close family members, are likely to know them best. They may also be able to help with communication or interpret signs that show the person's present wishes and feelings about the decision to be made. The fact that someone is seen as the person's next of kin does not mean their views are to be regarded as more important than those of anyone else who can provide the relevant information. Everybody's views are potentially of equal importance, even if they do not agree with each other. They must be considered alongside the views of the person who lacks capacity and other factors.

[57] Winspear v City Hospitals Sunderland NHS Foundation Trust [2015] EWHC 3250 (QB), available at:https://www.bailii.org/ew/cases/EWHC/QB/2015/3250.html.

5.91 When consulting, the decision-maker should strive to be aware of any potential conflicts of interest of those they consult and any fiduciary duty, where someone stands to gain financially from the decision. This does not necessarily mean that these people are unable to participate in decision-making. But they must be able to maintain focus on what the relevant issues are, in particular what the person themselves would have wanted. See paragraphs 5.113-5.117 below for guidance on dealing with conflicting views.

Scenario: Considering other people's views

Ms L has an acquired brain injury with severe communication difficulties. She is cared for at home by her parents and attends a day centre a couple of days a week.

The day centre staff would like to take some of the service users on a day trip to a farm educational centre. They explain the trip to Ms L using appropriate language and pictures which show Ms L what she can expect on the trip. Ms L's body language suggests she likes the idea of visiting the farm animals. A capacity assessment is completed, and it is believed that Ms L lacks capacity to make the decision about the trip due to her inability to weigh up the information in order to make a decision. The day centre staff speak to her parents as part of the process of assessing whether the trip would be in her best interests. Ms L's parents think that the trip would be a good experience for her as she loves outdoor activities. However, they are aware that Ms L gets anxious particularly when she is somewhere unfamiliar and has to interact with strangers who don't know how to communicate with her.

The staff and Ms L's parents discuss how to manage this in Ms L's best interests. A risk assessment is completed where it is agreed that a care assistant, to whom Ms L is particularly close, will accompany her throughout her time at the farm centre. The care assistant will use social situation stories throughout the trip to help Ms L's communication and minimise her anxiety.

5.92 Where an attorney has been appointed under a Lasting Power of Attorney or Enduring Power of Attorney, or a deputy has been appointed by a court, they must make the decisions on any matters they have been appointed to deal with. Attorneys and deputies should also be consulted, if practicable and appropriate, on other issues affecting the person who lacks capacity.

5.93 For instance, an attorney who is appointed only to look after the person's property and affairs should be contacted to see whether they have information about the person's beliefs and values, wishes and feelings, that could help work out what would be in the person's best interests regarding healthcare or treatment decisions. If so, they should be consulted. (See chapters 8 and 9 for more information about the roles of attorneys and deputies.)

5.94 It is good practice for healthcare and social care staff to record at the end of the process why they think a specific decision is in the person's best interests. This is particularly important if healthcare and social care staff decide against the views of somebody who has been consulted while working out the person's best interests. Guidance on record-keeping is detailed at paragraphs 5.102-5.108 below)

What if those involved in caring for the person or interested in the person's welfare have drawn up a future care and support plan?

5.95 Sometimes a 'future care and support plan' for a person who lacks capacity will have been drawn up and agreed, perhaps by family members, medical professionals and a care home, and particularly regarding end of life care.

5.96 Such a care and support plan is not of itself a best interests decision, but is important as a record of discussions and agreed recommendations, which should help inform a best interests decision on clinically appropriate medical care, at the time when this is required. It is therefore important that, where a future care and support plan is drawn up, it is recorded and made available so that it can help inform any best interests decision. Although not a best interests decision itself, those involved in drawing up a future care and support plan should follow the best interests decision-making principles of the Act as far as possible to ensure that the plan can help inform the best interests decision robustly.

How can decision-makers respect confidentiality?

5.97 Decision-makers must balance the duty to consult other people with the right to confidentiality of the person who lacks capacity. So if confidential information is to be discussed, they should only seek the views of people who it is appropriate to consult, where their views are relevant to the decision to be made and the particular circumstances.

5.98 There may be occasions where it is in the person's best interests for personal information (for example, about their medical condition, if the decision concerns the provision of medical treatment) to be revealed to the people consulted as part of the process of working out their best interests (further guidance on this is given in chapter 25). Healthcare and social care staff who are trying to determine a person's best interests must follow their professional guidance, as well as other relevant guidance, about confidentiality.

Reasonable belief about a person's best interests

5.99 Section 4(9) confirms that if someone acts or makes a decision in the reasonable belief that what they are doing is in the best interests of the person who lacks capacity, then – provided they have followed the checklist in section 4 – they will have complied with the best interests principle set out in the Act. Coming to an incorrect conclusion about a person's capacity or best interests does not necessarily mean that the decision-maker would not get protection from liability (this is explained in chapter 6). But they must be able to show that it was reasonable for

them to think that the person lacked capacity and that they were acting in the person's best interests at the time they made their decision or took action.

5.100 Where there is a need for a court decision, the court will require evidence of what might be in the person's best interests. This will include evidence from relevant professionals (for example, psychiatrists or social workers) See Chapter 7 for more details on the Court. In most day-to-day situations, there is no need for such formality. In emergency situations, it may not be practicable or possible to gather formal evidence.

5.101 Where the court is not involved, people are still expected to have reasonable grounds for believing that they are acting in somebody's best interests. This does not mean that decision-makers can simply impose their own views. They must have objective reasons for their decisions – and they must be able to demonstrate them. They must be able to show they have considered all relevant circumstances and applied all elements of the best interests checklist.

Scenario: Demonstrating reasonable belief

Ms Z was attacked in the street and was brought to hospital unconscious, with severe injuries, having lost a lot of blood. The medical team decided that an urgent blood transfusion was in her best interests as it was required to save her life, and the transfusion was carried out.

As Ms Z had no form of identification with her an appeal was put out to identify her and her family was later traced. When they were contacted, they advised the hospital that Ms Z's beliefs meant that she would have refused the blood transfusion had she had had capacity to make the decision.

As Ms Z arrived at the hospital unconscious and with no identification, the medical team had no information about her beliefs at the time they needed to make the urgent decision about emergency treatment. At the time the doctors made the best interests decision they had reasonable grounds for believing that the decision was in their patient's best interests. Therefore they were protected from liability.

Once the hospital team was aware of Ms Z's beliefs, they considered them, in consultation with her family, in subsequent best interests decisions about her medical treatment while she lacked capacity to make the decisions for herself.

Recording best interests decisions

Care and treatment decisions

5.102 Any staff involved in the care of a person who lacks capacity should make sure a record is kept of the process of working out the best interests for each decision.

5.103 The record that is kept of the process of working out the best interests of the person in respect of any decision will depend upon the nature of the decision. Where other people are going to be implementing the decision, it will be important for them easily to be able to understand why it is thought the act of care or treatment is in the person's best interests. In most cases, this will mean including a record in the person's care and support plan or file of:

- how the decision about the person's best interests was reached
- The views, wishes and feelings of the person, particularly if different from the decision made
- what the reasons for reaching the decision were
- who was consulted to help work out best interests, and
- what particular factors were taken into account, including any relevant cultural factors.

5.104 More serious decisions will require more detailed records. Certain decisions taken by health and social professionals or bodies will represent so serious an interference with the person's rights under the European Convention on Human Rights58 that a detailed record should be prepared. Preparation of such a record serves three purposes:

a) To ensure that the decision-maker has considered all the matters necessary in order to be able to rely upon the defense in section 5 of the Act

b) To ensure that, wherever possible, disputes in relation to serious issues are identified at an early stage so that consideration can be given as to how they can be resolved (including by the Court of Protection) **before** the action is taken. This is particularly important if the action in question will be irreversible

c) To ensure accountability after the event

5.105 These decisions include;:

- to move the person into long-term accommodation
- to restrict the person's contact with others (this could include named individuals or a class of individuals) (see paragraph 6.20-6.22)

[58] See for example *Shtukaturov v Russia* [2012] 54 EHRR 27 (App No 33985/96), *X v Finland* App No 34806/04, available at: https://www.hr-dp.org/files/2013/09/09/CASE_OF_SHTUKATUROV_v._RUSSIA_.pdf.

Lashin v Russia App No 33117/02, available at: https://www.bailii.org/eu/cases/ECHR/2013/63.html..

- to provide serious medical treatment (see paragraph 6.32-6.37)
- to administer “covert” medication or treatment (whether by misrepresenting to the person what is being administered or otherwise)
- to administer medication or treatment which the decision-maker knows, or reasonably suspects, to be against the person’s wishes

5.106 In such cases, the record should include:

- a description of the steps which have been taken to help the person to make the decision, or an explanation as to why it was not practicable to take such steps
- an explanation of why it is believed that the person lacks capacity in relation to the matter
- a description of the steps which have been taken to establish whether or not it is in the person’s best interests for the act to be done, including, in particular:

    a. a description of the steps taken to ascertain the person’s wishes, feelings, beliefs and values in relation to the matter and, if the decision to be taken conflicts with the person’s ascertained wishes, feelings, beliefs or values, an explanation of the reason why it is being taken

    b. a description of the consultation that has been carried out

    c. confirmation that any duty to provide an advocate (under this Act or any other Act) has been complied with

    d. (in the case of medical treatment) confirmation that the act would not be contrary to an advance decision to refuse that treatment

5.107 If the urgency of the situation means that the decision-maker cannot complete the record before the decision is carried out, the decision-maker should make sure that it is completed as soon as possible afterwards.

5.108 After the decision is made, the decision maker should ensure that it is recorded and communicated to everyone involved and that there is opportunity for all participants to offer feedback or raise objections. This record should remain on the person’s care and support plan or file.

Property and affairs decisions made by attorneys and deputies

5.109 Attorneys and deputies who are appointed to manage a person’s property and affairs should keep a record of transactions they make on the person’s behalf. See chapter 8 and 9 for further information. For significant financial decisions, the attorney or deputy should also record how they worked out what was in the best interests of the person.

5.110 Attorneys or deputies appointed for health and welfare should keep a record of all the significant decisions they make about the person’s health and welfare. Significant decisions might include choosing a care home, agreeing to medical treatment or making a change to the donor’s diet for health reasons. Attorneys and

deputies could do this by keeping a written journal or computer file recording the decisions made and when. This should record how they worked out what was in the person's best interests, including details of who was consulted and any disputes about the decision.

5.111 Keeping a record of how significant decisions were made may assist conversations with family members or help to deal with any concerns that might be raised. Keeping records of such decisions is particularly important if an attorney's decision goes against any of the donor's preferences listed in the LPA.

What problems could arise when working out someone's best interests?

5.112 It is important that the best interests principle and the statutory checklist are used flexibly. In some cases, a balance sheet of pros and cons of options may be a useful tool to ensure all factors have been included. However, it should only be used as an aid and not as a substitute for decision-making[59]. The fact that there are many entries in one column does not, in itself, give the answer. There may be only one entry in the other column, but it is of such importance that it outweighs all the entries in the other. The courts have referred to this as being a situation where there is a factor of 'magnetic importance'[60]. In all cases, it is important that proper consideration is given to prioritising all relevant factors so the outcome is the best possible for the person who lacks capacity to make the particular decision. Some decisions will be straightforward, and others more complex.

What happens when there are conflicting concerns?

5.113 A decision-maker may be faced with people who disagree about a person's best interests. Family members, partners and carers may disagree between themselves. Or they might have different memories about the views the person expressed in the past. Carers and family might disagree with a professional's view about the person's care or treatment needs.

5.114 The decision-maker will balance concerns in order to decide between them. The first approach should be to review all elements of the best interests checklist with everyone involved. They should include the person who lacks capacity (as much as they are able to take part) and anyone who has been involved in earlier discussions. It may be possible to reach an agreement at a meeting to air everyone's concerns, including those of people who are not able to attend the meeting itself. But an agreement in itself might not be in the person's best interests if it represents an agreement which suits the others around the table, rather than meeting the needs of the person. Ultimate responsibility for considering whether to act upon the agreement, or for taking some other step, lies with the decision-maker, as the

[59] Re D (Medical Treatment) [2017] EWCOP 15: D, Re (Medical Treatment) [2017] EWCOP 15 (05 September 2017), available at: https://www.bailii.org/ew/cases/EWCOP/2017/15.html.

[60] ITW v Z & Ors [2009] EWCOP 2525, available at: https://www.bailii.org/ew/cases/EWHC/Fam/2009/2525.html

person accountable for the action they then take based on their belief as to what is in the person's best interests. Disagreements are covered in more detail in chapter 24.

Family, partners and carers who are consulted

5.115 If disagreement continues, the decision-maker will need to weigh up the views of different parties. This will depend entirely upon the circumstances of each case, the people involved and their relationship with the person who lacks capacity. Sometimes the decision-maker will find that the person's current or former carers have an insight into how to interpret a person's wishes and feelings that can help them reach a decision.

5.116 The person's paid care workers and voluntary sector support workers may have specialist knowledge about up-to-date care options or treatments. Some may also have known the person for many years.

5.117 People with conflicting interests should not be cut out of the process (for example, those who stand to inherit from the person's will may still have a right to be consulted about the person's care or medical treatment). But decision-makers must always ensure that the interests of those consulted do not overly influence the process of working out a person's best interests. In weighing up different contributions, the decision-maker should consider:

- how long an individual has known the person who lacks capacity
- what their relationship is
- the level of contact they have with the person
- whether they have a vested interest in the decision
- whether their past or current conduct has been detrimental to the person who lacks mental capacity, and, if so, in what way

Advocacy

5.118 In some circumstances, an IMCA must be instructed and consulted to provide support for and represent the person who lacks capacity (see chapter 10). If someone does not qualify for an IMCA, other types of advocate may nevertheless be helpful. These could be a statutory or non-statutory advocate, for example a Care Act advocate, an Independent Mental Health Advocate, an independent advocate or a peer advocate. Such advocates may be useful in providing independent representation and support for the person who lacks capacity in the process of working out their best interests, if:

- family members disagree about the person's best interests
- family members and professionals disagree about the person's best interests
- there is a conflict of interest for people who have been consulted in the best interests assessment (for example, the sale of a family property where the person lives)
- the person who lacks capacity is already in contact with an advocate

- the proposed course of action may lead to the use of restraint or other restrictions on the person who lacks capacity
- there is a safeguarding concern

Scenario: Settling disagreements

Mr R has learning disabilities and autism and is about to leave his current residential special school. The Special Educational Needs and Disabilities (SEND) team in his local authority needs to make a decision about which placement would be best for Mr R from the available options.

An assessment has been completed which determines whether Mr R lacks the capacity to retain the information long enough to make a decision on his next placement. The school sets up a meeting, attended by Mr R, his parents, teachers from his school who also know him very well, and professionals involved in preparing Mr R's Education, Health and Care Plan (EHCP).

The meeting considers which placement would be best for Mr R from the available options. During the meeting the various available placements are explained including their location, size and facilities. These are also explained to Mr R in appropriate language, with pictorial aids. The SEND team have looked at Mr R's needs and recommends a place in a local supported living placement. However, Mr R's parents want him to go to a special school as they feel Mr R has enjoyed living in a residential school and think Mr R will not get the appropriate care in supported living. It is agreed, with Mr R's involvement, that it would be helpful for him to visit the available places with his parents to explore these two potential options.

After the visits there is further consultation with Mr R and his parents, where Mr R's wishes and feelings are discussed, again with him. Agreement is reached that a supported living placement near his family home would be in Mr R's best interests due to its ability to meet his emerging independence skills and proximity to his family.

Settling disputes about best interests

5.119 If someone wants to challenge a decision, they may wish to:

- Involve an advocate to act on behalf of the person who lacks capacity to make the decision (see paragraph 5.118 above).
- Get a second opinion.
- Hold a formal or informal meeting to try to reach consensus.
- Attempt some form of mediation (see chapter 24).

5.120 Ultimately, if all other attempts to resolve the dispute have failed, the court might need to decide what is in the person's best interests. Chapter 7 provides more information about the Court of Protection, and chapter 24 gives more detail on disputes and disagreements.

6. What protection does the Act offer for people providing care or treatment?

Section 5 of the Act allows carers, healthcare and social care staff to carry out certain tasks without fear of liability if they are acting in the person's best interests under section 4. These tasks involve the personal care, healthcare or treatment of people who lack capacity to consent to them. The aim is to give legal backing for acts that need to be carried out in the best interests of the person who lacks capacity to consent.

This chapter explains how the Act provides protection from liability, how that protection works in practice and where is it restricted or limited. It also explains when a carer can use a person's money to buy goods or services.

In this chapter, as throughout the Code, a person's capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

Quick summary

The following steps list all the things that people providing care or treatment should bear in mind to ensure they are protected by the Act.

- Acting in connection with the care or treatment of someone who lacks capacity to consent
- Is the action to be carried out in connection with the care or treatment of a person who lacks capacity to give consent to that act?
- Who is carrying out the action? Is it appropriate and proportionate for that person to do so at the relevant time?
- Does it involve major life changes for the person concerned? If so, it will need special consideration and a record of the decision will need to be made.
- Should the Court be asked to make the decision?

Checking whether the person has capacity to consent

- Have all possible steps been taken to try to help the person make a decision for themselves about the action?
- Has the test of capacity been applied?
- Are there reasonable grounds for believing the person lacks capacity to give permission?

Acting in the person's best interests

- Has the best interests checklist (see chapter 5) been applied and all relevant circumstances considered?
- Is a less restrictive option available?
- Is it reasonable to believe that the proposed act is in the person's best interests?
- Understanding possible limitations on protection from liability
- If restraint is being considered, is it necessary to prevent harm to the person who lacks capacity, and is it a proportionate response to the likelihood of the person suffering harm – and to the seriousness of that harm?
- Could the restraint be classed as a deprivation of the person's liberty?
- Does the action conflict with a decision that has been made by an attorney or deputy under their powers?

Paying for necessary goods and services

- If someone wishes to use the person's money to buy goods or pay for services for someone who lacks capacity to do so themselves, are those goods or services necessary and in the person's best interests?
- Is it necessary to take money from the person's bank or building society account or to sell the person's property to pay for goods or services? If so, formal authority will be required.

What protection do people have when caring for those who lack capacity to consent?

6.1. Every day, millions of acts are done for people who lack capacity either to:

- take decisions about their own care or treatment, or
- consent to someone else caring for them.

6.2. Such acts range from everyday tasks of caring (for example, helping someone to wash) to life-changing events (for example, serious medical treatment or arranging for someone to go into a care home).

6.3. In theory, many of these actions could be against the law. Legally, people have the right to a private and family life, home and correspondence, and to stop others from interfering with their body or property unless they give permission[61]. But what happens if someone lacks capacity to make the decision to give permission? Carers who dress people who cannot dress themselves are potentially interfering with someone without their consent, so could theoretically be prosecuted for assault. A neighbour who enters and cleans the house of a person who lacks capacity could be trespassing on the person's property.

6.4. Section 5 of the Act provides 'protection from liability'. In other words, it protects people who carry out these actions if they correctly follow the principles in the Act. It stops them being prosecuted for acts that could otherwise be classed as civil wrongs or crimes. By protecting family and other carers from liability, the Act allows necessary caring acts or treatment to take place as if a person who lacks capacity to consent had consented to them. People providing care of this sort do not therefore need to get formal authority to act.

6.5. Importantly, section 5 does not give people caring for or treating someone the power to make any other decisions on behalf of those who lack capacity to make their own decisions. Instead, it offers protection from liability so that they can act in connection with the person's care or treatment. The power to make decisions on behalf of someone who lacks capacity can be granted through other parts of the Act (such as the powers granted to attorneys and deputies, which are explained in chapters 8 and 9).

6.6. If people carry out actions in a way which does not comply with section 5 – for example by making a decision or performing an act which is not in the person's best interests – then they may be held liable for any consequences.

[61] Article 8 of the European Convention on Human Rights, available at: - https://www.echr.coe.int/documents/convention_eng.pdf.

What type of actions might have protection from liability?

6.7. Section 5(1) provides possible protection for actions carried out in connection with care or treatment. The action may be carried out on behalf of someone who has been assessed as lacking capacity to decide to give permission for the action (where all practicable support to enable them to make the decision has been given without success) so long as it is in that person's best interests (see chapter 5). Decisions should be recorded (see paragraph 6.42-6.44). The Act does not define 'care' or 'treatment', which should be given their normal meaning. However, section 64(1) makes clear that treatment includes diagnostic or other procedures. It also includes a decision to withdraw or withhold treatment.

6.8. Actions that might be covered by section 5 include:

Personal care

- helping with washing, dressing or personal hygiene
- helping with eating and drinking
- helping with communication
- helping with mobility (moving around)
- helping someone take part in education, social or leisure activities
- going into a person's home to drop off shopping or to see if they are alright
- doing the shopping or buying necessary goods with the person's money (but not to access their bank account, which would require legal authority)
- arranging household services (for example, arranging repairs or maintenance for gas and electricity supplies)
- providing services that help around the home (such as homecare or meals on wheels)
- undertaking actions related to care and support services (for example, day care, residential accommodation or nursing care) – but see also paragraphs 6.10–6.19 below

Healthcare and treatment

- carrying out diagnostic examinations and tests (to identify an illness, condition or other problem)
- providing professional medical, dental and similar treatment
- giving medication
- taking someone to hospital for assessment or treatment
- providing nursing care (whether in hospital or in the community)
- carrying out any other necessary medical procedures (for example, taking a blood sample) or therapies (for example, physiotherapy or chiropody)
- providing care in an emergency.

6.9. A person is only protected from liability if they:

- have firstly taken reasonable steps to establish whether the individual in question lacks the relevant decision-making capacity;
- reasonably believe that the person lacks capacity;
- believe that the act is in the person's best interests.

6.10. What are reasonable steps will depend upon the decision in question. Sometimes it will require the person to undertake their own assessment and to take steps to support the individual. In other situations, it will be appropriate for the person to rely upon an assessment carried out by someone else (see paragraph 6.52 onwards). Some acts in connection with care or treatment may cause major life changes with significant consequences for the person concerned. Those requiring particularly careful consideration include:

- a change of residence, perhaps into a care home or nursing home
- restriction of contact with certain people
- major decisions about healthcare and medical treatment
- administration of 'covert' medication or treatment
- administration of medication or treatment against a person's known wishes

6.11. These are described in the following paragraphs. Such decisions are likely to represent a serious interference with the person's rights under the European Convention on Human Rights. A detailed record of the decisions taken should therefore be prepared to ensure that the decision-maker has considered all the matters necessary to be able to rely upon the defence in section 5 of the Act. See paragraph 6.44 and chapter 5.

A change of residence

6.12. Sometimes a person cannot be safely supported to live in their own home, and they may have to move – perhaps to live with relatives or to go into a care home or nursing home. In the first instance steps should be taken to support the person to make their own decision if they have capacity to do so.

6.13. If the person lacks capacity to consent to a move, the decision-maker(s) must first consider all the available options. They must consider which of these is in the person's best interests (by referring to the best interests checklist in chapter 5 and in particular the person's past and present wishes and feelings, as well as the views of other relevant people). When doing this, the decision-maker(s) must consider whether there is a less restrictive option available (see chapter 2, principle 5). A move may amount to a deprivation of liberty. Chapter 13 provides more detail on Liberty Protection Safeguards procedures which must be followed in such cases.

6.14. The decision-maker should wherever practicable speak to:

- anyone currently involved in the person's care
- family carers and other family members close to the person and interested in their welfare
- others who have an interest in the person's welfare
- anyone the person has previously named as someone to be consulted
- an attorney or deputy who has been legally appointed to make particular decisions (about the care and/or its funding) on their behalf, and
- any statutory advocate supporting the person, for example under the Care Act 2014

6.15. Some cases will require an Independent Mental Capacity Advocate (IMCA). The IMCA represents and supports the person who lacks capacity and they will provide information to make sure the final decision is in the person's best interests (see chapter 10). An IMCA is needed when there is no-one close to the person who lacks capacity who is appropriate or available to give an opinion about what is best for them, and:

- an NHS body is proposing to provide serious medical treatment, or
- an NHS body or local authority is proposing to arrange accommodation in hospital or a care home or another longer-term residence change and
- the person will stay in hospital longer than 28 days, or
- they will stay in a care home for more than eight weeks.

6.16. Sometimes the final outcome may not be what the person who lacks capacity wanted. For example, they might want to stay at home, but those making the decision for them might decide a move is in their best interests. In all cases, those making the decision must first consider other options that might restrict the person's rights and freedom of action less (see chapter 2, principle 5).

6.17. In some cases, there may be no alternative but to move the person. Such a move would normally require the person's formal consent if they had capacity to give, or refuse, it. In cases where a person lacks capacity to consent, section 5 of the Act may allow carers to carry out actions relating to the move as long as the Act's principles and the requirements for working out best interests have been followed.

6.18. However, consideration should be given to whether there should be an application to the Court of Protection to decide what the person's best interests are and where they should live[62]. This may be the case for instance if there is a disagreement between

[62] London Borough of Hillingdon v Neary & Anor [2011] EWCOP 1377 London Borough of Hillingdon v Neary & Anor [2011] EWCOP 1377 (09 June 2011), available at: https://www.bailii.org/ew/cases/EWCOP/2011/1377.html. -

family members that cannot be settled in any other way. Any application to court should be made before a move, except in exceptional circumstances.

6.19. Section 6 places clear limits on the use of force or restraint by only permitting restraint to be used (for example, to transport the person to their new home) where this is necessary to protect the person from harm and is a proportionate response to the risk of harm (see paragraphs 6.69 – 6.75). Any action taken to move the person concerned or their property could incur liability unless protected under section 5.

Restriction of contact

6.20. In some circumstances, it may be necessary to restrict or supervise contact between the person and another person or category of people. In some cases, that restriction or supervision may align with the wishes of the person (for instance, they may not wish to see someone who has previously abused them). A record should be kept of why the steps have been taken and how they align with the wishes of the person.

6.21. In other cases, contact may be restricted or supervised in circumstances where it is clear the person wants to see the other person or people. This is likely to involve an interference with the person's right to respect for their private and family life under Article 8 of the European Convention on Human Rights and must always be considered very carefully (see paragraph 5.104). Any such interference must be necessary and proportionate to the risks which the person would otherwise be exposed to. The record kept should show, in particular, what less intrusive steps could have been taken to secure the person's interests.

6.22. It is not possible to rely upon the Liberty Protection Safeguards to authorise restrictions on contact. Only the Court of Protection can make a decision on a person's behalf not to see someone, and an application to the Court of Protection is likely to be necessary in any situation where there is doubt or disagreement about whether the restriction is in the person's best interests.

Healthcare and treatment decisions

6.23. Section 5 also allows actions to be taken to ensure a person who lacks capacity to consent receives necessary medical treatment. This could involve taking the person to hospital for out-patient treatment or arranging for admission to hospital. Even if a person who lacks capacity to consent objects to the proposed treatment or admission to hospital, the action might still be allowed under section 5 (but see paragraphs 6.25 - 6.30 below).

6.24. There are limits about whether force or restraint can be used to impose treatment (see paragraphs 6.75).

6.25. Major healthcare and treatment decisions will need special consideration. This also includes treatment against a person's known wishes and covert treatment. Unless

there is a valid and applicable advance decision to refuse the specific treatment, healthcare staff must carefully work out what would be in the person's best interests (see chapter 5). As part of the process of working this out, they must consider (where practicable and appropriate):

- the past and present wishes and feelings, beliefs and values of the person who lacks capacity to make the treatment decision, including any advance statement the person wrote setting out their wishes when they had capacity,
- the views of anyone previously named by the person as someone to be consulted,
- the views of anyone engaged in caring for the person,
- the views of anyone interested in their welfare, and
- the views of any attorney or deputy appointed for the person.

6.26. They must show they have thought carefully about who to speak to. If it is practicable and appropriate to speak to the above people, they must do so and must take their views into account.

6.27. They must be able to explain why they did not speak to a particular person when it would appear objectively that that person should be consulted. It is good practice to have a clear record of the reasons. A failure to consult with someone properly interested in the person's welfare when it is practicable and appropriate to do so will mean that the decision-maker cannot rely upon the defence in section 5[63].

6.28. In specific cases where there is no-one else available to consult about the person's best interests, an IMCA must be appointed to support and represent the person (see paragraph 6.15 above and chapter 10).

6.29. Healthcare staff must also consider whether there are alternative treatment options that might be less intrusive or restrictive (see chapter 2, principle 5). When deciding about the provision, withholding or withdrawal of life- sustaining treatment, anyone working out what is in the best interests of a person who lacks capacity must not be motivated by a desire to bring about the person's death (see chapter 5).

6.30. Multi-disciplinary meetings can sometimes be a helpful way to decide on a person's best interests (see chapter 5 regarding who the decision-maker is). They may bring together healthcare and social care staff with different skills to discuss the person's options and should where possible involve those who are closest to the person concerned. But final responsibility for deciding what is in a person's best interest lies with the member of healthcare staff responsible for the person's treatment.

[63] *Winspear v City Hospitals Sunderland NHS Foundation Trust* [2015] EWHC 3250 (QB), available at:https://www.bailii.org/ew/cases/EWHC/QB/2015/3250.html.

6.31. Although a decision to put a DNACPR (Do Note Attempt Cardio-Pulmonary Resuscitation) recommendation in the person's records is not strictly a best interests decision, the same principles should apply[64].

Scenario: A Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) recommendation

Ms R had experienced deteriorating health for some time, including chronic lung and kidney problems, and low immunity. When she became very ill with a chest infection her support team called an ambulance.

Ms R was admitted to hospital. Medically she was not responding to treatment and it was clear to her support team that she was becoming unresponsive to the people around her. Blood tests showed her condition was deteriorating.

Ms R's consultant met with the manager of her support team, her social worker, an advocate, and the learning disability nurse to make a decision about her care and treatment. Ms R did not have close family and her niece who was consulted said she did not feel she knew Ms R well enough to be involved.

The consultant was the decision-maker and aware that in order to make this decision, he needed to speak to people who knew Ms R well and who could explain what they thought she would want to happen.

The consultant explained the different outcomes for Ms R, including if she recovered from her chest infection. The doctor's medical opinion was that Ms R was very unlikely to recover and if she did, she would likely need to stay in hospital until the end of her life, most probably in a coma.

The consultant wanted to understand what Ms R's wishes and preferences would be in relation to her care. Her support manager had spoken with the support team about this and everyone agreed that Ms R would not want to stay in hospital. The support manager and social worker also explained how difficult the past few months had been for Ms R as she became more ill.

Following a long discussion to understand more about Ms R and what she would want, the consultant made a decision to put a DNACPR recommendation in place for Ms R.

[64] Winspear v City Hospitals Sunderland NHS Foundation Trust [2015] EWHC 3250 (QB) (13 November 2015), available at:https://www.bailii.org/ew/cases/EWHC/QB/2015/3250.html.

When should the court be asked to make a healthcare or treatment decision?

6.32. In some cases, the court must or should be asked to make the relevant decision, as without the court's scrutiny it is likely that medical professionals will not be able to say that they have a reasonable belief that they are acting in the person's best interests so as to be protected from liability under section 5[65].

6.33. In particular, the court must be asked to make the decision on behalf of the person as to whether or not to consent to life-sustaining medical treatment where, at the end of the decision-making process described in chapter 5 (see paragraph 5.59), the decision is finely balanced, there is a difference of medical opinion, or there is a lack of agreement as to the proposed course of action from those with an interest in the person's welfare. This includes the withdrawal or withholding of clinically assisted nutrition and hydration (CANH[66]).

6.34. In cases involving treatment which is not life-sustaining, but where the way forward is finely balanced, there is a difference of medical opinion, or a lack of agreement from persons with an interest in the patient's welfare, a court application should be made. Exceptions are where the person has previously made a Lasting Power of Attorney appointing an attorney to make such healthcare decisions for them (see chapter 8) or they have made a valid advance decision to refuse the proposed treatment (see chapter 11).

6.35. An application to the Court of Protection is likely to be necessary if there is a conflict of interest which cannot otherwise be appropriately managed (see paragraph 5.59).

6.36. Medical professionals should also consider asking the court to decide on the person's behalf in relation to medical treatment which will involve a serious interference with their right to private life (including their right to autonomy) protected by Article 8 of the European Convention on Human Rights (see paragraph 5.104). This is so even if everyone concerned with person's welfare is in agreement as to the person's capacity and best interests. Examples of such cases include:

6.37. where a medical procedure or treatment is for the primary purpose of sterilisation

[65] *Re P (Sexual Relations and Contraception)* [2018] EWCOP 10; *University College London Hospitals v KG* [2018] EWCOP 29, available at: https://www.bailii.org/ew/cases/EWCOP/2018/29.html

[66] British Medical Association, General Medical Council and Royal College of Physicians (joint guidance) 'Clinically assisted nutrition and hydration (CANH) and adults who lack the capacity to consent', available at: https://www.bma.org.uk/media/1161/bma-clinically-assisted-nutrition-hydration-canh-full-guidance.pdf.

6.38. where the procedure is for the purpose of a donation of an organ, bone marrow, stem cells, tissue or bodily fluid to another person

- a procedure for the covert insertion of a contraceptive device or other means of contraception
- the use of deception to deliver medical treatment to the person
- where it is proposed that an experimental or innovative treatment is to be carried out
- a case involving a significant ethical question in an untested or controversial area of medicine

6.39. Chapter 7 gives more information about the need to refer cases to court for a decision, and chapter 24 covers settling disagreements.

Healthcare and treatment decisions for 16-17 year olds

6.40. Chapter 21 explains that decision-making in relation to 16 and 17 year olds who lack capacity can in many cases be undertaken either by reference to the Act or by reference to the Children Act 1989 and the operation of parental responsibility. Professionals can therefore choose which regime to apply, but should be clear as to which one they are using. If they are using the Act, they will be able to rely on section 5 providing they correctly follow the principles of the Act.

When are acts seen as depriving a person of their liberty?

6.41. In some circumstances, arrangements for the person's care or treatment may amount to a deprivation of liberty. See chapter 12 for more information on when arrangements amount to a deprivation of liberty.

6.42. The decision-maker should always consider putting the least restrictive arrangements in place, as far as possible. However, if the arrangements amount, or may amount, to a deprivation of liberty, the Liberty Protection Safeguards (LPS) process should be triggered. Section 5 of the Act does not provide protection for such actions. Chapter 13 sets out information about how to seek authorisation for a deprivation of liberty.

6.43. If the person needs treatment for a mental disorder and meets the criteria for detention under the Mental Health Act 1983 (MHA), either the LPS or the MHA may be used to admit or keep the person in hospital (see chapter 22).

Record-keeping and protection from liability

6.44. Any staff involved in the care of a person who lacks capacity should make sure a record is kept of the process of working out the best interests of that person for each relevant decision. The sort of record that is kept of the process of working out the best

interests of the person in respect of any decision will depend upon the nature of the decision. Appropriately detailed records should be kept of decisions made. Chapter 5 contains more detail on this.

6.45. For healthcare and treatment decisions, responsibility for deciding what is in a person's best interests and recording this lies with the member of healthcare staff responsible for the person's treatment. They should record their decision, how they reached it and the reasons for it in the person's clinical notes. As long as they have recorded objective reasons to show that the decision is in the person's best interests, and the other requirements of section 5 of the Act are met, all healthcare staff taking actions in connection with the particular treatment will be protected from liability.

6.46. Where decisions represent a serious interference with the person's rights under the European Convention on Human Rights[67] a detailed record should be made. This is to ensure that the decision-maker has considered all the matters necessary in order to be able to rely upon the defence in section 5 of the Act. Details of decisions this may cover and of what such a record should include is set out in chapter 5.

Who is protected from liability by section 5?

6.47. Section 5 of the Act is most likely to affect:

- family carers and other kinds of carers
- care workers
- healthcare and social care staff
- others who may occasionally be involved in the care, treatment or support for a person who lacks capacity to consent (for example, ambulance staff, housing workers, police officers and volunteer support workers)
- staff caring for 16-17 year olds in residential special schools and children's homes.

6.48. At any time, it is likely that several people will be carrying out tasks that are covered by section 5 of the Act. Section 5 does not:

- give one person more rights than another to carry out tasks
- specify who has the authority to act in a specific instance
- allow somebody to make decisions relating to subjects other than the care or treatment of the person who lacks capacity, or

[67] See for example *Shtukaturov v Russia* [2012] 54 EHRR 27 (App No 33985/96) *X v Finland* App No 34806/04 and *Lashin v Russia* App No 33117/02, available at:

- https://www.hr-dp.org/files/2013/09/09/CASE_OF_SHTUKATUROV_v._RUSSIA_.pdf
- https://www.bailii.org/eu/cases/ECHR/2012/1998.html

- allow somebody to give consent on behalf of a person who lacks capacity to do so.

6.49. To receive protection from liability under section 5, all actions must be related to the care or treatment of the person who lacks capacity to consent. Before taking action, carers must first reasonably believe that:

- the person lacks the capacity to make that particular decision at the time it needs to be made (where all practicable support to enable them to make the decision has been given without success), and
- the action is in the person's best interests

6.50. This is explained further in paragraphs 6.52-6.62 below.

Scenario: Protecting multiple carers

Mr R has early stage dementia, and lives in his own home with the help of several people. Mr R's daughter cooks and brings meals and essential shopping for him. A nurse regularly visits him to change the dressing on a pressure sore, and a close friend takes Mr R for a walk most days, guiding him when they cross the road.

Mr R often has capacity to make decisions about these aspects of his care, such as what to have for lunch, or where to go for a walk, and when he does those who care for him act in accordance with his decision.

On occasions however Mr R gets confused. When his carers have taken reasonable steps to check whether Mr R has capacity to make a specific decision, and this leads to the reasonable belief that he lacks capacity to decide, they make that decision in his best interests. If they follow these steps each of them is protected from liability under section 5 of the Act.

6.51. Section 5 may also protect carers who need to use the person's money to pay for goods or services that the person needs but lacks the capacity to purchase for themselves. However, there are strict controls over who may have access to another person's money. See paragraphs 6.88-6.91 for more information.

6.52. Carers who provide personal care services must not carry out specialist procedures that are normally done by trained healthcare staff. If the action involves medical treatment, the doctor or other member of healthcare staff with responsibility for the patient will be the decision maker who has to decide whether the proposed treatment is in the person's best interests (see chapter 5). A doctor can delegate responsibility for giving the treatment to other people in the clinical team who have the appropriate

skills or expertise. People who do more than their experience or qualifications allow may not be protected from liability.

Care, support and treatment planning

6.53. Decisions about a person's care or treatment are often made by a multi-disciplinary team (a team of professionals with different skills that contribute to a person's care – see chapter 4 on who is the decision-maker), by drawing up a care and support plan with the person. The preparation of a care and support or treatment plan should always include an assessment of the person's capacity to consent to the actions covered by the care and support plan; a record of steps taken to support the person to make their own decision; and confirmation that those actions are agreed to be in the person's best interests. Healthcare and social care staff may then be able to assume that any actions they take under the care and support plan are in the person's best interests, and therefore receive protection from liability under section 5. But a person's capacity and best interests must still be reviewed and recorded regularly.

What steps should people take to be protected from liability?

6.54. As well as taking the following steps, somebody who wants to be protected from liability should always bear in mind the statutory principles set out in section 1 of the Act (see chapter 2).

6.55. First, reasonable steps must be taken to find out whether a person has the capacity to make a decision about the proposed action (section 5(1)(a)). If the person has capacity, they must give their consent for anyone to take an action on their behalf, so that the person taking the action is protected from liability. For guidance on what is classed as 'reasonable steps', see paragraphs 6.9 – 6.10. These steps must always include:

- taking all practicable and appropriate steps to help people to make a decision about an action themselves, and
- applying the test of capacity (see chapter 4)

6.56. The person who is going to take the action must have a 'reasonable belief' that the individual lacks capacity to give consent for the action at the time it needs to be taken.

6.57. Secondly, the person proposing to take action must have reasonable grounds for believing that the action is in the best interests of the person who lacks capacity. They should apply all elements of the best interests checklist (see chapter 5), and in particular:

- consider whether the person is likely to regain capacity to make this decision in the future. Can the action wait until then?
- consider whether a less restrictive option is available (chapter 2, principle 5), and
- have objective reasons for thinking an action is in the best interests of the person who lacks capacity to consent to it.

What is 'reasonable'?

6.58. Carers do not have to be experts in assessing capacity. But they must be able to show that they have taken reasonable steps to find out if the person has the capacity to make the specific decision. Only then will they have reasonable grounds for believing the person lacks capacity in relation to that particular matter. See paragraphs 4.62-4.69 for guidance on what is classed as 'reasonable' – although this will vary, depending on circumstances[68].

6.59. As explained in chapter 4, anyone assessing a person's capacity to make decisions for themselves or give consent must focus wholly on whether the person has capacity to make a specific decision at the time it needs to be made and not the person's capacity to make decisions generally.

6.60. Most of the time, formal assessment processes are unlikely to be required. But in some circumstances, formal procedures should be carried out (for example, where consent to medical treatment is required, the doctor will need to assess and record the person's capacity to consent). Under section 5, carers and professionals will be protected from liability as long as they are able to provide objective reasons that explain why they believe that the person lacks capacity to consent to the action. If somebody challenges their belief, both carers and professionals will be protected from liability as long as they can show that they have taken steps to find out whether the person has capacity and that they have a reasonable belief that the person lacks capacity.

6.61. Similarly, carers, relatives and others involved in caring for someone who lacks capacity must have reasonable grounds for believing that their action is in the person's best interests. They must not simply impose their own views. They must be able to show that they considered all relevant circumstances and applied the best interests checklist. This includes showing that they have tried to involve the person who lacks capacity, and find out their wishes and feelings, beliefs and values. They must also have asked other people's opinions, where practicable and appropriate. If somebody challenges their decision, they will be protected from liability if they can show that it was reasonable for them to believe that their action was in the person's best interests

[68] Commissioner of Police for the Metropolis v ZH [2013] EWCA Civ 69 (14 February 2013), available at: https://www.bailii.org/ew/cases/EWCA/Civ/2013/69.html.

– in all the circumstances of that particular case. See paragraph 6.42 – 6.44 and chapter 5 for guidance on recording these decisions.

6.62. If healthcare and social care staff are involved, their skills and knowledge will affect what is classed as 'reasonable'. For example, assessing capacity is a core clinical skill, so doctors will be expected to show a better understanding of how to assess capacity to consent to care and treatment than someone without medical training (see paragraph 4.63). They should also record in the person's healthcare record the steps they took and the reasons for the finding. Healthcare and social care staff should apply normal clinical and professional standards when deciding what treatments to offer. They must then decide whether the proposed treatment is in the best interests of the person who lacks capacity to consent. This includes considering all relevant circumstances and applying the best interests checklist (see chapter 5)[69].

6.63. Healthcare and social care staff can be said to have 'reasonable grounds for believing' that a person lacks capacity if:

- they are working to a person's care, support or treatment plan, and

[69] See *ZH v The Commissioner of Police for the Metropolis* [2012] EWHC 604 (QB), available at https://www.bailii.org/ew/cases/EWHC/QB/2012/604.html

- the planning process involved an assessment of the person's capacity to make a decision about actions in the plan.

Scenario: Working with a care and support plan

Ms M has physical disabilities and complex mental health needs. She lives in a nursing home and the multi-disciplinary team has prepared a care and support plan for her, in consultation with her relatives. The care and support plan covers the medication Ms M has been prescribed, the physiotherapy she needs, help with her personal care and recommended therapeutic activities such as art therapy.

Although attempts were made to involve Ms M in the care planning process, the doctor responsible for her care assessed her as lacking capacity to consent to most aspects of her care and support plan. The care and support plan is therefore relied on by the nurse or care assistant who administers the medication, by the physiotherapist and art therapist, and also by the care assistant who helps with Ms M's personal care. It provides them with reasonable grounds for believing that they are acting in her best interests.

However, as each act is performed, these professionals each take reasonable steps to communicate with Ms M to explain what they are doing and to ascertain whether she has the capacity to consent to the act in question at that time. If they believe that she does, they must obtain Ms M's consent for the care or treatment before proceeding.

6.64. It is also reasonable for them to assume that the care planning process assessed a person's best interests. But they must still make every effort to communicate with the person to find out if they still lack capacity and the action is still in their best interests.

What happens in emergency situations?

6.65. Sometimes people who lack capacity to consent will require urgent care or emergency medical treatment to save their life or prevent them from serious harm. In these situations, the steps that are 'reasonable' will differ to those in non-urgent cases. In emergencies, it will almost always be in the person's best interests to give urgent treatment without delay. One exception to this is when the healthcare staff giving treatment are satisfied that there is an advance decision to refuse treatment (see paragraph 6.65).

6.66. Emergency care or treatment may give rise to a deprivation of the person's liberty and more information about this can be found in chapter 12.

What is the effect of an advance decision to refuse treatment?

6.67. Sometimes people will make an advance decision to refuse treatment while they still have capacity to do so and bef ore they need that particular treatment. Healthcare staff must respect this decision if it is valid and applies to the proposed treatment.

6.68. If healthcare staff are satisfied that an advance decision is valid and applies to the proposed treatment, they are not protected from liability if they give any treatment that goes against it. But they are protected from liability if they did not know about an advance decision or they are not satisfied that the advance decision is valid and applies in the current circumstances (section 26(2)). See chapter 11 for further guidance.

What limits are there on protection from liability?

6.69. Section 6 imposes some important limitations on acts which can be carried out with protection from liability under section 5 (as described in the first part of this chapter). The key areas where acts might not be protected from liability are where there is inappropriate use of restraint or where a person who lacks capacity is deprived of their liberty without authorisation.

6.70. In addition, section 5 will not or may not provide a defence in the circumstances described in see paragraph 5.59, where an application to the Court of Protection will be required.

Using restraint

6.71. Section 6(4) of the Act states that someone is using restraint if they use force – or threaten to use force – to make someone do something that they are resisting, or restrict a person's freedom of movement, whether they are resisting or not.

6.72. Any action intended to restrain a person who lacks capacity will not attract protection from liability unless the following two conditions are met:

- the person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity, and
- the amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm.

6.73. See paragraphs 6.75–6.80 for more explanation of the terms *necessary, harm* and a *proportionate response*.

6.74. Healthcare and social care staff should also refer to:

- Specific guidance for children and young people in England[70] and Wales
- Relevant professional and other guidance on restraint or physical intervention
- limitations imposed by regulations and standards, such as the fundamental standards for care services (see chapter 14).

6.75. In addition to the Act, the common law allows necessary and proportionate steps to be taken to prevent the immediate risk of serious harm to another person[71]. Restraint for these purposes should always be used for the shortest period possible to enable the de-escalation of the situation. Consideration should be given to what legal frameworks are available to address the position (for instance, assessment for admission under the Mental Health Act 1983) (see paragraphs 6.39-6.41).

6.76. In some cases, a sustained act of restraint may become a deprivation of liberty. See chapter 12 for more information.

When might restraint be 'necessary'?

6.77. Anybody considering using restraint must have objective reasons to justify that restraint is necessary. They must be able to show that the person being cared for is likely to suffer harm unless proportionate restraint is used. A carer or professional must not use restraint just so that they can do something more easily. If restraint is necessary to prevent harm to the person who lacks capacity, it must be the minimum amount of force for the shortest time possible. There is less likelihood of restraint being necessary when the principles of the MCA are followed and there is a real understanding of the person's wishes, feelings, beliefs and values.

[70] Reducing the Need for Restraint and Restrictive Intervention Guidance, available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/812435/reducing-the-need-for-restraint-and-restrictive-intervention.pdf

[71] *Munjaz v Mersey Care National Health Service Trust & Ors* [2003] EWCA Civ 1036, available at: https://www.bailii.org/ew/cases/EWCA/Civ/2003/1036.html

Scenario: Appropriate use of restraint

Mr D has learning disabilities and has begun to behave in a challenging way. Staff at his care home think he might have a medical condition that is causing him distress. They take him to the doctor, who examines Mr D and thinks that he might have a hormone imbalance. The doctor needs to take a blood test to confirm this.

Mr D is comfortable with being in the doctor's consulting room and talking with him and his carer. The doctor and Mr D's carers explain to Mr D in simple language why the doctor needs to take the blood sample, and what will happen. This is in order to take all reasonable steps to support Mr D to make the decision to have the test. However the doctor concludes from Mr D's behaviour that he does not have capacity to understand why the test is needed and make the decision. The doctor decides that having the test is in Mr D's best interests, because (although the result might be negative) failing to treat a problem like a hormone imbalance might make it worse.

When the doctor tries to take the blood sample Mr D becomes frightened and attempts to fight him off. The doctor decides that it is in Mr D's best interests to be restrained momentarily in order to have the blood sample taken. He therefore calls for the support of two colleagues who are trained in holding a patient effectively for a blood test in a way that causes as little distress as possible. In this way, and along with Mr D's carers talking to him to reassure him as much as possible throughout the procedure, Mr D is restrained safely for the minimum time needed to take the blood sample.

The temporary restraint is in proportion to the likely harm caused by failing to treat the possible medical condition.

What is 'harm'?

6.78. The Act does not define 'harm', because it will vary depending on the situation. For example, a person with learning disabilities might run into a busy road without warning, if they do not understand the dangers of cars, or a person with dementia may wander away from home and get lost, if they cannot remember where they live.

6.79. Common sense measures can often help remove the risk of harm (for example, by locking away poisonous chemicals or removing obstacles). Also, care planning should include risk assessments and set out appropriate actions to try to prevent possible risks. But it is impossible to remove all risk, and a proportionate response is needed when the risk of harm does arise.

What is a ‘proportionate response’?

6.80. A ‘proportionate response’ means using the least intrusive type and minimum amount of restraint to achieve a specific outcome in the best interests of the person who lacks capacity. On occasions when the use of force may be necessary, carers and healthcare and social care staff should use the minimum amount of force for the shortest possible time.

6.81. For example, a carer may need to hold a person’s arm while they cross the road if the person does not understand the dangers of roads. But it would not be a proportionate response to stop the person going outdoors at all. It may be appropriate to have a secure lock on a door that faces a busy road, but it would not be a proportionate response to lock someone in a bedroom all the time to prevent them from attempting to cross the road.

Scenario: Avoiding restraint

Mr U has a learning disability and attends college. He says he enjoys his time at college and he is learning new skills. However on occasion he behaves aggressively towards others and himself, sometimes hitting a wall and hurting himself.

Mr U’s support worker stays with him at college, to support him. This includes when Mr U’s behaviour is challenging. The support worker is trained to use de-escalation techniques, and in some events to restrain Mr U physically, if he is at risk of harming himself, others or significant risk to the environment.

In order to manage these risks and reduce the need for restraint, the support worker and community team work with Mr U on a positive behaviour plan to identify and understand the triggers leading to his stress and subsequent aggressive behaviour. This also involves encouraging Mr U to develop self-management strategies.

Through ongoing work with Mr U, it is believed that his challenging behaviours are linked to anxiety and frustration. His support worker works with the college to put in place strategies to minimise the noisy and unpredictable environments which cause him stress. Mr U and his support worker work together to increase his awareness of his anxiety and practise using sign language or visual aids so when he does recognise himself feeling anxious, he can take time out. The plan is written down so that all members of the college team can support Mr U by recognising his tools to manage his anxiety,

In this way Mr U’s positive behaviour plan reduces the likelihood of challenging behaviour and the need for restraint

6.82. Carers and healthcare and social care staff should consider less restrictive options before using restraint. Where possible, they should ask other people involved in the person's care what action they think is necessary to protect the person from harm.

Negligence

6.83. Section 5 does not provide a defence in cases of negligence – either in carrying out a particular act or by failing to act where necessary. For example, a doctor may be protected against a claim of battery for carrying out an operation that is in a person's best interests. But if they perform the operation negligently, they are not protected from a charge of negligence. So the person who lacks capacity has the same rights in cases of negligence as someone who has consented to the treatment.

How does section 5 apply to attorneys and deputies?

6.84. Section 5 does not provide protection for actions that go against the decision of someone who has been authorised to make decisions for a person who lacks capacity to make such decision for themselves. For instance, if someone goes against the decision of an attorney acting under a Lasting Power of Attorney (LPA) (see chapter 8) or a deputy appointed by the Court of Protection (see chapter 9), they will not be protected under section 5.

6.85. Attorneys and deputies must only make decisions within the scope of the authority of the LPA or court order. Sometimes carers or healthcare and social care staff might feel that an attorney or deputy is making decisions they should not be making, or that are not in a person's best interests. If this is the case, and the disagreement cannot be settled any other way, either the carers, the staff or the attorney or deputy must apply to the Court of Protection before taking any action. If the dispute concerns the provision of medical treatment, medical staff can still give life-sustaining treatment, or treatment which stops a person's condition getting a great deal worse, while the court is coming to a decision (section 6(6)).

Who can pay for goods and services?

Contracts for necessary goods and services

6.86. Whenever a person agrees to buy goods or services a contract is formed. Such contracts can cover everyday matters, such as buying clothes in a shop or arranging for take-away food order to be delivered. In general, a contract that is entered into by a person who lacks capacity to make the contract cannot be enforced if the other

person knows, or must be taken to have known, of the lack of capacity[72]. Section 7 of the Act modifies this rule and states that where 'necessary' goods or services are supplied to a person who lacks capacity to enter into the contract, that person must pay a reasonable price for them.

What are necessary goods and services?

6.87. 'Necessary' means something that is suitable to the person's condition in life (their place in society, rather than any mental or physical condition) and their actual requirements when the goods or services are provided (section 7(2)). The aim is to make sure that people who lose capacity to make decisions can enjoy a similar standard of living and way of life to those they had before lacking capacity. For example, if a person who now lacks capacity previously chose to buy expensive designer clothes, these are still necessary goods – as long as they can still afford them. But they would not be necessary for a person who always wore budget clothes, no matter how wealthy they were.

6.88. Goods are not necessary if the person already has a sufficient supply of them. For example, it may be necessary for a person who lacks capacity to buy one or two new pairs of shoes. But a dozen pairs would probably not be necessary.

How should payments be arranged?

6.89. Where a person who lacks capacity has entered into a contract for the supply of necessary goods and services, their deputy or attorney for property and affairs will be required to pay any money that is owed under the contract on the person's behalf. If the person does not have a deputy or attorney for property and affairs, someone else who holds money belonging to that person (such as an appointee) could make the payment on their behalf. If there is no one who can make the payment on behalf of the person who lacks capacity, it may be necessary to apply to the Court of Protection for the appointment of a deputy for property and affairs to deal with the payment.

Expenditure in connection with care and treatment

6.90. Sometimes an act in relation to the care or treatment of a person who lacks capacity may involve the incurring of expenditure. For example, a carer could buy some food on behalf of the person lacking capacity or arrange for a chiropodist or hairdresser to provide a service at the person's home. Section 8 of the Act contains rules which deal with payment for such expenditure. However, these rules only apply where the act in question is covered by section 5 of the Act.

6.91. The carer must first take reasonable steps to decide whether the person lacks capacity to make the decision or do the act for themselves. If so, the carer must

[72] *Imperial Loan Company v Stone* [1892] 1 QB 599, available at: https://www.bailii.org/ew/cases/EWCA/Civ/2006/51.html

decide whether the decision or the act in question relates to the person's care or treatment and whether it is in their best interests. If they are satisfied that these conditions are met, the carer can then lawfully deal with payment for any expenditure that the decision or act involves one of three ways:

- If neither the carer nor the person who lacks capacity can produce the funds needed, the carer may promise that the person who lacks capacity will pay. However, a supplier may not be happy with this.
- If the person who lacks capacity has cash in their possession, the carer may use that money to pay for goods and services.
- The carer may pay for the goods and services with their own money. The person who lacks capacity must pay them back. This may involve using cash in the person's possession or running up an IOU.

6.92. These arrangements may not be appropriate for paid care workers, whose contracts might stop them handling their clients' money. They also do not give the carer any right to access a bank or building society account belonging to the person who lacks capacity. (If access to a bank or building society account is needed, see paragraphs 6.92 – 6.93 below).

6.93. Carers should keep bills, receipts and other proof of payment when incurring expenditure in relation to a person who lacks capacity. They will need these documents when asking to get money back. Keeping appropriate financial records and documentation is a requirement of the fundamental standards for care homes or domiciliary care agencies.

Access to a person's assets

6.94. The Act does not give a carer or care worker, or the person's parents, access to a person's income or assets. Nor does it allow them to sell the person's property.

6.95. Anyone wanting access to money in a person's bank or building society will need formal legal authority. They will also need legal authority to sell a person's property. Such authority could be given in a Lasting Power of Attorney (LPA) appointing an attorney to deal with property and affairs, or in an order of the Court of Protection (either a single decision of the court or an order appointing a deputy to make financial decisions for the person who lacks capacity to make such decisions).

6.96. Sometimes another person will already have legal control of the finances and property of a person who lacks capacity to manage their own affairs. This could be an attorney acting under an appropriate LPA or registered EPA (see chapter 8) or a deputy appointed by the Court of Protection (see chapter 9). Or it could be someone (usually a carer) that has the right to act as an 'appointee' (under Social Security Regulations) and claim benefits for a person who lacks capacity to make their own claim and use the money on the person's behalf. An appointee cannot deal with other assets or

savings from sources other than benefits and can only use the money that they hold for the person to whom it belongs.

6.97. Other arrangements under which one person may administer money on behalf of someone else, such as an informal family arrangement or a formal power of attorney under the Powers of Attorney Act 1971 may come to an end automatically if the person to whom the money belongs loses capacity to manage it for themselves.

6.98. Section 6(6) makes clear that a family carer or other carer cannot incur expenditure in relation to the care or treatment of a person who lacks capacity if this conflicts with a decision made by someone who has formal powers over the person's money and property, such as an attorney or deputy acting within the scope of their authority. Where there is no conflict and the carer has incurred expenditure in relation to the care or treatment of a person who lacks capacity the carer may ask for the money back from an attorney, a deputy or where relevant, an appointee.

Scenario: Being granted access to a person's assets

A storm severely damages the roof of a house owned by Mr G, who has an acquitted brain injury sustained in an attack in the street. Mr G is upset by the damage to his house and asks his son for help to fix it. His son tries to help Mr G to understand the decisions that need to be made about the repairs. However he finds that, while Mr G has since his attack regained capacity to manage simple day to day expenditure, at present he lacks capacity to understand and retain more complex information and make the decisions required in relation to repairs to the house and the insurance claim.

Mr G's son decides to organise the repairs and pay for them in the first instance, as his father doesn't have enough money. He applies to the Court of Protection for authority to claim the insurance on his father's behalf, and to be reimbursed from his father's bank account to cover the cost of the repairs once the insurance payment is received.

Mr G's capacity to make decisions has slowly been improving as he has gradually recovered from his attack with treatment and support. In future he may regain capacity to make more complex decisions.

7. What is the role of the Court of Protection?

This chapter describes the role of the Court of Protection. It explains the powers that the court has and the types of decisions and declarations it can make. It also explains when applications must or should be made to court, who should bring an application and how the court deals with cases.

In this chapter, as throughout the Code, a person's capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

Quick summary

The Court of Protection has powers to

- decide whether a person has capacity to make a particular decision for themselves
- make declarations, decisions or orders on financial or welfare matters affecting people who lack capacity to make such decisions
- make decisions relating to deprivations of liberty
- appoint deputies to make decisions for people lacking capacity
- decide whether a Lasting Power of Attorney (LPA) or Enduring Power of Attorney (EPA) is valid
- remove deputies or attorneys

In some cases, the Court of Protection *must* be asked to make the relevant decision, while in others, the Court of Protection *may* be asked to make a decision depending on the circumstances.

In relation to Liberty Protection Safeguards authorisations, the Court can consider the following:

- whether Schedule AA1 of the Act applies to the arrangements, or whether the authorisation conditions are met;
- what period the authorisation has effect for;
- what the authorisation relates to.

- The Court may also consider the application of section 4B of the Act. This section enables decision makers to take steps to deprive a person of their liberty, without an authorisation, where certain conditions are met

What is the Court of Protection?

7.1 The Court of Protection makes decisions about mental capacity and best interests. This may include making decisions for and on behalf of adults (and children in a few cases – see chapter 21) where there is reason to believe that they lack capacity to make specific decisions for themselves. It deals with decisions about property and financial affairs, and healthcare and personal welfare matters including, in some cases, deprivations of liberty (see chapter 12 onwards).

7.2 The Court of Protection has the same powers, rights, privileges and authority as the High Court. When reaching any decision, the court must apply all the statutory principles set out in section 1 of the Act. In particular it must be satisfied that all practicable steps have been taken to help the person make the decision without success before finding that the person lacks capacity to make the decision in question. If they do lack that capacity, the court must make a decision in the best interests of the person. There will usually be a fee for applications to the court. The court usually sits in public, with reporting restrictions to protect the identity of the person involved. The court is able to make orders or declarations at any time of the day or night if necessary[73].

What powers does the Court of Protection have?

7.3 The Court of Protection may:

- make declarations (rulings), decisions and orders on financial and health and welfare matters affecting people who lack, or are alleged to lack, capacity (the lack of capacity must relate to the particular issue being presented to the court)
- appoint deputies to make decisions for people who lack capacity to make those decisions (see chapter 9)
- decide whether an advance decision to refuse medical treatment exists, is valid and/or applies to a specific treatment or treatments (see chapter 11)
- remove deputies or attorneys who act inappropriately. The court can also hear cases about LPAs and EPAs. The court's powers concerning EPAs are set out in Schedule 4 of the Act

[73]Guidance on making an or emergency application to the Court of Protection, available at:https://www.gov.uk/emergency-court-of-protection

- consider questions in relation to Liberty Protection Safeguards (see chapter 12)

7.4 The court must always follow the statutory principles set out in section 1 of the Act (see chapter 2) and make the decision in the best interests of the person concerned (see chapter 5).

What declarations can the court make?

7.5 Section 15 of the Act provides the court with powers to make a declaration (a ruling) on specific issues.

7.6 It can make a declaration as to whether a person has capacity to make a particular decision or give consent to a particular action. The court will require evidence of any assessment of the person's capacity, is likely to want to see relevant written evidence (for example, a diary, letters or other papers), and may wish to hear evidence from professionals, family members and friends. If the court decides the person has capacity to make that decision, they will not take the case further. The person can then make the decision for themselves.

7.7 In some cases, the only declaration that the court may be asked to make is whether a person has capacity to make a particular decision. This could be where:

- professionals disagree about a person's capacity to make a specific (usually serious) decision
- there is a dispute over whether the person has capacity (for example, between family members)
- a person wants to challenge an assessment by a professional that they lack capacity

7.8 The court can make an interim declaration (under section 48) that it has reason to believe that the person lacks capacity to make the decision in question whilst the relevant evidence is gathered.

7.9 In most cases where the court makes a final declaration on all the evidence that a person lacks capacity to make a particular decision or decisions, it will then go on to consider how that decision should be taken: see paragraphs 7.11 below.

7.10 The court can also make a declaration as to whether a specific act relating to a person's care or treatment is lawful (either where somebody has carried out the action or is proposing to). Decisions since the Act came into force have made clear that this is a power that should only rarely be used[74]. It could, though, be relevant in a situation where a person has fluctuating capacity to make a decision, because

[74] *N v ACCG* [2017] UKSC 22*; Bagguley v E* [2019] EWCOP 49, available at:https://www.bailii.org/uk/cases/UKSC/2017/22.html

the court has the power under section 15(1)(c) to make a declaration as to what can and cannot be done in relation to the person at the point when they lack capacity[75].

What decisions can the court make?

7.11 If the court has declared that a person lacks capacity to make a specific decision or decisions, it can make the decision for the person, either by appointing a deputy (see chapter 9) or making the decision itself on behalf of the person.

7.12 When the court is making the decision itself, it is choosing between the options which are available to the person at the time and are in their best interests76.

7.13 If the decision is in relation to medical treatment, the court is consenting or refusing on behalf of the person. If the court refuses medical treatment on behalf of the person, then it will not be lawful to give it. Providing that they act reasonably and without negligence, the person's clinical team will therefore not be in breach of any duty to their patient if they withhold or withdraw the treatment[77].

Scenario: Appointing a deputy

Mr P was in a motorbike accident where he sustained a significant and permanent brain injury.

An assessment of his mental capacity and wellbeing as part of his recovery identified that Mr P lacked the capacity to make decisions regarding how his finances were managed – both day to day expenses and longer-term investments.

Mr P's parents were closely involved in his care after his accident and felt that it would be in his best interests if they managed his financial affairs. They therefore jointly applied to the Court of Protection to be appointed property and finance deputies. The court granted the deputyship order. This enabled Mr P's parents to contact the banks and other financial institutions where Mr P held funds, and companies where he had financial obligations. They were then in a position to ensure his financial affairs remained in order and were managed in his best interests.

[75] *Guys And St Thomas NHS Foundation Trust v R* [2020] EWCOP 4, available at: https://www.bailii.org/ew/cases/EWCOP/2020/4.html

[76] *N v ACCG* [2017] UKSC 22, available at: https://www.bailii.org/uk/cases/UKSC/2017/22.html

[77] *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, available at:https://www.bailii.org/uk/cases/UKSC/2013/67.html

What declarations and decisions can the court not make?

7.14 The court cannot make any decisions on behalf of a person who has the capacity to make that decision. It can, though, declare that the person has that capacity, which can be important if there is a dispute. If there is concern about the welfare or interests of a person who has capacity to make the relevant decisions, but reasonably appears to be vulnerable, then an application will need to be made to the High Court. A judge of the High Court can exercise that court's inherent jurisdiction by making the orders that are necessary and proportionate to secure the interests of the person concerned[78].

7.15 The court can only grant declarations that fall within the scope of section 15 of the Act. There are some declarations that do not fall within its scope, for instance a declaration that a marriage abroad is not to be recognised in England & Wales. If such a declaration is needed to secure the person's interests, then this will have to be granted by a High Court in the exercise of its inherent jurisdiction[79].

7.16 The court cannot decide on behalf of a person to accept or refuse medical treatment for mental disorder where that person is detained under the Mental Health Act 1983 and subject to the compulsory treatment regime under that Act[80].

7.17 As set out above, the court is deciding on behalf of the person between the options actually available to them. The court cannot create options that are not available, for instance where a public body has applied the criteria set down in community care legislation and decided that it will not fund a particular care package. The court can test the public body's reasoning for not supplying the care package, but it cannot order the public body to fund the package. Challenges to a decision not to fund must (in most cases) be brought by way of judicial review. Similarly, where clinicians consider that a particular treatment is not on offer (whether because it is not clinically appropriate or for some other reason) the court cannot require them to provide that treatment, although if the situation is before the Court of Protection, the judge can test the reasons that it is not on offer. A challenge to the decision not to provide that treatment must (in most cases) be brought by way of judicial review.

When is an application to the Court of Protection required?

Property and affairs

7.18 In some cases, the court must make a decision because someone needs specific authority to act and there is no other route for getting it. This commonly occurs in relation to the property and affairs of a person who lacks capacity. Examples of where this would be required include the following situations:

[78] *Re DL* [2012] EWCA Civ 253- https://www.bailii.org/ew/cases/EWCA/Civ/2012/253.html

[79] XCC v AA &Ors [2012] EWHC 2183 (COP), available at: https://www.bailii.org/ew/cases/EWHC/COP/2012/2183.html

[80] Section 28 of the Act, available at:https://www.legislation.gov.uk/ukpga/2005/9/section/28

- Where there is no property and affairs LPA in place and someone needs to make a financial decision for a person who lacks capacity to make that decision. This might involve the court making a one-off decision on behalf of the person lacking capacity (for example, deciding to enter into or terminate a tenancy agreement) or the court might decide to appoint a deputy to make a wider range of decisions relating to the person's property and affairs. (For more information on the role of court appointed deputies see chapter 9).

7.19 Where it is in the best interests of a person who lacks capacity to make a will, or to amend an existing will, on their behalf.

7.20 Where an attorney under an LPA thinks it is in the best interests of a person who lacks capacity to make gifts from their assets that exceed the restrictions on gifting imposed by the Act. (For more information on the limits of an attorney under an LPA to make gifts see paragraphs 8.49-8.59).

Medical treatment

7.21 In some cases, the court must be asked to make the relevant decision in order to secure the person's rights under the European Convention on Human Rights81. In particular, the court must be asked to make the decision on behalf of the person as to whether or not to consent to life-sustaining medical treatment where, at the end of the decision-making process described in chapter 5:

- the decision is finely balanced;
- there is a difference of medical opinion; or
- there is a lack of agreement as to the proposed course of action from those with an interest in the person's welfare[82].

7.22 Where the treatment is to be carried out against the patient's known wishes, feelings, beliefs or values, medical professionals should consider and document:

- On what basis they can properly say that they reasonably believe the treatment is in the person's best interests;
- Whether they have considered all other options which are less restrictive;
- Whether delivery of the treatment will require the use of physical force, and, if so, whether this will require the authority of the Court of Protection.

[81] *NHS Trust v Y* [2018] UKSC 46, available at:https://www.supremecourt.uk/cases/docs/uksc-2017-0202-judgment.pdf

[82] In some situations, the real issue is not whether the medical treatment is in the person's best interests, but that the clinical team consider that they cannot properly offer it (because it is not clinically appropriate, or for some other reason). This is not ultimately an issue for the Court of Protection. If clinicians consider in such circumstances that they need legal confirmation that they are acting appropriately in not providing the treatment, they should seek such confirmation of this from the High Court by way of an application under Part 8 of the Civil Procedure Rules.

7.23 The court must also be asked to authorise arrangements to deliver medical treatment that will give rise to a deprivation of the person's liberty if that deprivation of liberty cannot be authorised under the Liberty Protection Safeguards (see 7.33).

When *may* an application to the Court of Protection be required?

Property and affairs

7.24 There may also be cases involving a person's property and affairs where the court should be asked to make a decision on behalf of a person who lacks capacity, even if an attorney or deputy has been appointed. This is likely to be the case where there is disagreement as to whether a particular decision is in the person's best interests, or where there is concern as to whether a decision is within the scope of the powers of an attorney or a deputy. Examples might include:

- Where an attorney under an LPA wishes to sell property belonging to a person who lacks capacity, but there is a dispute among the wider family as to whether such a sale is in the person's best interests.
- Where there is a conflict of interest between an attorney or deputy and the person for whom they are acting, for example where a property and affairs deputy wishes to purchase a property that belongs to the person for whom they have been appointed to take decisions.

Scenario: Settling disagreements outside of the court

Ms W has Alzheimer's disease and cannot care for herself in her own home any more, even with the assistance of carer visits. She is assessed as needing to move into a care home and her son and daughter, who are health and welfare attorneys, have different views as to which care home Ms W should move to. Ms W has enough money to pay the fees of a care home, but she lacks the capacity to make the decision about where to live.

Ms W's solicitor acts as attorney in relation to her property and financial affairs. He has no remit to decide which care home is best in terms of Ms W's welfare and meeting her needs.

Rather than there immediately being an application to the Court of Protection to decide which care home would be in Ms W's best interests (or even to appoint a health and welfare deputy to make the decision), the solicitor arranges pay for mediation between Ms W's son and daughter to resolve the issue. The mediation is successful, with Ms W's son and daughter exploring all the issues and agreeing the most appropriate home for their mother. The issue is resolved more quickly and less expensively than an application to the court would have been.

Medical treatment

7.25 In any case involving medical treatment, even if not life-sustaining, the presence of any of the factors set out at paragraph 7.19 (fine balance, disagreement or doubt) will mean it is unlikely that the medical professionals can properly say that they reasonably believe they are acting in the best interests of the person, so as to be protected from liability under section 5 of the Act[83]. If they cannot resolve the issue, the court should be asked to decide what is in the best interests of the person.

7.26 There may also be situations in which those involved in the decision-making process have a potential conflict of interest. Given that best interests decision-making needs to involve consultation with all those close to the person, as well as those who are involved with their care, it would be rare to find a case in which one or more of those involved could not be said to have a potential conflict of interest of one kind or another. For instance,

- A decision to continue life-sustaining treatment can mean that a care home continues to receive income, that the family is spared from experiencing the final loss of their loved one or that the clinical team does not have to face managing treatment withdrawal and end-of-life care
- Conversely, a decision to withdraw treatment can mean that the commissioner or service provider would no longer have to fund or provide on-going care or that a family member would be relieved of caring duties/ responsibilities or may benefit sooner from a patient's will
- Either way, different individuals (both professionals and family members) may have their own strongly held views.

7.27 These types of potential conflicts are part of everyday life and do not necessarily mean that people are unable to participate in decision-making, so long as they are able to maintain focus on what the relevant issues, in particular, what the person themselves would have wanted. Clinical bodies are used to dealing with potential conflicts of interest, in particular by ensuring that there is transparency as to potential conflicts. If a potential conflict of interest cannot be appropriately managed, then an application to the Court of Protection is likely to be required so that the medical professionals involved can properly say that they reasonably believe they are acting in the best interests of the person.

7.28 Medical professionals should also consider asking the court to decide on the person's behalf in relation to medical treatment which will involve a serious interference with their right to private life (including their right to autonomy) protected by Article 8 of the European Convention on Human Rights. This is the

[83] *Re P (Sexual Relations and Contraception)* [2018] EWCOP 10, available at: https://www.bailii.org/ew/cases/EWCOP/2018/10.html;and, *University College London Hospitals v KG* [2018] EWCOP 29, available at:- https://www.bailii.org/ew/cases/EWCOP/2018/29.html

case even if everyone concerned with person's welfare is in agreement as to the person's capacity and best interests. Examples of such cases include:

- where a medical procedure or treatment is for the primary purpose of sterilisation
- where the procedure is for the purpose of a donation of an organ, bone marrow, stem cells, tissue or bodily fluid to another person
- a procedure for the covert insertion of a contraceptive device or other means of contraception
- the use of deception to deliver medical treatment to the person
- where it is proposed that an experimental or innovative treatment is to be carried out
- a case involving a significant ethical question in an untested or controversial area of medicine

7.29 Without the scrutiny of the court in such a case, it is likely that medical professionals will not be able to say that they have a reasonable belief they are acting in the person's best interests so as to be protected from liability under section 5 of the Act84.

7.30 Separately, the court should be asked to resolve doubts or disagreements as to whether an advance decision to refuse medical treatment (ADRT) exists, is valid and/or applies to a specific treatment or treatments. This may either happen before there is any question of whether or not the relevant treatment(s) should be given, or at the time when they are under consideration.

Other cases

7.31 In any other case where there is doubt or disagreement between those interested in the person's welfare which cannot be resolved, the court should be asked to make the decision on their behalf if it is believed that they do not have capacity to make the decision. Key decisions include where the person should live and who the person should see, but this principle applies to any significant issue involving the person's welfare.

Delay

7.32 The Act imposes an obligation to take all practicable steps to enable the individual to gain or regain a level of capacity to make the decision required. Agreement should also be sought, if possible, between those involved in the decision-making process. However, taking such steps must not come at the cost of the person's welfare, especially if delay would have a bearing on potential treatment outcomes

[84] *Re P (Sexual Relations and Contraception)* [2018] EWCOP 10, available at: https://www.bailii.org/ew/cases/EWCOP/2018/10.html; and, *University College London Hospitals v KG* [2018] EWCOP 29, available at: https://www.bailii.org/ew/cases/EWCOP/2018/29.html

(for instance the chances of surviving a particular form of cancer)[85]. Early consideration must always be given as to how long it is reasonable to spend seeking to support the person or reaching agreement before making an application to the court.

What powers does the court have in relation to Powers of Attorney?

7.33 The Court of Protection can determine the validity of an LPA or EPA and can give directions as to how an attorney should use their powers under an LPA (see chapter 8). In particular, the court can cancel an LPA and end the attorney's appointment. The court might do this if the attorney is not carrying out their duties properly or acting in the best interests of the donor. The court must then decide whether it is necessary to appoint a deputy to take over the attorney's role.

7.34 The OPG may apply to the court in some circumstances before registering an LPA if there are provisions in it that would prevent it from being valid. It can also apply to remove an attorney or ask the court to determine any matters about the way an LPA is being used.

The Court of Protection and deprivation of liberty

7.35 Where a person is subject to arrangements that amount to a deprivation of liberty, in most cases, this will have been considered under the Liberty Protection Safeguards. The Court of Protection Rules 2017 allow any person can apply to the Court of Protection without permission where it concerns the Liberty Protection Safeguards. This includes the person, their Appropriate Person or IMCA.

7.36 Where authorised arrangements are already taking place, or an authorisation is to have effect on a date specified in the authorisation record within 28 days, (please see chapter 13 for more details), under s.21ZA of the Act the court can consider the following:

- whether Schedule AA1 of the Act applies to the arrangements, or whether the authorisation conditions are met
- what period the authorisation has effect for;
- what the authorisation relates to.

7.37 When considering these matters, the court will consider the relevant evidence. The court may decide on one of the following actions:

[85] *Sherwood Forest Hospitals NHS Foundation Trust & Anor v H* [2020] EWCOP 5, available at: https://www.bailii.org/ew/cases/EWCOP/2020/5.html; and, *QJ v A Local Authority* [2020] EWCOP 7, available at: https://www.bailii.org/ew/cases/EWCOP/2020/7.html

- vary or terminate the authorisation, or
- direct the Responsible Body to vary or terminate the authorisation.

7.38 Additionally, in a limited number of cases it may be necessary to deprive a person of liberty before the proposed arrangements have been authorised or pending a court decision relevant to the question of whether the decision maker is authorised to deprive a person of liberty. This might arise, for example, in truly urgent situations and in sudden emergencies. Section 4B of the MCA can authorise decision makers to take steps to deprive a person of liberty without an authorisation in place but only to enable life-sustaining treatment or to prevent a serious deterioration in the person's health. An application to the court can be made regarding the use of section 4B. It may be that this is considered during a challenge to an LPS authorisation, once one is in place, or as a stand-alone issue. See chapter 19 for more information on s4B.

Will the Court ever make an order on arrangements amounting to a deprivation of liberty?

7.39 The LPS are designed to ensure that everyone who is under arrangements amounting to a deprivation of liberty has access to the same safeguards to their Article 5 rights. Authorising the arrangements should no longer be the role of the Court of Protection except in rare circumstances. Therefore, Responsible Bodies should not make applications for an authorisation to the Court of Protection.

7.40 The court may be making a decision relating to other matters, such as serious medical treatment or in respect of family contact, at the same time that a deprivation of liberty is being considered. Whilst it is ultimately a matter for the court to decide how to proceed, it would be expected that in most cases, the court would consider this as a standalone decision and ask the relevant Responsible Body to consider the deprivation of liberty.

7.41 However, in some cases, a Responsible Body may have made an application to the court for another issue, such as a tenancy agreement, which is closely intertwined with the arrangements amounting to a deprivation of liberty. Where this is the case, the court may decide to consider them together. In such circumstances, the court may consider the whole case, and where relevant, make an Order under section 16 of the Act.

Implementing a declaration or decision of the court

7.42 Anyone implementing a declaration or decision of the court must still also follow the Act's principles. They are bound by the court's declaration as to capacity or decision

as to best interests. There may be a need to go back to court if the person's capacity has changed or the decision is no longer in their best interests[86].

Cases involving young people aged 16 or 17

7.43 Either a court dealing with family proceedings or the Court of Protection can hear cases involving people aged 16 or 17 who lack capacity. In some cases, the Court of Protection can hear cases involving people younger than 16 (for example, when somebody needs to be appointed to make longer-term decisions about their financial affairs). Under section 21 of the Act, the Court of Protection can transfer cases concerning children to a court that has powers under the Children Act 1989. Such a court can also transfer cases to the Court of Protection, if necessary. Chapter 21 gives more detail on cases where this might apply.

Who should bring an application?

7.44 Who should bring the application to court will depend upon the nature of the issue, but in general:

- If social care staff are concerned about a decision that affects the welfare of a person who lacks capacity, the relevant local authority should make the application.
- In cases involving issues as to medical treatment, the organisation which is, or will be, responsible for commissioning or providing clinical or caring services to the person should normally be the applicant
- For decisions about the property and affairs of someone who lacks capacity to manage their own affairs, the applicant will usually be the person (for example family carer) who needs specific authority from the court to deal with the individual's money or property
- Where there is a disagreement among family members, a family member may wish to apply to the court to settle the disagreement – bearing in mind the need, in most cases, to get permission beforehand (see paragraphs 7.47 below)
- A person wishing to challenge a determination that they lack capacity may apply to the court, supported by others where necessary
- Any person who is otherwise interested in the person's welfare can make an application to court, but in most cases, they are likely to require permission (see paragraph 7.47 below)

[86] *AMDC v AG & Anor* [2020] EWCOP 58, available at: https://www.bailii.org/ew/cases/EWCOP/2020/58.html. An NHS Trust v AF & Anor [2020] EWCOP 55 (09 November 2020), available at: https://www.bailii.org/ew/cases/EWCOP/2020/55.html

Scenario: A court order about housing

Mr T, who has lived at his property for most of his adult life, has developed paranoid personality disorder and a persistent delusional disorder. The symptoms include a sense of persecution by his landlord. As a result of his illness he hoards items and has refused his landlord access to complete inspections or repairs. Mr T's home is now a fire and safety risk and has become infested with vermin. Mr T lacks insight into his mental health diagnosis and is not engaging with any support agencies to assist him to manage his circumstances.

His landlord accordingly brings an application for possession of his property. A psychiatrist is instructed in the possession proceedings and concludes that as a result of his mental illness Mr T lacks the capacity to make decisions relating to his tenancy, including regarding clearing his property. The psychiatrist also provides guidance as to how to minimise any distress to Mr T should decisions have to be made on his behalf.

The local authority makes an application to the Court of Protection to seek an order to assist Mr T to remain in his home, including a declaration that it is lawful for the local authority to enter his home to organise access for third parties to clear away some of his excess property and rubbish. This enables the property to be made safe and habitable and for Mr T to retain his home.

7.45 The courts have emphasised that it is the responsibility of public bodies to ensure that disputes about significant welfare issues in relation to those for whom they have caring responsibilities are brought to the court if they cannot be resolved by discussion[87]. A failure to bring an appropriate case to the court may result in violation of the person's rights under Articles 5 or 8 of the Human Rights Act.

7.46 The position in relation to deprivation of liberty is set out at 7.35. This includes the position where the application is brought by the cared-for person's Appropriate Person or an Independent Mental Capacity Advocate.

How can someone make an application to the Court of Protection?

7.47 The form of the application will depend on the nature of the issue for consideration. The Court of Protection Rules and Practice Directions can be found on gov.uk[88].

[87] London Borough of Hillingdon v Neary & Anor [2011] EWCOP 1377, available at: https://www.bailii.org/ew/cases/EWCOP/2011/1377.html

[88] https://www.gov.uk/courts-tribunals/court-of-protection

7.48 The court's guidance includes what should happen before a case is brought in relation to:

- personal welfare
- property and affairs
- mixed personal welfare and property and affairs

7.49 In some cases, the person making the application will require permission from the Court of Protection[89]. This requirement never applies to the person who lacks, or is said to lack, capacity. It also never applies in relation to applications concerning deprivation of liberty.

How will the Court of Protection deal with the case?

7.50 Exactly how the court will deal with the case will depend upon the type of application. Many cases are decided without a court hearing, especially those relating to the person's property and affairs which are brought because someone needs authority to make the relevant decision(s) (see 7.18 above).

7.51 In every case, the court must consider as a first step how the person concerned will participate in the proceedings. If the applicant is the person who is alleged to lack capacity, they will always be a party to the court proceedings. In all other cases, the court will decide whether the person who lacks, or is alleged to lack, capacity should be involved as a party to the case and how they may participate in the case90.

7.52 People who lack capacity to instruct a solicitor or conduct their own case will need a litigation friend, or a court-appointed accredited legal representative91. The litigation friend can instruct the solicitor and conduct the case on behalf of a person who lacks capacity to give instructions.

7.53 The Official Solicitor will act as litigation friend if:

- nobody else is suitable and willing to be litigation friend
- there is money available to pay the Official Solicitor's costs, for example legal aid
- the person's doctor or another medical professional, for example their psychiatrist, confirms they lack capacity to manage the case (unless they're a child)

[89] See Court of Protection Practice Direction 8A, available at: https://www.judiciary.uk/publications/practice-direction-8a-permission/

[90] See rule 1.2 of the Court of Protection Rules 2017, available at: https://www.legislation.gov.uk/uksi/2017/1035/part/1/article/1n2

[91] Rule 1.2 of the Court of Protection Rules 2017, available at:- https://www.legislation.gov.uk/uksi/2017/1035/part/1/article/1n2

7.54 The court will appoint the Official Solicitor - if they agree - at the relevant time.

7.55 In cases concerning the person's health and welfare, the court will consider at a case management hearing the steps to be taken to allow it to decide the questions before it. The number of further hearings needed to enable the court to make a decision will depend upon how complicated the case is. The parties before the court are under a duty to cooperate to enable the case to be dealt with justly and at proportionate cost[92].

7.56 In cases concerning a person's property and affairs, how the case will be decided will depend on whether there is a dispute about any aspect. If there is, then the court will usually fix a dispute resolution hearing. This is a chance to see whether the case can be resolved and avoid unnecessary litigation. The hearing is therefore held in private, and before a different judge to the one who would then hear the case if the dispute cannot be resolved. In almost all circumstances, nothing said at the hearing can be relied upon if the dispute cannot be resolved, and a judge must then decide the outstanding issues. Before and, if necessary, after the dispute resolution hearing, the parties are under a duty to cooperate to enable the case to be dealt with justly and at proportionate cost[93].

7.57 Cases concerning the deprivation of a person's liberty are described at 7.35.

7.58 Court of Protection hearings, except for the dispute resolution hearing, are usually held in public, with reporting restrictions to protect the identity of the person involved.

7.59 The Court of Protection has the power to award costs[94]. It will, in particular, be likely to award costs if a party's conduct before or during proceedings has led either to unnecessary or unnecessarily extended or expensive proceedings.

Will public legal funding be available?

7.60 Depending on their financial situation, people may be entitled to:

- publicly funded legal advice (legal help) from accredited solicitors or advice agencies
- legal representation before the Court of Protection in some health and welfare cases.

[92] Part 1 of the Court of Protection Rules 2017, available at: https://www.legislation.gov.uk/uksi/2017/1035/part/1/made

[93] Part 1 of the Court of Protection Rules 2017, available at: https://www.legislation.gov.uk/uksi/2017/1035/part/1/made

[94] Part 19 of the Court of Protection Rules 2017, available at: https://www.legislation.gov.uk/uksi/2017/1035/part/19/made

When can someone get legal help?

7.61 Legal help is a type of legal aid (public funding) that pays for advice and assistance on legal issues, including those affecting a person who lacks capacity. But it does not provide representation for a court hearing.

7.62 To qualify for legal help, applicants must show that:

- they earn less than a certain amount and do not have savings or other financial assets in excess of a specific amount
- they would benefit sufficiently from legal advice to justify the amount it costs

7.63 Legal help can include:

- advice and guidance on the Mental Capacity Act and the person's rights
- help from a solicitor or other representative in writing letters
- in exceptional circumstances, getting a barrister's opinion
- assistance in preparing and supporting an application to the Court of Protection

When can someone get legal representation?

7.64 Public funding for legal representation in the Court of Protection is only available for the cases that concern a person's:

- right to life
- liberty or physical safety
- medical treatment (within the meaning of the Mental Health Act 1983)[95]
- capacity to marry, to enter into a civil partnership or to enter into sexual relations
- right to family life

7.65 Cases that do not concern these areas may still receive funding through the Exceptional Case Funding (ECF) scheme if a failure to provide legal aid would breach an individual's human rights, or through rights preserved under UK laws following the UK's exit from the European Union.

7.66 Where an application is made under s.21ZA or in relation to section 4B of the Act, where it is used prior to a decision being made about an LPS authorisation, there is no means test for legal aid for legal representation when an application is made by the person or their Appropriate Person. This means that the person or their Appropriate Person, even where they are not acting as the person's litigation friend,

[95] But the Court of Protection cannot make a decision on a person's behalf whether to accept or refuse treatment under Part 4 of the Mental Health Act 1983, details available at: https://www.legislation.gov.uk/ukpga/1983/20/part/IV

can make an application relating to a deprivation of liberty to the court without having to satisfy a means test.

7.67 For all other individuals making an application in relation to s.21ZA or s.4B, or for matters not covered by 21ZA of the Act, the individual bringing the application to Court will have to satisfy a means test for legal aid.

7.68 To qualify for legal representation, where a means test applies, people will generally have to satisfy more detailed merits criteria than applicants for legal help. For instance, the prospects of the case being successful, whether the case justifies public funding given the costs, and whether the court has ordered (or is likely to order) an oral hearing will all be considered. They will also have to establish that the case could not be brought by someone else or funded in another way and that there are no alternatives to court proceedings, such as complaints systems and ombudsman schemes, that should be explored first.

7.69 This type of work can be undertaken by solicitors who hold a Legal Aid Agency contract for Mental Health or Community Care. Details of legal aid advisers with a legal aid contract in England and Wales can be found online[96]. Further information about legal aid and public funding can be obtained from the Legal Aid Agency[97].

[96] Find A Legal Aid Adviser, available at: https://find-legal-advice.justice.gov.uk/ [NB this is a Beta site at the time of publishing]

[97] Legal aid and public funding, available at: https://www.gov.uk/government/organisations/legal-aid-agency

8. Lasting Powers of Attorney

This chapter explains what Lasting Powers of Attorney (LPAs) are and how they should be used. It sets out the types of decisions that people can appoint attorneys to make and when an LPA can and cannot be used. It also sets out the duties and responsibilities of attorneys, the standards required and measures for dealing with attorneys who don't meet appropriate standards.

This chapter also explains how LPAs differ from Enduring Powers of Attorney.

In this chapter, as throughout the Code, a person's capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

Quick summary

- A Lasting Power of Attorney (LPA) allows someone to appoint a trusted person or people to make financial and/or personal welfare decisions on their behalf.
- An LPA must be registered with the Office of the Public Guardian (OPG) before it can be used.

When acting under an LPA, attorneys must:

- Make sure that the Act's statutory principles are followed
- Check whether the person has the capacity to make that particular decision for themselves. If they have capacity:
    - a personal welfare LPA cannot be used – the person must make the decision
    - a property and affairs LPA can be used if the donor has specified that in the LPA, and if they have given permission to make the decision.
- Ensure anything done under the authority of the LPA is in the person's best interests
- Have regard to guidance in this Code of Practice that is relevant to the decision that needs to be made

- Only act within the limits of their power and with regard to any instructions in the LPA
- Fulfil their responsibilities and duties to the person who lacks capacity

What is a Lasting Power of Attorney (LPA)?

8.1 An LPA is a legal document that allows someone to plan ahead for a possible future loss of mental capacity. It allows the person (called "the donor") to appoint a trusted person or people (called "attorneys" or "donees") to make financial and/or personal welfare decisions on their behalf. Using an LPA, the attorney can make decisions that are as valid as those made by the person.

8.2 There are two types of LPA;

- property and affairs – covering finances, money and property
- personal welfare – covering healthcare, social care and consent to medical treatment. This is often called a 'health and welfare' or 'health and care decisions' LPA

8.3 See paragraphs 8.40-8.59 for more information about property and affairs LPAs. See paragraphs 8.60-8.68 for more information about health and welfare LPAs.

8.4 Both types of LPA must be registered with the OPG before they can be used.

8.5 Once registered, a property and affairs LPA can be used when the donor has capacity, if the donor has specified that in the LPA, and if they have given permission to make the decision. But a personal welfare LPA can only be used if the donor does not have capacity to make the decision.

8.6 The donor can choose one person or several people as their attorney to make different kinds of decisions.

How does a donor create an LPA?

8.7 The donor must follow the right procedures for creating and registering an LPA, as set out at paragraphs 8.24-8.29. Otherwise the LPA might not be valid and cannot be registered. The OPG is the registering authority for LPAs. If an LPA is not registered, it cannot be used by the attorney.

8.8 It is not necessary to get legal or medical advice to create an LPA but it may be a good idea if the donor's circumstances are complicated.

8.9 Only adults aged 18 or over can make an LPA, and they can only make an LPA if they have the mental capacity to do so. This does not mean the donor needs to have the capacity to make all decisions at the time they make the LPA. It means they must have the mental capacity to decide to make and then execute the LPA even if they lack the mental capacity to make some of the decisions the LPA would cover.

8.10 For an LPA to be valid:

- it must be in the statutory form prescribed by regulations
- it must include the information requested in the form, for example, detail who the donor wants to appoint as their attorney/s and how they should make decisions
- the donor must sign a statement saying that they have read the prescribed information in the form (or somebody has read it to them)
- if they are creating a property and affairs LPA, the donor must decide whether they want the LPA to apply only when they no longer have capacity, and if they do, indicate this on the form
- the document must name people (not any of the attorneys) who should be told about an application to register the LPA, or it should say that there is no-one they wish to be told
- the attorneys must sign a statement saying that they have read the prescribed information and that they understand their duties – in particular the duty to act in the donor's best interests (chapter 5)
- the form includes a certificate which must be completed by an independent third party. This could be a friend, colleague, or someone the donor has known well for at least two years – they must be more than just an acquaintance. Or it could be the donor's doctor or lawyer or someone with the professional skills to judge that the donor understands what they are doing and is not being forced into it[98]. If possible, the certificate provider should discuss the LPA with the donor in private, without the attorneys or other people present, before they sign their part of the form. The certificate provider must sign to confirm that:

    i. in their opinion, the donor understands the LPA's purpose
    ii. nobody used fraud or undue pressure to trick or force the donor into making the LPA and
    iii. there is nothing to stop the LPA being created.

[98] Further details of who may and who may not be a certificate provider are available in regulations at: http://www.legislation.gov.uk/uksi/2007/1253/regulation/8/made

8.11 There are some people who cannot be certificate providers, including people who are named in the LPA as attorneys or replacement attorneys and family members of attorneys. The OPG's guidance gives more details.

8.12 A donor can decide at any time that they wish to cancel an LPA that they have created, as long as they have mental capacity to make that decision. If the LPA has not been registered, this means destroying the original document and any copies that have been made. If the LPA has been registered, the Public Guardian requires the donor to complete a 'deed of revocation'[99], which must be signed and dated by the donor and a witness (the witness does not need to be the same person who witnessed the LPA). The donor must inform all the attorneys that they are cancelling the LPA and send the document to the OPG along with the original LPA document.

8.13 If the donor wishes to make a new LPA, they should cancel any registered one, as it will not automatically be revoked. If so, they should follow the process above.

Who can be an attorney?

8.14 A donor should think carefully before choosing someone to be their attorney. An attorney should be trustworthy, competent and reliable. They should have the skills and ability to carry out the necessary tasks.

8.15 Attorneys must be at least 18 years of age. For property and affairs LPAs, the attorney could be either:

- an individual (as long as they are not bankrupt at the time the LPA is made), or
- a trust corporation (often part of a bank, other financial institution or solicitor firm)

8.16 If an attorney nominated under a property and affairs LPA becomes bankrupt at any point, they will no longer be allowed to act as an attorney for property and affairs. People who are bankrupt can still act as an attorney for a health and welfare LPA.

8.17 A person who is on the Disclosure and Barring Service's barred list cannot act as an attorney (or deputy). It is a criminal offence for an individual on the barred list to engage in a regulated activity such as "assistance in the conduct of an adult's own affairs"[100].

8.18 The donor must name an identifiable individual as an attorney rather than a job title in a company or organisation, (for example, 'Director of Adult Services' or 'my

[99] Example text for a deed of revocation is available in the OPG guidance on LPAs: LP12 Make and register your lasting power of attorney a guide - Make, register or end a lasting power of attorney: End your lasting power of attorney, available at:https://www.gov.uk/power-of-attorney.

[100] https://www.legislation.gov.uk/ukpga/2006/47/schedule/4 paragraph 7 (3E)

solicitor' would not be sufficient). A paid care worker who is looking after the donor (such as a care home manager) should not agree to act as an attorney, apart from in unusual circumstances (for example, if they are the only close relative of the donor). This is because it could create a conflict of interest for the care worker between their duty to the donor and their role as a paid professional, particularly in relation to best interests decisions and gifts.

8.19 A donor can appoint one (a sole) or more attorneys. Where the donor appoints more than one attorney, they need to specify whether the attorneys should act 'jointly', 'jointly and severally', or 'jointly in respect of some matters and jointly and severally in respect of others' (section 10(4)):

- Joint attorneys must always act together. All attorneys must agree decisions and sign any relevant documents. If one attorney can no longer act, then none of them can act and, if replacements have been appointed, they will take over.
- Joint and several attorneys can act together but may also act independently if they wish. Any action taken by any attorney alone is as valid as if they were the only attorney. If one attorney can no longer act, the others can continue to do so unless it is in relation to an issue they must act jointly on. If appointed, replacement attorneys will take over from the one who can no longer act, and will be responsible for any joint decisions.

8.20 The donor may want to appoint attorneys to act jointly in some matters but jointly and severally in others. For example, a donor could choose to appoint two or more financial attorneys jointly and severally. But they might then say when selling the donor's house, the attorneys must act jointly. The donor may appoint welfare attorneys to act jointly and severally but specify that they must act jointly in relation to giving consent to surgery. If a donor who has appointed two or more attorneys does not specify how they should act, they must always act jointly (section 10(5)).

8.21 In choosing to appoint attorneys jointly, or jointly and severally, the donor should consider the implications of each option. Appointing attorneys jointly can reduce the risk of abuse or conflicts of interest arising but may not always be practicable (for instance visiting a bank or signing off payments together). On the other hand, appointing attorneys jointly and severally allows attorneys to act independently and without each other's oversight. This can increase the risk of conflicts of interest or abuse, but it allows more flexibility in approach and can split the burden of responsibility across multiple individuals.

8.22 Whether the attorneys are appointed jointly or jointly and severally, if in making a significant decision on the donor's behalf, they disagree on what is in the donor's best interests and they cannot settle the disagreement, they will need to apply to the Court of Protection (see chapter 7).

8.23 Section 10(8) says that donors may choose to name replacement attorneys to take over their duties in certain circumstances (for example, in the event of an attorney's death). The donor may name a specific attorney to be replaced, or the replacements can take over from any attorney, if necessary. Donors cannot give their attorneys the right to appoint a substitute or successor.

How should somebody register and use an LPA?

8.24 An LPA must be registered with the OPG before it can be used. An unregistered LPA will not give the attorney any legal powers to make a decision for the donor. The donor can register the LPA while they still have mental capacity to do so, or the attorney can apply to register the LPA at any time.

8.25 There are advantages to registering the LPA soon after the donor makes it. For example, this ensures that there is no delay when the LPA needs to be used and that there are no errors which prevent it being registered. If the donor loses capacity and there are errors in the form, it will not be possible to correct these and therefore the LPA cannot be registered.

8.26 There is no requirement to register an LPA immediately and some people choose not to in order to save money on the registration fee or to retain the flexibility to change their arrangements before they register it. However, this should be considered against the benefits of registering it as soon as it is signed.

8.27 While they still have capacity, donors should let the OPG know of permanent changes of address for the donor or the attorney or any other changes in circumstances. If the donor no longer has capacity to do this, attorneys should report any such changes to the OPG. Examples include a property and affairs attorney becoming bankrupt or the ending of a marriage between the donor and their attorney. Keeping the OPG records up to date will help make sure that attorneys do not make decisions that they no longer have the authority to make. The OPG should also be notified if the donor or any of the attorneys dies, or if any of the attorneys loses mental capacity to act under the LPA.

8.28 Once registered with the OPG, a property and affairs LPA will also need to be provided to the donor's bank, building society or other financial institutions the donor uses, before it can be used. These organisations may have their own registration processes.

8.29 Although it is not necessary, once a personal welfare LPA has been registered, it is recommended that a copy is lodged with any medical professionals working with the donor in advance of it being used. This could include their doctor, GP practice, hospital or care providers.

Can foreign powers of attorney be used in England and Wales?

8.30 Where an LPA or equivalent has been granted in another jurisdiction (i.e. outside of England and Wales), then if it is valid under the law of that jurisdiction it should be treated as automatically effective in England and Wales. If the attorney experiences difficulty in operating the power, they can make an application to the Court of Protection for a declaration that they are acting lawfully when exercising the power[101]. The attorney must, when using the power in England and Wales, act as if they were governed by the Act and follow the guidance in the Code. It is important to note that a 'foreign' power of attorney includes one granted in other parts of the United Kingdom, including Scotland and Northern Ireland.

What guidance should an attorney follow?

8.31 Section 9(4) states that attorneys must meet the requirements set out in the Act. Most importantly, they have to follow the statutory principles (section 1) and make decisions in the best interests of the person who lacks capacity (section 4). See chapter 2 for guidance on how to apply the Act's principles.

8.32 Attorneys must also respect any conditions or restrictions that the LPA document contains. Conditions may be a direct instruction, in which case the attorney must follow them (for example "my attorneys must not consent to any treatment involving blood products as this is against my religion"); or they may express the donor's wishes or preferences, in which case they should inform the attorney when making a best interests decision (for example "I'd prefer to live within 5 miles of my sister").

8.33 The court has ruled that a donor cannot instruct, or express a preference for, their attorneys to act in a way that is inconsistent with the Act or is illegal[102]. So a condition or instruction that an attorney should do something to end a donor's life, or assist in that process, is ineffective and the attorney cannot use it to justify acting illegally. Neither is it effective if it is an instruction that is conditional upon a future change in law.

8.34 A donor can instruct their attorney to obtain the consent of a third party before acting, for example, obtain the consent of the donor's children before selling their home.

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[101][101] The Court of Protection Rules 2017 (legislation.gov.uk), available at: https://www.legislation.gov.uk/uksi/2017/1035/part/23/made

[102] See *The Public Guardian v DA & Ors* [2018] EWCOP 26, available at: https://www.bailii.org/ew/cases/EWCOP/2018/26.html

8.35 Before acting under their power, an attorney should always attempt to support the donor to make the decision themselves. Chapter 3 gives suggestions of ways to help people make their own decisions in accordance with the Act's second principle. Attorneys should also refer to the guidance in chapter 4 when assessing the donor's capacity to make decisions, and in particular, should follow the steps suggested for establishing a 'reasonable belief' that the donor lacks capacity (see paragraphs 4.67-4.69).

8.36 When deciding what is in the donor's best interests, attorneys should refer to the guidance in chapter 5. If the donor has made a mandatory instruction in the LPA which appears to conflict with what is in the donor's best interests, then an application to the Court of Protection is likely to be required to resolve the issue. The instruction may need to be severed from the LPA in order for the LPA to be valid, as the attorney has a statutory obligation to make a best interests decision103.

8.37 See paragraphs 8.101-8.115 for a description of an attorney's duties.

Scenario: Making decisions in a donor's best interests

Mr Y was an environmental campaigner for many years. He appointed his solicitor as his attorney under a property and affairs LPA and has subsequently lost capacity to make complex financial decisions about investments.

Mr Y did not specifically state in the LPA that investments made on his behalf must be ethical investments. When the attorney assesses his client's best interests, however, the attorney considers Mr Y's past wishes, values and beliefs, including his work as an environmental campaigner.

When the attorney makes financial decisions on Mr Y's behalf he invests only in investment products with strong ethical and environmentally responsible policies.

[103] See Re [2019] EWCOP 40 'In The Matter Of Various Lasting Powers of Attorney', available at:https://www.bailii.org/ew/cases/EWCOP/2019/40.html

What should someone, such as a social worker or doctor, do when a person claims to be an attorney for their client or patient?

8.38 Where someone claims to be acting as another person's attorney, either in relation to financial decisions or personal welfare decisions, staff are entitled to:

- ask to see the original document or a certified copy to verify it has been registered and the person is named as an attorney
- ask to see photo ID to show proof of the identity of the person claiming to be the attorney
- check with the OPG that the document has not be withdrawn and the attorney is still lawfully able to act

8.39 If after seeing the LPA and proof of ID, staff still want to check if someone has another person acting on their behalf, they can ask the OPG to check their register by completing form the 'OPG 100', which is a free service. These checks can be expedited in urgent cases[104]. The OPG also has an electronic 'Use a lasting power of attorney' service[105].

What decisions can an attorney make?

Property and affairs LPAs

8.40 A donor can make an LPA giving an attorney the right to make decisions about property and affairs (including financial matters). After being registered a property and affairs LPA can be used when the donor has capacity, if the donor has specified that in the LPA, and if they have given permission to make the decision. The LPA will continue to apply when the donor no longer has capacity.

8.41 Alternatively, a donor can state in the LPA document that the LPA should only apply when they lack capacity to make a relevant decision. It is the donor's responsibility to decide who should assess their capacity. For example, the donor may trust the attorney to carry out an assessment in line with the Act, or they may say that the LPA only applies if their GP or another doctor confirms in writing that they lack capacity to make specific decisions about property or finances. Financial institutions may wish to see the written confirmation before recognising the attorney's authority to act under the LPA.

[104] Regarding COVID 19 - NHS and social care staff guidance: check if a COVID-19 patient has an attorney or deputy (GOV.UK), available at: https://www.gov.uk/guidance/nhs-staff-searching-our-registers-of-attorneys-and-deputies.,

[105] Use a lasting power of attorney (GOV.UK), available at: https://www.gov.uk/use-lasting-power-of-attorney.

8.42 The fact that someone has made a property and affairs LPA does not mean that they cannot continue to carry out financial transactions for themselves. The donor may have capacity, but perhaps anticipates that they may lack capacity at some future time. Or they may have fluctuating capacity and therefore be able to make some decisions (at sometimes) but need an attorney to make others (at other times). The attorney should allow and encourage the donor to do as much as possible and should only act when the donor asks them to or to make those decisions the donor lacks capacity to make. However, in other cases, the donor may wish to hand over responsibility for all decisions to the attorney, even those they still have capacity to make.

8.43 If a donor does not restrict decisions the attorney can make, the attorney will be able to make decisions about any or all of the person's property and financial affairs. This might include:

- buying or selling property in the donor's name
- changing and signing tenancy agreements
- opening, closing or operating any bank, building society or other account in the donor's name
- giving access to the donor's financial information
- claiming and receiving all benefits, pensions, allowances and rebates to an account in the donor's name and using them on the donor's behalf (unless the Department for Work and Pensions has already appointed someone, and everyone with an interest in the donor's welfare is happy for this to continue)
- receiving any income, inheritance or other entitlement to an account in the donor's name on behalf of the donor
- dealing with the donor's tax affairs
- paying the donor's mortgage, rent and household expenses
- insuring, maintaining and repairing the donor's property
- investing the donor's savings
- making limited gifts on the donor's behalf (but see paragraphs 8.49–8.59 below)
- paying for private medical care and residential care or nursing home fees
- applying for any entitlement to funding for NHS care, social care or adaptations for the donor
- using the donor's money to buy a vehicle or any equipment or other help the donor needs
- repaying interest and capital on any loan taken out by the donor

8.44 A general property and affairs LPA will allow the attorney to carry out any or all of the actions above (although this is not a full list of the actions they can take). However, the donor may want to specify the types of powers they wish the attorney to have, or to exclude particular types of decisions. If the donor holds any assets as trustee, they should get legal advice about how the LPA may affect this.

8.45 Whether the attorney has a general power in relation to property and affairs or a limited power restricted to when the donor has lost capacity, the attorney does not have the authority to create a Will for the donor. If arrangements to make a Will need to be put in place, this will require an application to the Court of Protection.

8.46 The attorney must make these decisions personally and cannot generally give someone else authority to carry out their duties (see paragraphs (8.106-8.107). But if the donor wants the attorney to be able to give authority to a specialist to make specific decisions, they need to state this clearly in the LPA document (for example, appointing an investment manager to make particular investment decisions). A donor will also need to state clearly in the LPA if they want a specialist they have already appointed to continue to act once the LPA comes into force, otherwise they will not be able to continue to act.

8.47 Donors may like to appoint someone (perhaps a family member or a professional) to go through their accounts with the attorney from time to time. This might help to reassure donors that somebody will check their financial affairs when they lack capacity to do so. It may also be helpful for attorneys to arrange a regular check that everything is being done properly. The donor should ensure that the person is willing to carry out this role and is prepared to ask for the accounts if the attorney does not provide them. They should include this arrangement in the signed LPA document. The LPA should also say whether the person can charge a fee for this service, and if they can, at what rate.

8.48 If the donor wishes to appoint a professional (for example, a solicitor or an accountant) as their attorney, they should specify in the LPA whether the professional can charge a fee, and if so, at what rate.

What gifts can an attorney make under a property and affairs LPA?

8.49 There are strict limits on the kinds of gifts that attorneys can give on a donor's behalf. An attorney can only make gifts of the donor's money or belongings to people who are related to or connected with the donor (including the attorney) on specific "customary" occasions, including:

- births or birthdays
- weddings or wedding anniversaries
- civil partnership ceremonies or anniversaries, or
- any other occasion when families, friends or associates usually give presents, for example, Christmas, Eid, Diwali, Hanukkah, Chinese New Year (section 12(3)(b))

8.50 If the donor previously made donations to any charity regularly or from time to time, the attorney can make donations from the person's funds. This also applies if the donor could have been expected to make such payments (section 12(2)(b)). But the

value of any gift or donation must be reasonable and take into account the size of the donor's estate. For example, it would not be reasonable to buy expensive gifts at Christmas if the donor had to go without essential items in order to pay for them.

8.51 In certain circumstances, gifts can be made up to the annual Inheritance tax exemption, and the annual small gifts exemption to a maximum of ten people. Such gifts can be made where:

- the donor has a life expectancy of less than five years
- the donor's estate exceeds the nil rate band for Inheritance Tax purposes
- the gift is affordable given the donor's circumstances
- there is no evidence that the donor would oppose the gift

8.52 If the attorney wishes to make a gift outside of these limits, then an application to the Court of Protection may be needed.

8.53 The donor cannot use the LPA to make more extensive gifts than those allowed under section 12 of the Act. But they can impose stricter conditions or restrictions on the attorney's powers to make gifts. They should state these restrictions clearly in the LPA document when they are creating it.

8.54 When deciding on appropriate gifts, the attorney should consider the donor's wishes and feelings to work out what would be in the donor's best interests.

8.55 The donor may also include a statement in the LPA expressing their wish for the attorney to use the donor's funds to benefit someone other than the donor (including the attorney). Such a provision in an LPA may be valid, as long as it is a statement only of the donor's wishes, rather than being expressed as mandatory instructions for the attorney to follow. This is because the attorney must make every decision in accordance with the donor's best interests at the time of the decision[106].

8.56 Examples of payments which an attorney may authorise if provided for as above in a valid LPA, without seeking the approval of the Court of Protection, might include:

- trust funds for grandchildren
- payment of school fees for grandchildren
- interest-free loans to family
- maintenance for any family member other than the donor's wife, husband, civil partner or child under 18
- investments in the attorney's business, or the business of a family member
- payments for holidays, cars or items of value for family members

[106]See Re [2019] EWCOP 40 'In The Matter Of Various Lasting Powers of Attorney', available at: https://www.bailii.org/ew/cases/EWCOP/2019/40.html

8.57 It is also not necessary for an attorney to apply to the Court for permission to use the donor's funds to benefit another person (including the attorney) in the same way as the donor did whilst they had capacity.

8.58 The attorney can apply to the Court of Protection for permission to make gifts that are not included in the LPA (for example, for tax planning purposes).

8.59 The OPG provides guidance for attorneys on providing gifts[107].

Personal welfare LPAs

8.60 A personal welfare LPA enables attorneys to make decisions about personal welfare, which can include healthcare and medical treatment decisions. Unlike a property and affairs LPA, a personal welfare LPA can only be used at a time when the donor lacks capacity to make a specific health or welfare decision.

8.61 Personal welfare LPAs might include decisions about:

- where the donor should live and who they should live with
- the donor's day-to-day care, including diet and dress
- who the donor may have contact with
- consenting to or refusing medical examination and treatment on the donor's behalf
- arrangements needed for the donor to be given medical, dental or optical treatment
- assessments for and provision of care services
- whether the donor should take part in social activities, leisure activities, education or training
- the donor's personal correspondence and papers
- rights of access to personal information about the donor
- complaints about the donor's care or treatment

8.62 There are also limits on the types of decisions that an attorney can make. Decisions a personal welfare attorney cannot make include:

- specifying the particular treatment a person should have
- imposing the attorney's own medical choices
- withholding food and drink from the donor without consultation
- instructing staff to carry out care that has not been agreed

[107] The OPG Guidance on providing gifts, available at:www.gov.uk/government/publications/giving-gifts-a-guide-for-deputies-and-attorneys.

8.63 Donors can add restrictions or conditions to areas where they would not wish the attorney to have the power to act. For example, a donor might only want an attorney to make decisions about their social care and not their healthcare. Donors can also set preferences for how they want the attorney to approach best interests decisions. There are particular rules for LPAs authorising an attorney to make decisions about life-sustaining treatment (see paragraphs 8.75-8.77 below).

Scenario: Restricting the decisions an attorney can make

Ms H is in the early stages of Alzheimer's disease. She wants to get her affairs in order while she has capacity to do so, and makes a personal welfare LPA, appointing her daughter as attorney.

Ms H knows that relationships are strained between her daughter and some other members of the family. It is very important to Ms H that this does not impact on the contact that she has with the other family members.

Ms H states in the LPA that her attorney does not have the authority to restrict who can contact her. Therefore, if her daughter wanted to prevent anyone having contact with Ms H, she must apply to the Court of Protection for a decision on this.

8.64 Before making a decision under a personal welfare LPA, the attorney must be sure that:

- the LPA has been registered with the OPG
- the donor lacks the capacity to make the particular decision or the attorney reasonably believes that the donor lacks capacity to take the decisions covered by the LPA (having applied the Act's principles)
- if the donor's capacity is fluctuating (see paragraph 4.50), that the decision cannot be delayed until the donor regains capacity to make it themselves
- they are making the decision in the donor's best interests
- they have complied with any instructions provided by the donor within the LPA, including obtaining medical evidence on capacity if this has been specified

8.65 Where an attorney feels unable to make a decision, those needing to make care and treatment decisions should make a best interests decision if the person lacks capacity (chapter 5), and accordingly will be protected from liability under section 5 of the Act (chapter 6).

8.66 When healthcare or social care staff are involved in preparing a care and support plan for someone who has appointed a personal welfare attorney, they must first assess whether the donor has capacity to agree to the care and support plan or to parts of it. If the donor lacks capacity and the decision is within the scope of the donor's LPA, professionals must then consult the attorney and get their agreement to the care and support plan. Even if it is outside the scope of the LPA, the professionals will need to consult the attorney when considering what action is in the person's best interests.

8.67 Health and social care staff can ask the OPG to search the register of LPAs to confirm that a personal welfare LPA has been registered or to confirm that an attorney has been appointed and is able to act.

8.68 Where a person is funding their own care and has both a health and welfare and property and affairs attorney, both attorneys must work together to make a decision (see paragraphs 8.81 for more details).

Decisions that a health and welfare attorney can and cannot make

8.69 A personal welfare LPA allows attorneys to make decisions to accept or refuse healthcare or treatment unless the donor has stated clearly in the LPA that they do not want the attorney to make these decisions.

8.70 Even where the LPA indicates healthcare decisions can be made, attorneys do not have the right to consent to or refuse treatment in situations where:

- the donor has capacity to make the particular healthcare decision (section 11(7)(a)). An attorney has no decision-making power if the donor can make their own treatment decisions.
- the donor has subsequently made an advance decision to refuse the proposed treatment (section 11(7)(b)). An attorney cannot consent to treatment if the donor has made a valid and applicable advance decision to refuse a specific treatment (see chapter 9). But if the donor made and registered an LPA after the advance decision, and gave the attorney the right to consent to or refuse the treatment, the attorney can choose not to follow the advance decision.
- a decision relates to life-sustaining treatment, unless given express authorisation to do so (section 11(7)(c)). An attorney has no power to consent to or refuse life-sustaining treatment, unless the LPA document expressly authorises this (see paragraphs 8.75-8.77).
- the donor is detained under the Mental Health Act (section 28). An attorney cannot consent to or refuse treatment for a mental disorder for a patient detained under the Mental Health Act 1983, with two exceptions:

iv. an attorney can refuse to allow electro-convulsive therapy where the donor lacks the capacity to consent to its use
v. an attorney can consent to treatment under a community treatment order where the treatment is immediately necessary and the donor lacks the capacity to consent.

8.71 See chapter 22 for further information on the interaction between the Act and the Mental Health Act.

8.72 LPAs do not give attorneys the power to demand specific forms of medical treatment that healthcare staff do not believe are necessary or appropriate for the donor's particular condition.

8.73 Attorneys must always follow the Act's principles and make decisions in the donor's best interests. If healthcare staff disagree with the attorney's assessment of best interests, they should discuss the case with other medical experts and/or get a formal second opinion. Then they should discuss the matter further with the attorney. A healthcare professional cannot override an attorney's decision. If they cannot settle the disagreement, they must apply to the Court of Protection (see paragraphs 8.85–8.91 below). While the court is coming to a decision, healthcare staff can give life-sustaining treatment to prolong the donor's life or stop their condition getting worse.

8.74 A donor should not include instructions or requests related to euthanasia or assisted dying in an LPA. This is not provided for under the law of England and Wales and the OPG will apply to the Court of Protection to strike out any such provision when the LPA is sent for registration.

Personal welfare LPAs that authorise an attorney to make decisions about life-sustaining treatment

8.75 An attorney can only consent to or refuse life-sustaining treatment on behalf of the donor if, when making the LPA, the donor has specifically stated in the LPA document that they want the attorney to have this authority.

8.76 As with all decisions, an attorney must act in the donor's best interests when making decisions about such treatment. This will involve applying the best interests checklist (see chapter 5) and consulting with carers, family members and others interested in the donor's welfare. In particular, the attorney must not be motivated in any way by the desire to bring about the donor's death (see chapter 5). Anyone who doubts that the attorney is acting in the donor's best interests can apply to the Court of Protection for a decision.

8.77 As set out at paragraph 8.70, and in more detail at chapter 11, an attorney cannot overrule an advance decision to refuse treatment unless an LPA has been subsequently made and the attorney has been given the power to make decisions about health care.

Scenario: Making decisions about life-sustaining treatment

Ms J is diagnosed with cancer. She saw her father suffer after invasive treatment for cancer and is clear that she would not want to undergo similar treatment herself. As her treatment plan progresses, she continues to discuss her wishes and feelings about it with her husband.

Ms J makes a personal welfare LPA appointing her husband as her attorney with authority to make all her welfare and healthcare decisions if she loses capacity to do so. She includes a specific statement in the LPA authorising her husband to consent to or refuse life-sustaining treatment.

Ms J had many discussions with her husband about her father's treatment, and now has ongoing discussions with him about her own treatment. For instance she says often that if her cancer progresses beyond a certain stage her wish would be for palliative pain management and relief over treatments which may prolong her life but would have challenging side effects. Ms J is confident that her husband is very aware of, and will respect, her wishes and feelings if he ever has to make a decision about treatment in her best interests, if she later lacks capacity to make those decisions herself.

Decisions that involve personal welfare, and property and affairs

8.78 There will be instances where a decision needs to be made that relates to both the donor's personal welfare and their property and affairs. This will generally be the case where there is a need to purchase items, pay for services or sign contracts which relate to health or social care for the donor. This could include:

- Decisions about where the donor should live which involve buying or selling property, or signing tenancy agreements, including changes to private accommodation or moving into a care home
- Consenting to, arranging and paying for medical, dental or optical treatment.
- Arranging assessments for community care where these involve means testing
- Decisions about social and leisure activities, education or training where these involve financial payments

8.79 This list does not include every example and attorneys will need to identify when a decision requires consideration of both issues.

8.80 How an attorney should approach these decisions will depend on whether the same individual holds power of attorney for both types:

- If an attorney has the power to make decisions about personal welfare, and property and affairs, they should ensure that they consider the best interests of the donor from both perspectives in making the decision.
- If different attorneys have been appointed to make decisions about personal welfare to those appointed for property and affairs, the attorneys must work together to make the decision. Each will need to consider the donor's best interests in relation to the element of the decision they are responsible for and agree with the other attorney how best to proceed. This will involve balancing the donor's health or welfare needs with their financial position to reach an informed decision.

8.81 Where two or more attorneys are responsible for different types of decision and they are unable to reach an agreement, it may be necessary to make an application to the Court of Protection. This could arise in circumstances where the donor needs to go into a privately funded care home and the attorneys cannot agree which home even after a consideration of the donor's best interests, personal welfare needs and finances.

Are there any other restrictions on attorneys' powers?

8.82 Attorneys are not protected from liability if they do something that is intended to restrain the donor, unless:

- the attorney reasonably believes that the donor lacks capacity to make the decision in question, and
- the attorney reasonably believes that restraint is necessary to prevent harm to the donor, and
- the type of restraint used is in proportion to the likelihood and the seriousness of the harm

8.83 If an attorney needs to make a decision or take action which may involve the use of restraint, they should take account of the guidance set out in chapter 6.

8.84 Attorneys have no authority to take actions that result in the donor being deprived of their liberty. Any deprivation of liberty will only be lawful if this has been properly authorised. Chapter 12 and 13 describes Liberty Protection Safeguards and chapter 22 explains detention under the Mental Health Act 1983.

What powers does the Court of Protection have over LPAs?

8.85 The Court of Protection has a range of powers to:

- determine whether an LPA is valid
- give directions about using the LPA
- remove an attorney (for example, if the attorney does not act in the best interests of the donor)

8.86 Chapter 7 gives more information about the Court of Protection's powers.

8.87 If somebody has doubts over whether an LPA is valid, they can ask the court to decide whether the LPA:

- meets the Act's requirements
- has been revoked (cancelled) by the donor, or
- has come to an end for any other reason

8.88 The court can also stop somebody registering an LPA or rule that an LPA is invalid if:

- the donor made the LPA as a result of undue pressure or fraud, or
- the attorney behaves, has behaved or is planning to behave in a way that goes against their duties or is not in the donor's best interests

8.89 The court can also clarify an LPA's meaning, if it is not clear, and it can tell attorneys how they should use an LPA. If an attorney thinks that an LPA does not give them enough powers, they can ask the court to extend their powers if the donor no longer has capacity to authorise this. The court can also authorise an attorney to give a gift that the Act does not normally allow (section 12(2)), if it is in the donor's best interests.

8.90 The OPG may apply to the court in some circumstances before registering an LPA if there are provisions in it that would prevent it from being valid. They can also apply to remove attorneys or to ask the court to determine any matters about the way an LPA is being used.

8.91 All attorneys should keep records of their dealings with the donor's affairs (see also paragraph 8.114 below). The court can order attorneys to produce records (for example, financial accounts) and to provide specific reports, information or documentation. If somebody has concerns about an attorney's payment or expenses, the court could resolve the matter. The OPG also has a power to request records where someone has raised a concern about an attorney's actions.

Scenario: Concerns about a welfare attorney

Ms L has vascular dementia and lives with her son, Mr J, who for some time has supported his mother with her care. Mr J also acts as a personal welfare attorney for Ms L, who now lacks capacity to make decisions regarding her care.

Ms L's health deteriorates, and she needs additional help with her self-care. A carer who has been employed to give Ms L greater support, notices some quite severe scratches and bruising on Ms L's arms and legs. The carer asks Mr J about this, and he advises her that he had not noticed the marks on Ms L, saying that she probably fell over.

The carer speaks to her supervisor who raises a safeguarding alert with the local authority as she is concerned that Ms L may have been physically abused by Mr J.

As part of their enquiries, a social worker from the local authority contacts the OPG which confirms that there is a health and welfare LPA, with Mr J being Ms L's attorney. The local authority shares the outcome of its investigation with the OPG so a decision can be made as to whether the LPA should stay in place.

What responsibilities do attorneys have?

8.92 A donor cannot insist on somebody agreeing to become an attorney. It is down to the proposed attorney to decide whether to take on this responsibility. They should consider whether they have the skills and ability to act as an attorney and whether they actually want to be an attorney and take on the duties and responsibilities of the role. When an attorney accepts the role by signing the LPA document, this is confirmation that they are willing to act under the LPA once it is registered. An attorney can withdraw from the appointment if they ever become unable or unwilling to act, but if the LPA has been registered they must follow the correct procedures for withdrawing (see paragraph 8.117 below).

8.93 Before acting under an LPA, attorneys must make sure the LPA has been registered with the Public Guardian. There is no obligation on an attorney to act, because an LPA confers a power rather than a duty. But once the attorney starts to act under an LPA, they must meet certain standards. If they don't carry out the duties below, they could be removed from the role. In some circumstances they could face charges of fraud or negligence.

What duties does the Act impose?

8.94 Attorneys acting under an LPA have a duty to:

- follow the Act's statutory principles (see chapter 2)
- make decisions in the donor's best interests
- have regard to the guidance in the Code of Practice
- only make those decisions the LPA gives them authority to make
- share the documentation that demonstrates they have power of attorney with relevant third parties.

Principles and best interests

8.95 Attorneys must act in accordance with the Act's statutory principles (section 1) and in the best interests of the donor (the steps for working out best interests are set out in section 4). In particular, attorneys must consider whether the donor has capacity to make the decision for themselves, and take all practicable and appropriate steps to support them to make their own decisions (see chapter 3). If the donor does not have capacity, they should consider whether the donor is likely to regain capacity to make the decision in the future. If so, it may be possible to delay the decision until the donor can make it.

The Code of Practice

8.96 As well as this chapter, attorneys should pay special attention to the following guidance set out in the Code:

- chapter 2, which sets out how the Act's principles should be applied
- chapter 3, which describes the steps which can be taken to try to help the person make decisions for themselves
- chapter 4, which describes the Act's definition of lack of capacity and gives guidance on assessing capacity, and
- chapter 5, which gives guidance on working out the donor's best interests.

8.97 In some circumstances, attorneys might also find it useful to refer to guidance in:

- chapter 6, which explains when attorneys who have caring responsibilities may have protection from liability and gives guidance on the few circumstances when the Act allows restraint in connection with care and treatment
- chapter 7, which gives a summary of the Court of Protection's powers relating to LPAs
- chapter 11, which explains how LPAs may be affected if the donor has made an advance decision to refuse treatment
- chapter 24, which describes ways to settle disagreements.

Only making decisions covered by the LPA

8.98 There may be circumstances where a property and affairs attorney is required to make a decision on behalf of the donor, which has a personal welfare element. A property and affairs attorney can make the decision if it impacts on the property and financial affairs of the donor. Of course the same person could be appointed as attorney for both property and finance and health and welfare matters.

8.99 Under any LPA, the attorney will have authority to make a wide range of decisions. But if a donor includes restrictions in the LPA document, this will limit the attorney's authority (section 9(4)(b)). If the attorney thinks that they need greater powers, they can apply to the Court of Protection which may decide to give the attorney the authority required or alternatively to appoint the attorney as a deputy with the necessary powers (see chapter 7).

8.100 It is good practice for decision-makers to consult attorneys about any decision or action, whether or not it is covered by the LPA. This is because an attorney may have important information about the person's wishes and feelings. Researchers can also consult attorneys if they are thinking about involving the donor in research (see chapter 26).

Scenario: Consulting attorneys

Mr V makes and registers a personal welfare LPA appointing his son and daughter as joint attorneys. He also makes a property and affairs LPA, appointing his son and his solicitor to act jointly and severally.

Mr V later has a stroke, and, following the hospital team's attempts to involve and support him in decisions about his immediate treatment, he is assessed as lacking capacity to make these decisions for the time being. His welfare attorneys therefore step in to make these decisions in Mr V's best interests. They agree that it would not be appropriate at the present time to make decisions about Mr V's future care, because he might regain capacity to make the decisions himself at the time they need to be made.

Although the solicitor has no authority to make welfare decisions, the welfare attorneys consult him about Mr V's best interests with regard to decisions about his most immediate care needs. They speak to him about immediate treatment decisions and their suggestion to not prematurely make decisions about his longer term care. Similarly, the property and affairs attorneys consult Mr V's daughter about the financial decisions that need to be made as Mr V does not have the capacity to make these himself.

What are an attorney's other duties?

8.101 An attorney appointed under an LPA is acting as the chosen agent of the donor and therefore, under the law of agency, the attorney has certain duties towards the donor. An attorney takes on a role which carries a great deal of power, which they must use carefully and responsibly. They have a duty to:

- apply certain standards of care and skill (duty of care) when making decisions
- carry out the donor's instructions
- act in the best interests of the donor and not take advantage of their position to benefit themselves (fiduciary duty)
- not delegate decisions, unless authorised to do so
- act in good faith
- respect confidentiality
- comply with the directions of the Court of Protection
- not give up the role without telling the donor and the OPG (see paragraph 8.117).
- notify the responsible body where their actions have resulted in a deprivation of liberty for the donor.
- provide evidence that they hold a current power when requested by third parties such as banks or doctors.

8.102 In relation to property and affairs LPAs, they have a duty to:

- keep accounts
- keep the donor's money and property separate from their own. The only exception is if there is a long-standing arrangement of having joint finances, e.g. a husband and wife with joint accounts.

Duty of care

8.103 'Duty of care' means applying a certain standard of care and skill – depending on whether the attorney is paid for their services or holds relevant professional qualifications:

- Attorneys who are not being paid must apply the same care, skill and diligence they would use to make decisions about their own life.
- An attorney who claims to have particular skills or qualifications (for example, an accountant or solicitor) must show a level of skill in those particular areas that is consistent with their claims.
- If attorneys are being paid for their services, they should demonstrate a high degree of care and skill, appropriate to their level of payment.
- Attorneys who undertake their duties in the course of their professional work (such as solicitors or corporate trustees) must display professional competence

and follow their profession's rules and standards. There is specific guidance for professional attorneys available from the OPG.

Fiduciary duty

8.104 A fiduciary duty means attorneys must not take advantage of their position. Nor should they put themselves in a position where their personal interests conflict with their duties. They also must not allow any other influences to affect the way in which they act as an attorney. Decisions should always benefit the donor, and not the attorney. Attorneys must not profit or get any personal benefit from their position, apart from receiving gifts where the Act allows it, whether or not it is at the donor's expense.

8.105 Where an attorney believes they need to take an action that is in breach of their fiduciary duty to the donor, they may need to make an application to the Court of Protection. This could include, for instance, where they wish to take payment from the donor's estate for care duties they carry out for the donor108, or to reimburse expenses they have incurred as a result of their role as an attorney but this has not been included within the LPA.

Scenario: Attorney seeking payment for providing care to donor.

Ms H lives with her daughter who is her attorney for finance and property. Following a stroke, Ms H needs help with personal care and Ms H's daughter wants to give up work to care for her. She works out that Ms H could afford to give her some money each week for the care she gives, to compensate her for her lost earnings. This would be more affordable than employing a care agency.

Ms H's daughter therefore applies to the Court of Protection, which authorises these payments for the care she provides to her mother.

Duty not to delegate

8.106 Attorneys cannot usually delegate their authority to someone else. They must carry out their duties personally. The attorney may seek professional or expert advice (for

[108] The OPG produces guidance on taking payments for care: "Family care payments", available at:https://www.gov.uk/government/publications/public-guardian-practice-note-family-care-payments

example, investment advice from a financial adviser or advice on medical treatment from a doctor). But they cannot, as a general rule, allow someone else to make a decision that they have been appointed to make, unless this has been specifically authorised by the donor in the LPA.

8.107 In certain circumstances, attorneys may have limited powers to delegate (for example, through necessity or unforeseen circumstances, or for specific tasks which the donor would not have expected the attorney to attend to personally). But attorneys cannot usually delegate any decisions that rely on their discretion.

Duty of good faith

8.108 Acting in good faith means acting with honesty and integrity. For example, an attorney must try to make sure that their decisions do not go against a decision the donor made while they still had capacity (unless it would be in the donor's best interests to do so, for example not going against the original decision would put the donor at risk).

Duty of confidentiality

8.109 Attorneys have a duty to keep the donor's affairs confidential, unless:

- before they lost capacity to do so, the donor agreed that some personal or financial information may be revealed for a particular purpose (for example, they have named someone they want to check their financial accounts), or
- there is some other good reason to release it (for example, it is in the public interest or the best interests of the person who lacks capacity, or there is a risk of harm to the donor or others).

8.110 In the latter circumstances, it may be advisable for the attorney to get legal advice if the situation and considerations are particularly complex. Chapter 25 gives more information about confidentiality.

Duty to comply with the directions of the Court of Protection

8.111 Under sections 22 and 23 of the Act, the Court of Protection has wide-ranging powers to decide on issues relating to the operation or validity of an LPA. It can also:

- give extra authority to attorneys
- order them to produce records (for example, financial accounts), or
- order them to provide specific information or documentation to the court.

8.112 Attorneys must comply with any decision or order that the court makes.

Duty not to disclaim without notifying the donor and the OPG

8.113 Once someone becomes an attorney, they cannot give up that role without notifying the donor and the OPG. If they decide to give up their role, they must follow the relevant guidance from the OPG (paragraph 8.116- 8.120).

Duty to keep accounts

8.114 Property and affairs attorneys must keep accounts of transactions carried out on the donor's behalf. Sometimes the Court of Protection or the Public Guardian will ask to see accounts. If the attorney is not a financial expert and the donor's affairs are relatively straightforward, a record of the donor's income and expenditure (for example, through bank statements) may be enough. The more complicated the donor's affairs, the more detailed the accounts may need to be.

Duty to keep the donor's money and property separate

8.115 Property and affairs attorneys should usually keep the donor's money and property separate from their own or anyone else's. There may be occasions where donors and attorneys have agreed in the past to keep their money in a joint bank account (for example, if a husband is acting as his wife's attorney). It might be possible to continue this under the LPA. But in most circumstances, attorneys must keep finances separate to avoid any possibility of mistakes or confusion.

What should an attorney do if they are unable to carry out their duties?

8.116 It may be that after a person has become an attorney they find out they are unable to carry out their duties. This could be for a number of reasons, for instance, they have new responsibilities that make it difficult to meet their duty to the donor, or they find themselves unable to make the decisions that the donor needs them to make. Alternatively, they may find themselves in circumstances where they legally have to stop acting, such as if their own capacity is inhibited.

8.117 An attorney can step down from their role through a process called "disclaiming". They must send a "disclaim a lasting power of attorney" form to the donor (if the LPA hasn't been registered), or to the donor and the OPG (if the LPA has been registered)[109]. They should also notify any other attorneys appointed by the LPA.

8.118 If a number of attorneys have been appointed jointly and severally, the other attorneys can continue to act. If there are no other attorneys or they have been

[109] Details of 'how to stop being an attorney under a lasting power of attorney (LPA)', available at:, https://www.gov.uk/government/publications/disclaim-a-lasting-power-of-attorney.

appointed jointly, they will also have to stop acting. Replacement attorneys will take on the role if they have been named in the LPA.

8.119 If an attorney is unable to fulfil their duties, it may be in the donor's best interests for them to step down so that others can meet these responsibilities, either through the other attorneys in the LPA or via the appointment of a deputy if necessary. If the attorney is unable to disclaim their role (for example, due to a sudden loss of mental capacity), the OPG should be contacted for advice.

8.120 As stated at paragraph 7.31, the Court of Protection has the power to remove an attorney, which could include in circumstances where the attorney is no longer carrying out their duties.

How does the Act protect donors from abuse?

What should someone do if they think an attorney is abusing their position?

8.121 Attorneys are in a position of trust, whether they hold lasting power of attorney for property and affairs, personal welfare or both. Donors can help prevent abuse by carefully choosing a suitable and trustworthy attorney. But others have a role to play in looking out for possible signs of abuse or exploitation and reporting any concerns to the OPG. In an urgent situation the person can go straight to the Court of Protection for a decision regarding the person's health and welfare or property and finance.

8.122 Signs that an attorney may be exploiting the donor (or failing to act in the donor's best interests) include:

- stopping relatives or friends contacting the donor – for example, the attorney may prevent contact, or the donor may suddenly refuse visits or telephone calls from family and friends for no understandable reason
- sudden unexplained changes in living arrangements (for example, someone moves in to care for a donor they've had little contact with)
- not allowing healthcare or social care staff to see the donor
- taking the donor out of hospital against medical advice, while the donor is having necessary medical treatment
- unpaid bills (for example, residential care or nursing home fees)
- an attorney opening a credit card account for the donor
- spending money on things that are not obviously related to the donor's needs
- the attorney spending money in an unusual or extravagant way
- transferring financial assets to another country

8.123 The OPG has a duty to deal with any complaints or other representations it receives about how an attorney is carrying out their duties. Chapter 23 sets out what the OPG will do.

8.124 The OPG may make an application to the Court of Protection. The court may revoke (cancel) the LPA or (through the OPG) prevent it being registered, if it decides that:

- the LPA does not meet the legal requirements for creating an LPA
- the LPA has been revoked or come to an end for any other reason
- somebody used fraud or undue pressure to get the donor to make the LPA
- the attorney has done something that they do not have authority to do, or
- the attorney has behaved or is planning to behave in a way that is not in the donor's best interests.

8.125 The court might then consider whether the authority previously given to an attorney can be managed by:

- the court making a single decision, or
- appointing a deputy.

Scenario: Concerns about a finance attorney

Mr A employed a gardener, and became quite close to him, eventually appointing the gardener as his property and finance attorney.

Mr A was living with dementia but was able to get out and about quite well when accompanied by someone else. His neighbour regularly met Mr A for a cup of tea and became concerned when he heard Mr A often talking about his gardener and how Mr A had paid for lunches and afternoon tea on multiple occasions. The neighbour also learned that the gardener had taken on various DIY projects for Mr A. He asked Mr A whether the gardener was reasonably priced for the DIY work, and Mr A responded by saying that he did not know as he'd given the gardener his debit card and PIN to withdraw any money required for the jobs.

This alarmed Mr A's neighbour as he felt Mr A may be being subject to financial abuse. He decided to contact the Office of the Public Guardian to advise them of his concerns.

What should an attorney do if they think someone else is abusing the donor?

8.126 An attorney who thinks someone else is abusing or exploiting the donor should report it to their local authority safeguarding team. They should contact the police if they suspect physical or sexual abuse, theft or serious fraud.

8.127 Chapter 23 gives more information about protecting vulnerable people from abuse, ill treatment or neglect. It also discusses the duties and responsibilities of the various agencies involved, including the OPG and local authorities. In particular, it is a criminal offence (with a maximum penalty of five years' imprisonment, a fine, or both) for anyone (including attorneys) to wilfully neglect or ill-treat a person in their care who lacks capacity to make decisions about their care for themselves (under section 44 of the Act).

What is an EPA and how does it differ from an LPA?

8.128 Before the Mental Capacity Act came into force in 2007 it was possible for someone to make an Enduring Power of Attorney (EPA). An EPA allows an attorney to make decisions about property and finance on behalf of a donor. The Mental Capacity Act removed the ability to make new EPAs and created the Lasting Power of Attorney (LPA) in its place, but EPAs made before 1 October 2007 can still be used.

8.129 There are a number of differences between LPAs and EPAs. These are summarised as follows:

- EPAs only cover property and affairs. LPAs can also cover personal welfare.
- EPAs can be used before registering them with the OPG. LPAs must be registered before they can be used.
- EPAs must be registered with the OPG when the donor can no longer manage their own affairs (or when they start to lose capacity).
- Attorneys acting under an LPA have a legal duty to have regard to the guidance in this Code of Practice. EPA attorneys do not. But the Code's guidance will still be helpful to them.
- There are some differences in the laws and procedures for EPAs and LPAs.

8.130 There are some similarities between LPAs and EPAs:

- Attorneys making decisions under a registered EPA or LPA must follow the Act's principles and act in the best interests of the donor.
- The duties under the law of agency apply to attorneys of both EPAs and LPAs (see paragraphs 8.101).
- Decisions that the courts have made about EPAs may also affect how people use LPAs.

What is the position with EPAs?

8.131 Some donors created EPAs before the Act came into force with the expectation that their chosen attorneys would manage their property and affairs in the future, whether or not they had capacity to do so themselves.

8.132 EPA donors with capacity can cancel the EPA and make an LPA covering their property and affairs. They should also notify attorneys and anyone else aware of the EPA (for example, a bank) that they have cancelled it.

8.133 Some donors chose not to cancel their EPA or may lack the capacity to do so now. In such cases, the Act allows EPAs, whether registered or not, to continue to be valid so that attorneys can meet the donor's expectations (Schedule 4). An EPA must be registered with the OPG when the attorney thinks the donor lacks capacity to manage their own affairs or is beginning to lack capacity to do so.

8.134 It is possible for a person to have an EPA for property and finance affairs and an LPA (or deputyship) for health and welfare matters. If these roles are held by different people they should work collaboratively on matters where their responsibilities may overlap.

8.135 EPA attorneys may find guidance in this chapter helpful. In particular, all attorneys must comply with the duties described (in paragraphs 8.101-8.115) above. EPA attorneys can also be found liable under section 44 of the Act, which sets out the new criminal offences of ill treatment and wilful neglect. EPA attorneys may also find the OPG's guidance for attorneys acting under an LPA useful.

9. What is the role of court-appointed deputies?

This chapter describes the role of court-appointed deputies and the role of the Office of the Public Guardian (OPG) in supervising deputies. It looks at how the court appoints a deputy (or deputies) to act and make decisions on behalf of someone who lacks capacity to make those decisions. In particular, it gives guidance on a deputy's duties, their supervision and the consequences of not carrying their duties out responsibly.

The OPG produces detailed guidance for deputies. Check the website for details of the publications and how to get them[110].

In this chapter, as throughout the Code, a person's capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

Quick summary

The Court of Protection has powers to appoint deputies to make decisions for people lacking capacity to make those decisions, and to remove deputies who fail to carry out their duties.

- Anyone acting as a deputy must follow the Act's statutory principles (see chapter 2), including:
    - considering whether the person has capacity to make a particular decision for themselves. If they do, the deputy should allow them to do so unless the person agrees that the deputy should make the decision
    - taking all possible steps to try to help a person make the particular decision
- always make decisions in the person's best interests and have regard to guidance in the Code of Practice that is relevant to the situation
- only make those decisions that they are authorised to make by the order of the court

[110]Office of the Public Guardian website and publications, available at: https://www.gov.uk/government/organisations/office-of-the-public-guardian

- fulfil their duties towards the person concerned (in particular the duty of care and fiduciary duties to respect the degree of trust placed in them by the court)
- keep, correct accounts of all their dealings and transactions on the person's behalf and periodically submit these to the Public Guardian as directed, so that the OPG can carry out its statutory function of supervising the deputy.

When can or should the court appoint a deputy?

9.1 In cases of serious dispute, where there is no other way of finding a solution or when the authority of the court is needed in order to make a particular decision or take a particular action, the court can be asked to make the decision in the person's best interests using its powers under section 16 of the Act.

9.2 However, if there is a need for ongoing decision-making powers and there is no relevant Lasting Power of Attorney (LPA) or Enduring Power of Attorney (EPA) (see chapter 8), the court may appoint a deputy to make future decisions. It will also state which decisions the deputy has the authority to make on the person's behalf.

9.3 In deciding what type of order to make, the court must apply the Act's principles and the best interests checklist (see chapter 5). In addition, it must follow two further principles, intended to make any intervention as limited as possible:

- Where possible, the court should make the decision itself in preference to appointing a deputy.
- If a deputy needs to be appointed, their appointment should be as limited in scope and for as short a time as possible.

9.4 Sometimes it is not practicable or appropriate for the court to make a single declaration or decision. In such cases, if the court thinks that somebody needs to make future or ongoing decisions for someone whose condition makes it likely they will lack capacity to make some further decisions in the future, it can appoint a deputy to act for and make decisions for that person. A deputy's authority should be as limited in scope and duration as possible in order to be a less restrictive way forward.

9.5 It is for the court to decide who to appoint as a deputy. This decision must be in the best interests of the person who lacks capacity. Different skills may be required depending on whether the deputy's decisions will be about a person's welfare (including healthcare), their finances or both. The court will decide whether the

proposed deputy has an appropriate level of skill and competence to carry out the necessary tasks.

9.6 In many cases, the deputy is a family member or someone who knows the person well. But in some cases, the court may decide to appoint a deputy who is independent of the family (for example, where the person's affairs or care needs are particularly complicated). This could be, for example, a relevant office holder in the relevant local authority (but see paragraph 9.17 below) or a professional deputy. The OPG has a panel of professional deputies (mainly solicitors who specialise in this area of law) who may be appointed to deal with property and affairs if the court decides that would be in the person's best interests, for instance if there is no one else to take on the role.

When might a deputy need to be appointed?

9.7 Whether it is in the best interests of a person who lacks capacity to make specific decisions to have a deputy appointed for them will depend on:

- the individual circumstances of the person concerned
- whether future or ongoing decisions are likely to be necessary, and
- whether the appointment is for decisions about property and affairs or personal welfare.

Property and affairs

9.8 If a person who lacks capacity to make decisions about property and affairs has not made an LPA or EPA, applications to the court for the appointment of a deputy are necessary:

- to permit access to their assets (for example cash held in a bank account or investments)
- for selling a person's property, or
- where the person has a level of income or capital that the court thinks a deputy needs to manage.

9.9 In cases where the OPG has applied to the court to remove an attorney or deputy and revoke an LPA or discharge a deputy's appointment, it may recommend that the court appoints a deputy to manage the person's property and financial affairs and, where financial abuse has occurred, pursue recovery of monies. The court will decide if such an appointment is necessary and on what terms.

9.10 If the only income of a person who lacks capacity is social security benefits and they have no property or savings, there may not be a need for a deputy to be appointed. This is because the person's benefits can be managed by an appointee,

appointed by the Department for Work and Pensions[111] to receive and deal with the benefits of a person who lacks capacity to do this for themselves. Although appointees are not covered by the Act, they still owe fiduciary duties to the person whose money they are managing (see para 9.33) and they must act in the person's best interests. If the court appoints a property and affairs deputy for someone who has an appointee, the deputy would become responsible for managing the person's benefits.

Scenario: Deputy not needed

Mr G lives in a supported living placement in the community. There is a new tenancy agreement for his accommodation. Mr G does not have capacity to make the decision to sign this and therefore requires someone to do so on his behalf.

Mr G does not have a court appointed deputy for property and affairs. He has few savings, and his only income is from state derived benefits.

Mr G's brother is his appointee for his benefits. Mr G's brother considers whether a deputyship for property and affairs is required in order to sign the tenancy agreement and decides that this is not appropriate and would be unnecessarily restrictive for his brother.

Mr G's brother therefore applies to the Court of Protection for a tenancy order which gives him the legal authority to sign the tenancy on Mr G's behalf. He continues to act as Mr G's appointee.

9.11 Anybody considered for appointment as a property and affairs deputy will need to sign a declaration giving details of their circumstances and ability to manage financial affairs. The declaration will include details of the tasks and duties the deputy must carry out. The deputy must assure the court that they have the skills, knowledge and commitment to carry them out.

[111] Details on 'Becoming an appointee', available at: https://www.gov.uk/become-appointee-for-someone-claiming-benefits

Personal welfare (including healthcare)

9.12 There are fewer personal welfare deputies than property and financial affairs deputies. Many decisions regarding care and treatment can be made applying the process set out in section 5 of the Act (see chapter 6). Some decisions can only be made by the court itself (see chapter 7), and the court must always consider first whether it should make any relevant decision itself rather than appoint a deputy to do so.

9.13 In deciding whether to appoint a personal welfare deputy, the court will ask itself whether an appointment is in the best interests of the person[112]. The wishes and feelings of the person will form an aspect of that decision, for instance if it is clear that they wish a family member to be appointed to make decisions on their behalf.

9.14 The court will also consider whether there is evidence that the collaborative decision-making process set out in section 5 of the Act has not been working in the person's interests. This could include situations such as:

- Disputes within the person's family that are having a detrimental effect on their care and will continue to do so unless one specific person is appointed to make necessary decisions
- A person with a particular medical condition requiring repeated assessment and/or treatment, where there is clear evidence that a family member who is well-placed to advocate their wishes and feelings and make decisions on their behalf has not been appropriately consulted
- Ongoing decisions on behalf of the person relating to the planning and implementation of a publicly-funded care package, where there is a clear evidence that a family member who is well-placed to advocate their wishes and feelings and make decisions on their behalf has not been appropriately consulted

Personal welfare decision-making by property and affairs deputies

9.15 There may be circumstances where a property and affairs deputy is required to make a decision on behalf of the person who lacks capacity, which has a personal welfare element. A property and affairs deputy in this situation can make the decision providing it impacts on the property and financial affairs of the person who lacks capacity and there is no other reason why the deputy is unable to make the decision (for example, if the deputyship order specifically prevents it). Where the decision relates only to the personal welfare of the person who lacks capacity, the

[112] Re Lawson, Mottram and Hopton (appointment of personal welfare deputies) [2019] EWCOP 22 - https://www.bailii.org/ew/cases/EWCOP/2019/22.html

Court of Protection accepts that the general authority of a property and affairs deputy extends as far as permitting an application to the Court of Protection to draw to the attention of the court a need for consideration of a welfare issue[113].

Scenario: The role of a property and affairs deputy in making a hybrid financial and welfare decision

Ms G has a learning disability and is unable to manage complex financial matters. She has a professional property and affairs deputy.

Ms G inherits a substantial sum of money and wishes to use the funds to purchase a property in which to live. This is supported by her social worker and others close to Ms G.

Under the deputyship order, the deputy has authority to deal with all the financial elements relating to the purchase of the property, which include identifying potential properties, obtaining a care needs assessment to ensure the property meets the needs of Ms G, dealing with the legal elements of the purchase, and identifying and arranging any adaptations required to the property.

The professional deputy may charge for this work in accordance with the terms of the deputyship order.

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Who can be a deputy?

9.16 Section 19(1) states that deputies must be at least 18 years of age. Deputies with responsibility for property and affairs can be either an individual or a trust corporation (a special type of company, often run by a legal firm). No-one can be appointed as a deputy without their consent.

9.17 Paid care workers for the person (for example care home managers) should not act as the person's deputy, because of the possible conflict of interest (where their decisions or actions in one of the roles could be influenced by their position in the other role) – unless there are exceptional circumstances (for example, if the care

[96] ACC & Ors (property and affairs deputy; recovering assets costs for legal proceedings) [2020] EWCOP 9 (27 February 2020), available at: https://www.bailii.org/ew/cases/EWCOP/2020/9.html

worker is the only close relative of the person who lacks capacity). The court can appoint someone who holds a specified position (for example, an office holder in the relevant local authority) as a deputy. In this situation, the court will need to be satisfied that there is no conflict of interest before making such an appointment (see paragraphs 9.39-9.42).

9.18 Before accepting an appointment a proposed deputy should consider whether:

- they have the skills and ability to carry out a deputy's duties
- they want to take on the duties and responsibilities

9.19 The court can appoint two or more deputies and state whether they should act 'jointly', 'jointly and severally' or 'jointly in respect of some matters and jointly and severally in respect of others' (section 19 (4)(c)):

- Joint deputies must always act together. They must all agree decisions or actions, and all sign any relevant documents.
- Joint and several deputies can act together, but they may also act independently if they wish. Any action taken by any deputy alone is as valid as if that person were the only deputy.

9.20 Deputies may be appointed jointly for some issues and jointly and severally for others. For example, two deputies could be appointed jointly and severally for most decisions, but the court might say that they must act jointly when selling property.

Scenario: Acting jointly and severally

Mr T has a road accident which causes a brain injury and physical disabilities. He gets significant financial compensation but lacks capacity to manage this amount of money or make decisions about his future care.

Mr T's parents are divorced and, while they are both keen to be involved in his care, they have conflicting views about where Mr T should live and

how his compensation money should be used. Mr T has a sister, to whom he is close. She is keen to be involved in his care, particularly as Mr T's injuries may be lifelong and he is likely to outlive his parents. Mr T's sister is anxious though about being responsible for managing large sums of money.

Mr T's sister discusses the situation with her parents and applies to the Court of Protection regarding the decisions that need to be made for Mr T regarding his current and future accommodation and financial needs.

The court decides where Mr T will live. It also appoints his sister and a solicitor as joint and several deputies to manage his property and affairs. His sister makes the day-to-day financial decisions that Mr T lacks capacity to make. The solicitor makes the more complex financial decisions that Mr T's sister is unequipped to make.

What happens if a deputy can no longer carry out their duties?

9.21 When appointing a deputy, the court can also appoint someone to be a successor deputy (someone to take over the deputy's duties in certain situations). The court will state the circumstances under which this could occur. In some cases, it will also state a period of time in which the successor deputy can act. Appointment of a successor deputy might be useful if the person appointed as deputy is elderly and wants to be sure that a particular person will take over their duties in the future, if necessary. However, in most cases the court may prefer to wait until the original deputy is no longer able to act before it selects a successor deputy.

9.22 If a deputy is no longer willing or able to carry out their duties, an application should be made to the Court of Protection for the deputy to be formally discharged and replaced.

Scenario: A professional deputy

Ms A lacks capacity to manage her financial and property affairs. She has three adult children. One of Ms A's sons decides that he is best placed to be the deputy for property and affairs for Ms A and makes an application to the Court of Protection.

As part of the process the son has to serve notice on his siblings of the application. The siblings do not agree with the proposed appointment and contest the application for sole deputyship. The three siblings agree to enter into mediation to try to resolve their dispute. This leads to agreement that it would be in Ms A's best interests for a solicitor to be appointed as a professional and independent deputy to manage Ms A's property and affairs.

The Court makes an order to that effect.

Can the court protect people lacking capacity from financial loss?

9.23 Under section 19(9)(a) of the Act the court will ask a property and affairs deputy to provide some form of security (for example, a guarantee bond) to the Public Guardian to cover any loss as a result of the deputy's actions in carrying out their role. The Public Guardian has a scheme to enable deputies to get access to a form of security bond, although it is possible to provide security in other ways as well. The costs of providing the security will usually be payable out of the funds of the person who the deputy has been appointed to represent. Additionally, the court will usually require a deputy to provide reports and accounts to the Public Guardian, as it sees fit.

What must the deputy do?

9.24 Once a deputy has been appointed by the court, the order of appointment (known as the deputyship order) will set out their specific powers and the scope of their authority. On taking up the appointment, the deputy will assume a number of duties and responsibilities and will be required to act in accordance with certain standards. Failure to comply with the duties set out below could result in the court revoking the order appointing the deputy and, in some circumstances, the deputy could be personally liable to claims for negligence or criminal charges of fraud.

9.25 Deputies should always inform any third party they are dealing with (such as banks and other financial organisations for a property and financial affairs deputy and doctors, social workers, care workers or a care home for a personal welfare deputy) that the court has appointed them as deputy. The court will give the deputy official documents to prove their appointment and the extent of their authority.

9.26 A deputy must act whenever a decision or action is needed and it falls within their duties as set out in the court order appointing them. A deputy who fails to act at all in such situations could be in breach of duty.

9.27 Deputies must:

- follow the Act's statutory principles (see chapter 2), including supporting the person to make their own decisions wherever possible
- if the person lacks capacity to make a specific decision, make a decision or act in the best interests of the person
- have regard to the guidance in this Code of Practice
- only make decisions the court has given them authority to make

Principles and best interests

9.28 Deputies must act in accordance with the Act's statutory principles (section 1, see chapter 2) and in particular the best interests of the person who lacks capacity (the steps for working out best interests are set out in section 4). In particular, deputies must consider whether the person has capacity to make the decision for themselves and support them to do so wherever possible (see chapter 3).

9.29 When making decisions about the person's property and affairs, deputies must consider the best interests of the person in the round. This should include taking into account the person's welfare.

Scenario: A supported decision even with a deputyship

Ms J had a traumatic brain injury six years ago and her parents are her health and welfare deputies.

She was seizure-free until recently when she had two in close proximity. Her medical consultant gave minimal and quite hurried information at the subsequent appointment which Ms J attended with her parents. He stated that the cause of the seizures was most likely to be post-traumatic epilepsy and was to be expected. He recommended that Ms J started new medication immediately.

Ms J agreed to this, but her parents knew that 'yes' was her preferred response in these kinds of situations as Ms J liked to agree and to please people. Their view was that Ms J had not demonstrated capacity to make the decision that needed to be made.

As deputies the decision about Ms J's medication was for them to make if Ms J lacked capacity to do so, but Ms J's parents wanted to support Ms J to make the decision if this was possible. Following the meeting they took several days to consider and talk over the side effects of the medication with Ms J, which the consultant had not explained in a way Ms J could understand. They sought a second medical opinion and went with Ms J to see an epilepsy nurse. The nurse explained the medication in a way Ms J understood and also spoke about the possibility of Sudden Unexpected Death from Epilepsy. Together the nurse and Ms J's parents worked through the risks of this with the possible side effects of the medication with Ms J.

Having had all the relevant information about the medication, and been supported to use and weigh the information, Ms J demonstrated that she had capacity to make the decision. She decided to take the medication. Her parents supported her rather than use their deputyship decision-making powers.

The

Code of Practice

9.30 As well as this chapter, deputies should pay special attention to the following guidance set out in the Code:

- chapter 2, which sets out how the Act's principles should be applied
- chapter 3, which describes the steps which can be taken to try to help the person make decisions for themselves
- chapter 4, which describes the Act's definition of lack of capacity and gives guidance on assessing capacity

- chapter 5, which gives guidance on working out someone's best interests

9.31 In some situations, deputies might also find it useful to refer to guidance in:

- chapter 6, which explains when deputies who have caring or other welfare responsibilities may have protection from liability and gives guidance on the few circumstances when the Act allows restraint in connection with care and treatment
- chapter 24, which describes ways to settle disagreement.

Only making decisions the court authorises a deputy to make

9.32 A deputy has a duty to act only within the scope of the powers given by the court, which are set out in the order of appointment. It is possible that a deputy will think their powers are not enough for them to carry out their duties effectively. In this situation, they must apply to the court either to:

- ask the court to make the decision in question, or
- ask the court to change the deputy's powers

What are a deputy's other duties?

9.33 Section 19(6) of the Act states that a deputy is to be treated as the 'agent' of the person who lacks capacity when they act on their behalf. Being an agent means that the deputy has legal duties (under the law of agency) to the person they are representing. It also means that when they carry out tasks within their powers, they are not personally liable to third parties.

9.34 Deputies must carry out their duties carefully and responsibly. These are often referred to as fiduciary duties (see also paragraph 9.38-9.42). They have a duty to:

- act with due care and skill (duty of care)
- not take advantage of their situation
- indemnify the person against liability to third parties caused by the deputy's negligence
- not delegate duties unless authorised to do so
- act in good faith
- respect the person's confidentiality
- comply with the directions of the Court of Protection

9.35 Property and affairs deputies also have a duty to:

- keep accounts
- keep the person's money and property separate from their own finances

Duty of care

9.36 'Duty of care' means applying a certain standard of care and skill, which depend on whether the deputy is paid for their services or holds relevant professional qualifications:

9.37 Deputies who are not being paid must use the same care, skill and diligence they would use when making decisions for themselves or managing their own affairs. If they do not, they could be held liable for acting negligently. A deputy who claims to have particular skills or qualifications must show greater skill in those particular areas than a person who does not make such claims.

9.38 If deputies are being paid for their services, they are expected to demonstrate a higher degree of care or skill when carrying out their duties.

9.39 Deputies whose duties form part of their professional work (for example, solicitors or accountants) must demonstrate professional competence and follow their profession's rules and standards.

9.40 The OPG publishes details of professional and public authority deputy standards which set out what is expected of these deputies and include a checklist of actions and behaviour that they should follow[114].

Fiduciary duty

9.41 A fiduciary duty means deputies must always act in the best interest of the person for whom they are deputy, and not take advantage of their position.

9.42 A deputy should never put themselves in a position where their personal interests conflict with their duties. For example, deputies should not buy property that they are selling for the person they have been appointed to represent. They should also not accept a third-party commission in any transactions. They cannot use their position for any personal benefit, whether or not it is at the person's expense.

9.43 In many cases, the deputy will be a family member. In certain situations (for example if the deputy and the person who they have been appointed to represent both own shares in a family business), this could lead to potential conflicts of interests. When making decisions, deputies should follow the Act's statutory principles, apply the best interests checklist and not allow their own personal interests to influence the decision. If a conflict of interest arises (for example if the

[114] Professional and public authority deputy standards, available at: https://www.gov.uk/government/publications/office-of-the-public-guardian-deputy-standards.

deputy wishes to use the person's funds to make loans to himself or other family members, or proposes to invest the person's funds in the deputy's business) they must apply to the court for it to make the decision[115].

9.44 Sometimes the court will consider appointing an office holder from the relevant local authority as a deputy. The court will need to be satisfied that the authority has arrangements to avoid possible conflicts of interest. For example, where the person for whom a financial deputy is required receives care and support services from the local authority, the court will wish to be satisfied that decisions about the person's finances will be made in the best interests of that person, regardless of any implications for the services provided.

9.45 Certain professional deputies such as solicitors, or trust corporations owned by legal firms may have a conflict of interest if they also provide other services (such as conducting legal proceedings) for the person who lacks capacity. In such cases the deputy should consider any guidance that the court has provided as to the steps that should be taken to address such a conflict116. In some cases, to avoid a conflict of interest arising, the deputy may need to apply to the court for it to make the decision on the person's behalf.

Scenario: A local authority deputy

Ms K lives in her own home. She has dementia and is visited by care workers everyday who assist her with daily tasks.

There are concerns that Ms K is no longer able to manage paying her bills and her GP assesses her as not having capacity to make decisions concerning large financial transactions or property. Ms K does not have any family members who can take make these decisions for her.

Ms K's local authority applies to the Court of Protection to be appointed as Ms K's deputy for property and affairs.

Duty not to delegate

9.46 A deputy may seek professional or expert advice (for example, investment advice from a financial adviser or a second medical opinion from a doctor) but they cannot

[115] Re Buckley; Public Guardian v C [2013] EWHC 2965 (COP) (22 January 2013), available at https://www.bailii.org/ew/cases/EWCOP/2013/2965.html.

[116] See *Re ACC & Others* [2020] EWCOP 9, available at: https://www.bailii.org/ew/cases/EWCOP/2020/9.html.

delegate the responsibility for making decisions on behalf of the person to anyone else, unless they have been authorised by the court to do so. For example, the court will usually authorise a deputy to appoint a discretionary investment manager to make decisions about the day to day investment of the person's assets.

9.47 Deputies may delegate certain administrative and other tasks which the court would not have expected the deputy to attend to personally. For example, a deputy may use a rent collector to collect rents for properties owned by the person they are appointed to represent. Where the deputy is an office holder in the relevant local authority, or a solicitor, they may delegate certain tasks to members of their staff (such as paying regular bills on behalf of the person). Deputies cannot usually delegate any decisions that rely on their discretion. Even where delegation is permitted, the deputy is still responsible for any actions or decisions taken and can therefore be held accountable for any errors that are made.

Duty of good faith

9.48 Acting in good faith means acting with honesty and integrity. For example, a deputy should not try to hide a conflict of interest that they may have or make a decision on behalf of the person they represent in the hope of obtaining a benefit for themselves.

Duty of confidentiality

9.49 Deputies have a duty to keep the person's affairs confidential, unless:

- before they lost capacity to do so, the person agreed that information could be revealed where necessary
- there is another good reason to release information (for example, it is in the public interest or in the best interests of the person who lacks capacity, or where there is a risk of harm to the person concerned or to other people).

9.50 In the latter circumstances, it is advisable for the deputy to contact the OPG for guidance or get legal advice. See chapter 25 for more information about revealing personal information.

Duty to comply with the directions of the Court of Protection

9.51 The Court of Protection may give specific directions to deputies about how they should use their powers. It can also order deputies to provide reports (for example, financial accounts or reports on the welfare of the person who lacks capacity) to the Public Guardian at any time or at such intervals as the court directs. Deputies must comply with any direction of the court or request from the Public Guardian.

Duty to keep accounts and to report to the OPG

9.52 A deputy appointed to manage property and affairs is expected to keep, and periodically submit to the Public Guardian, correct accounts of all their dealings and transactions on the person's behalf. The OPG notifies all newly appointed deputies of the frequency of reporting requirements following appointment and scrutinises reports to ensure that the deputy is carrying out their duties correctly.

Duty to keep the person's money and property separate

9.53 Property and affairs deputies should keep the person's money and property separate from their own or anyone else's. This is to avoid any possibility of mistakes or confusion in handling the person's affairs.

Changes of contact details

9.54 A deputy should inform the OPG of any changes of contact details or circumstances (for the deputy or the person they are acting for). This will help make sure that the OPG has up-to-date records. It will also allow the court to discharge people who are no longer eligible to act as deputies.

What can a deputy not do?

9.55 Section 20 sets out some specific restrictions on a deputy's powers. In particular a deputy has no authority to make decisions or take action:

- if they think that the person concerned has capacity to make the particular decision for themselves
- if they do something that is intended to restrain the person who lacks capacity – apart from under certain circumstances (guidance on the circumstances when restraint might be permitted is given in chapter 6)
- if their decision goes against a decision made by an attorney - if there is a concern or a dispute about the way an attorney has acted it is for the court to consider that
- to prohibit contact between the person and someone else (although they may be able to restrict contact)117
- to refuse the provision or continuation of life-sustaining treatment for
- a person who lacks capacity to consent – such decisions must be taken by the court
- to make a will on behalf of the person - any decision to make a will must be made by the court

[117] *PB v RB & Ors* [2013] EWCOP B41, available at: https://www.bailii.org/ew/cases/EWCOP/2013/B41.html

9.56 A deputy also cannot authorise anything which would constitute a deprivation of the person's liberty. Any deprivation of liberty will only be lawful if it has been properly authorised (see chapter 13).

9.57 If a deputy thinks their powers are not enough for them to carry out their duties effectively, they can apply to the court to change their powers (see paragraph 7.22).

When can a deputy make gifts or similar payments?

9.58 The extent to which a deputy may use the person's funds to make gifts and payments for the benefit of others (including the deputy) will be set out in the court order appointing the deputy. Gifts, such as birthday or Christmas presents to relatives or friends, are usually allowed if they are of a reasonable amount and it is in the best interests of the person to make them. What is "reasonable" may depend upon the extent of the person's assets and any gifts that they made when they had capacity to do so. Other payments to maintain family members (such as the person's spouse, partner or children) are also usually allowed if they are reasonable and are payments that the person themselves might have made if they had capacity to do so. The OPG has further guidance on the circumstances in which deputies may make gifts118.

9.59 Where a family member is providing care to a person who lacks capacity, it may be in the person's best interests for their carer to receive some payment (often called "family care payments") for that care. This might be because it is in the person's best interests that they are cared for by a family member rather than a paid care worker, or it may be to ease the carer's own financial situation. The OPG has provided guidance on the circumstances in which a deputy can make family care payments[119]. This guidance includes that:

- If the deputy is a professional, they can authorise family care payments provided that they are satisfied that it is in the person's best interests to do so. If they are in doubt as to whether a payment is in the person's best interests, they should apply to the court for guidance.
- If the deputy, or a member of their family, is the carer then they should always apply to the court for permission to make the payments.

[118] Public Guardian Guidance OPG2, available at: https://www.gov.uk/government/publications/giving-gifts-a-guide-for-deputies-and-attorneys/opg2-giving-gifts-for-someone-else-web-version

[119] Public Guardian Practice Note SD14, available at: - https://www.gov.uk/government/publications/public-guardian-practice-note-family-care-payments

What is the role of the Public Guardian and Office of the Public Guardian?

9.60 The role of the Public Guardian for England and Wales was created under section 57 of the Act. The OPG is an executive agency of the Ministry of Justice (MoJ) and supports the Public Guardian in discharging his or her statutory functions.

9.61 The OPG is responsible for establishing and maintaining registers of LPAs, EPAs (see chapter 8 for its role regarding LPAs and EPAs) and of all court orders appointing deputies. It is also responsible for supervising deputies and for investigating concerns raised about the actions of deputies.

Supervision of deputies

9.62 Deputies are accountable to the Court of Protection. The OPG has a statutory duty to supervise both health and welfare and finance and property deputies. Its role is to ensure a deputy is complying with the court order under which they are appointed and that they are acting in the best interests of the person who lacks capacity. The OPG provides guidance online120 for deputies, to assist with decision-making and planning.

9.63 Deputies have a duty to report to the OPG. Following appointment, the OPG contacts the deputy to discuss the frequency and process for reporting. The OPG examines all reports to ensure that deputies are carrying out their duties correctly and to identify any further support that may be required.

Scenario: Supporting a new deputy

Ms E has dementia and has moved to a care home. Her daughter applies to be appointed as her deputy to manage her mother's finances and property following the move.

As part of the OPGs support for new deputies it makes contact with Ms E's daughter soon after the appointment to answer any questions she may have regarding her role.

During the discussion Ms E's daughter explains that she now wishes to put her mother's property on the market for sale, but says she is unsure

[120] Deputy Guidance: how to carry out your duties, available at: https://www.gov.uk/government/publications/deputy-guidance-how-to-carry-out-your-duties

whether she has the authority to do so. The OPG officer checks the terms of the deputyship order for any instructions it contains as to whether Ms E's deputy can sell the property without further directions from the court. The OPG officer then provides guidance to Ms E's daughter on the options available.

9.64 If the OPG has any concerns with the contents of the report it seeks to resolve these with the deputy and may start an investigation if it is concerned that financial or personal welfare abuse may be taking place.

9.65 Anybody who suspects that a deputy is abusing their position or is not acting in the best interests of the person for whom they are appointed as deputy should contact the OPG immediately so that an investigation can take place.

9.66 The OPG may instruct a Court of Protection Visitor to visit a deputy to investigate any matter of concern. It can also apply to the court to cancel a deputy's appointment.

9.67 The OPG considers carefully any concerns or complaints against deputies. If somebody suspects physical or sexual abuse or serious fraud, they should contact the police and/or social services immediately, as well as informing the OPG. Chapter 23 gives more information about the role of the OPG regarding protecting people who lack capacity. It also discusses the protection of people who lack capacity from abuse, ill treatment or wilful neglect and the responsibilities of various relevant agencies.

Scenario: The role of a Court of Protection visitor

Ms D has capacity to manage only simple day to day financial transactions. Her son is appointed to manage Ms D's other finances and property.

The OPG identifies that the poor quality of the annual report which Ms D's son has submitted suggests that he has struggled with this aspect of his deputyship role. The OPG flags the deputyship for a review.

To assist this process the OPG appoints an independent Court of Protection Visitor to meet with Ms D's son and offer some support, checking whether he fully understands his duties as a deputy. As part of the visit, the visitor also meets with Ms D, to establish her wellbeing and

determine whether she can provide any views, wishes and feelings about her son acting as her deputy.

The visitor helps Ms D's son to understand how to complete his annual report and establishes that Ms D is keen to retain him as her deputy.

Ms D's son is then able to submit reports of an acceptable quality.

What is the OPG's role in provision of security?

9.68 One of the Public Guardian's statutory functions is to receive security ordered by the court, and it makes checks following appointment of a deputy to ensure that this is in place.

9.69 The Public Guardian can also apply to the court to enforce security where a deputy is in breach of duty.

9.70 Under regulations, the Public Guardian can make arrangements to facilitate the provision of security bonds, which it does by appointing a 'preferred provider' which provides suitable surety bonds for the purposes of security to all deputies appointed by the court. Deputies are not bound to enter into any arrangement within the scheme and if they wish can make their own arrangements.

10. What is the Independent Mental Capacity Advocate role?

This chapter describes the circumstances where the Act requires an Independent Mental Capacity Advocate (IMCA) to be instructed or appointed to represent and support someone who lacks the relevant mental capacity to make a decision.

Advocacy is a way of supporting an individual to have their voice heard and ensure their rights are upheld even if the individual is unable to express their wishes or feelings or beliefs. IMCAs work with and support people who lack the relevant capacity and represent their views to those who are working out their best interests.

The purpose of the IMCA under sections 37, 38 and 39 of the Act is to advocate for and support people who lack the capacity to make important decisions in certain cases about serious medical treatment, and the provision of long term accommodation. In these circumstances, an IMCA would be instructed if the person has no family or friends that it would normally be appropriate to consult in determining the person's best interests.

Representation and support are also key safeguards offered by LPS to ensure that a person's human rights are protected. IMCAs play a key role in this, representing and supporting the person throughout the LPS process and while an LPS authorisation is in place. In some circumstances, IMCAs will also support the person's Appropriate Person to

represent and support the person. (Please see more information on the Appropriate Person role under LPS in chapter 15).

In this chapter, as throughout the Code, a person's capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

Quick summary

Criteria to become an IMCA

- IMCAs must have the appropriate experience, training and character, as well as other requirements as specified in the Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006.
- IMCA services are often provided by advocacy organisations that are independent from local authorities, NHS bodies and health boards.
- Some IMCAs are freelance and can be approved by the local authority to act as an IMCA.

Understanding the role of the IMCA service in decisions about serious medical treatment or accommodation (section 37 -39 of the MCA)

- An IMCA must be instructed to provide independent advocacy and safeguards for people who lack capacity to make certain important decisions and have no-one else (other than paid staff) whom it would be appropriate to consult to determine what is in the person's best interests.
- IMCAs must be able to act independently of the person or body instructing them.

Instructing and consulting an IMCA for decisions about serious medical treatment or accommodation (section 37 - 39 of the MCA)

- IMCAs can only work with an individual once they have been instructed by the appropriate body. For accommodation decisions, this will be the

local authority or NHS body responsible for the arrangements. For serious medical treatment decisions this will be the NHS body that has responsibility for the person's treatment.

- An NHS body or local authority must instruct and consult an IMCA when there is no one else for it to consult it (other than paid staff) to determine the best interests of a person who lacks capacity to make the decision, whenever:
    - the NHS body is proposing to provide serious medical treatment, or
    - the NHS body or local authority is proposing to arrange accommodation (or a change of accommodation) in hospital or a care home or residential accommodation, and
        - **the person will stay in hospital longer than 28 days, or**
        - **they will stay in the care home or residential accommodation for more than eight weeks**
- An IMCA may be instructed when an NHS body or local authority is proposing to review accommodation arrangements which have been provided for more than 12 weeks.

Ensuring an IMCA's views are taken into consideration in decisions about serious medical treatment or accommodation (section 37 -39 of the MCA)

- The IMCA's role is to independently represent and support the person who lacks the relevant capacity. Their views should not be influenced by how the IMCA service is funded.
- In order to carry out their role, IMCAs have a right to see and take copies of relevant healthcare and social care records.
- Any information or reports provided by an IMCA must be taken into account when determining whether a proposed decision is in the person's best interests.

Appointing an IMCA under the LPS

- In cases where there person has no friends or family suitable to represent and support them, the Responsible Body must take all reasonable steps to appoint an IMCA to represent and support the person, in most cases.
- If someone does have family or friends suitable to represent and support them, this role is called an Appropriate Person. In some cases,

an IMCA will be appointed to support the Appropriate Person representing and supporting the person.

Understanding the role of the IMCA in the LPS

- The aim of the IMCA under the LPS is to represent and support an individual, or their Appropriate Person, throughout the LPS authorisation process and whilst any LPS authorisation is in force.
- The IMCA should represent the wishes and feelings of the person to the decision-maker.
- The IMCA should ensure that person's rights are upheld.

Who is responsible for the IMCA service?

10.1 The IMCA service is available in England and Wales. Both countries have regulations for setting up and managing the service.

10.2 In England, the IMCA service is delivered through local authorities, who work in partnership with NHS organisations. Local authorities are responsible for commissioning and funding the IMCA service for their local area.

10.3 In Wales the service is delivered through Local Health Boards (LHBs), who have financial responsibility for the service and work in partnership with local authorities and other NHS organisations.

10.4 Section 35 of the Act places a duty on the local authority and LHBs to ensure that there are enough IMCAs available to carry out the functions set out in the Act in the local area. Local authorities in England and LHBs in Wales should work with other Responsible Bodies and IMCA service providers in their area to consider the likely local demand for IMCAs to ensure sufficient provision, including for people who are not ordinarily resident in their area.

Who can be an IMCA?

10.5 An individual can act as an IMCA if they meet the criteria set out in the Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006. Local authorities and health boards will usually commission independent advocacy organisations to provide the IMCA service. These organisations should

work to appropriate organisational standards set through the contracting/ commissioning process.

10.6 Individual IMCAs must:

- have appropriate experience and training
- have integrity and a good character, and
- be able to act independently of the person or body instructing them.

10.7 Before undertaking any IMCA roles, the commissioned service must ensure that each IMCA has an enhanced criminal record check through the Disclosure and Barring Service (DBS).

10.8 IMCAs must be able to act independently. People should not act as IMCAs if they:

- provide care or treatment (in a paid capacity) to the person relating to the decisions in question, or
- have such links to the person instructing them, decision-maker or other individuals involved in the person's care or treatment that may mean they are unable to act independently.

What is the IMCA service under section 37 - 39 of the MCA (decisions about serious medical treatment or accommodation)?

10.9 The IMCA role is defined in the Act and supporting regulations. Sections 37 to 39 of the Act require an NHS Body or local authority to instruct an IMCA in specified circumstances, to advocate for people who lack capacity to make a specific decision at the time it needs to be made and have nobody (other than paid staff) whom it would be appropriate to consult in the process of determining their best interests.

10.10 An IMCA must be instructed in the following circumstances (please see paragraphs 10.14-10.16 for more information):

- providing, withholding or stopping serious medical treatment
- moving a person into long-term care in hospital or a care home or residential accommodation (see paragraph 10.47 for definition),
- moving the person to a different hospital, care home or residential accommodation

10.11 An IMCA may be instructed when reviewing accommodation arrangements which have been in place for 12 weeks. The Act does not set out any other circumstances where an IMCA may be instructed. If a decision-maker thinks that the person would benefit from an advocate regarding other decisions, they should consider other

means to enable the person to get that support. The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006 had introduced a role for IMCAs in certain adult protection cases (regulation 4). Following the introduction of the Care Act 2014, this particular regulation no longer applies. In certain cases, there may be a duty to appoint an independent advocate under the Care Act 2014.

10.12 The duty to instruct an IMCA does not apply where an urgent decision is needed or in cases where the decision or accommodation is being made under the Mental Health Act.

10.13 Further detail on the situations where there is a duty to instruct an IMCA is given in paragraphs 10.36-10.52.

Who qualifies for an IMCA under section 37-39 of the MCA?

10.14 IMCAs must be instructed for people who:

- lack capacity to make a specific decision about serious medical treatment or long-term accommodation, and
- have no person (other than paid staff) who it would be appropriate to consult in determining the person's best interests, and
- have not previously named someone who could help with a decision, and
- have not made a relevant Lasting Power of Attorney or Enduring Power of Attorney (see paragraph 10.16 below).

10.15 A person who lacks the relevant capacity and already has an advocate representing and supporting them in relation to another matter may still be entitled to an IMCA. If the advocate is not trained as an IMCA, it may be that the advocate continues in their role and an IMCA is appointed to work alongside them. Alternatively, it may be more appropriate for a new advocate, who is trained as an IMCA, to be appointed to carry out both roles. This should be considered on a case by case basis.

10.16 The duty to instruct an IMCA does not apply if:

- the person who lacks the relevant capacity previously named a person that should be consulted about the decisions in question, and they are both appropriate and willing to be consulted,
- the person who lacks the relevant capacity has appointed an attorney, under a Lasting Power of Attorney to make the decisions in question,
- the Court of Protection has appointed a deputy to make the decisions in question.

Who is it ‘appropriate to consult’ for best interest decisions?

10.17 The IMCA is an advocate for those people who lack capacity, who have no-one accessible to them whom ‘it would be appropriate to consult’ regarding the accommodation and serious medical treatment decisions described above. The advocacy IMCAs provide is for those people who have little or no network of support, such as close family or friends who take an interest in their welfare or no-one willing or able to be formally consulted in decision-making processes.

10.18 Those whom it might be appropriate to consult may include, depending on the circumstances of the case, anyone:

- engaged in caring for them, or
- interested in their welfare (see chapter 5).

10.19 The decision-maker must determine if it is appropriate to consult these people with regard to the specific decision that needs to be made. If it is not appropriate to consult anyone, an IMCA should be instructed.

10.20 There may be situations where a person who lacks capacity has family or friends, but it is not appropriate to consult them. For example, a family member may simply refuse to be consulted, or if they do not have a positive relationship and the consultation would lead to a further deterioration in that relationship.

What is an IMCA’s role in decisions about serious medical treatment or accommodation (sections 37 to 39 of the MCA)?

10.21 The information the IMCA provides must be taken into account by decision-makers whenever they are determining what is in a person’s best interests. For more information on who is a decision-maker, see chapter 5.

10.22 For the purposes of sections 37 to 39, an IMCA:

- must confirm that the individual instructing them has the authority to do so
- must determine how best to represent and support the person
- must identify the support provided to the person so that they may participate as fully as possible in any relevant decision
- should interview the person, to the extent that it is practicable and appropriate to do so
- may interview the person in private

- must act in accordance with the principles of the Act (as set out in section 1 of the Act and chapter 2 of the Code) and take account of relevant guidance in the Code
- must ascertain the extent of the support the person has had to help them participate in making any decision about the matter in question
- should satisfy themselves that a capacity assessment has been carried out and that reasons for the outcome have been clearly recorded
- may challenge the outcome of a capacity assessment if necessary
- may examine and take copies of any health, social services or other record held by the provider which the person holding the record considers may be relevant to the IMCA's investigation
- must ascertain what the person's wishes and feelings would be likely to be, and the beliefs and values that would influence the person if he or she had the relevant capacity
- must consult the professionals and paid workers providing care or treatment for the person who lacks the relevant capacity, as is practicable and appropriate
- must consult anybody else who can give information about the wishes and feelings, beliefs or values of the person who lacks the relevant capacity, as is practicable and appropriate
- must take all practicable steps to obtain any other information they consider to be necessary
- must find out what alternative options are available
- must, in relevant cases, consider whether getting another medical opinion would benefit the person who lacks the relevant capacity
- should communicate their findings when attending, representing and supporting the person about the decision needing to be made,
- must prepare a detailed report on their findings, on the person's behalf, for the local authority or NHS body that instructed them.

10.23 As far as reasonably ascertainable, decision-makers must consider the person's past and present wishes and feelings. The IMCA should provide the decision-maker with as much information as appropriate on the person's wishes and feelings. The report they give the local authority or NHS body may include questions about the proposed action or may include suggested alternatives.

10.24 An important part of the IMCA's role is communicating their findings. Decision-makers should find the most effective way to enable them to do this. Some decisions need a very quick IMCA response, others will allow more time. The IMCA should ask for the decision to be delayed if they feel they need more time and it is reasonable to delay the decision.

Scenario: An IMCA challenges a capacity assessment

Mr Q has autism and has lived with support in a house for the last 20 years. The house will be sold, and Mr Q has to move. He avoids speaking to people he doesn't know. When the social worker visits to discuss options, Mr Q does not engage.

After several visits the social worker concludes that Mr Q lacks capacity to decide where to live and prepares to arrange a move to a new independent unit for autistic men 10 miles away. The IMCA meets with one of Mr Q's support workers who describes to the IMCA how Mr Q expresses his likes and preferences, and where and how he demonstrates that he feels safe. Via the support worker Mr Q communicates his wish to only live with one or two people and to be in the countryside.

The IMCA outlines the different ways that Mr Q communicates feelings of safety and happiness, through touch, eye contact, silence and isolating in his room and verbalising. She details in her report, referring to the criteria for assessing capacity, how Mr Q demonstrates his ability to understand, use, weigh and retain information and communicate. She highlights that he needs support but may have capacity to decide his next accommodation.

The social worker requests a capacity assessment from an occupational therapist specialising in sensory needs. The conclusion is that Mr Q has capacity to decide where he lives if appropriately supported to do this.

Representing and supporting the person who lacks the relevant capacity under sections 37 to 39 of the MCA

10.25 IMCAs must take account of the guidance in chapter 5:

- IMCAs must find out the extent to which the decision-maker has given all practicable and appropriate support to help the person to participate in making any decision about the matter in question. If the person has communication difficulties, the IMCA should also find out if the decision-maker has obtained any specialist help that may be relevant (for example, from a speech and language therapist).
- Sometimes an IMCA may find information to suggest a person might regain the relevant capacity in the future, either so they can make the decision themselves or be more involved in decision-making. In such a situation, the IMCA should consider whether it is appropriate to ask the decision-maker to delay the decision.

- The IMCA should obtain as much information as possible about and must evaluate what the person's wishes and feelings would be likely to be, and the beliefs and values that would be likely to influence the person if they had the relevant capacity. This includes the person's religion and any cultural factors that may influence the decision.

10.26 Sometimes the NHS body or local authority will not have time to instruct an IMCA (for example if a decision is urgent). If this is the case, the NHS body or local authority should record the decision with the reasons why an IMCA has not been instructed. Where the decision concerns a move of accommodation, the NHS body or local authority should appoint an IMCA as soon as possible afterwards. Sometimes the IMCA will not have time to carry out lengthy investigations. In these situations, the IMCA must make a judgement about what they can achieve in the time available to represent and support the person who lacks the relevant capacity.

10.27 Sometimes an IMCA may not be able to ascertain a clear picture of what the person's wishes and feelings, and beliefs and values would be, if they had the relevant capacity. The IMCA should still try to make sure the decision-maker considers all relevant information by:

- raising relevant issues and questions, and
- providing additional, relevant information to help the final decision.

Ascertaining and evaluating information

10.28 Section 35(6) provides IMCAs with certain powers to enable them to carry out their duties. These include:

- the power to have an interview in private with the person who lacks the relevant capacity, and
- the power to examine and take copies of any relevant health record or social services record or other record held by the provider which may be relevant to the IMCA's investigation

10.29 The IMCA must consult, as far as it is practicable and appropriate to do so, professionals or paid care workers providing care or treatment for the person who lacks the relevant capacity. These people can help assess the information in case records or other sources. They can also comment on possible alternative courses of action. Ultimately, it is the decision-maker's responsibility to decide whether a proposed course of action is in the person's best interests. However, the Act requires the decision-maker to take account of the reports made and information given by the IMCA. In most cases a decision on the person's best interests should be made following consultation involving all the relevant people, including those who are providing care or treatment, as well as the IMCA.

Finding out the person's wishes and feelings, beliefs and values

10.30 The IMCA must try to ascertain what the person's wishes and feelings might be, and the beliefs and values that would be likely to influence the person if they had the relevant capacity. The IMCA should try to communicate both verbally and non-verbally with the person, as appropriate. For example, this might mean using pictures or photographs. But there will be situations where the person cannot communicate at all. The IMCA may also talk to other professionals or paid care workers directly involved in providing present or past care or treatment, and the person's family and friends, in order to find out about the person's wishes and feelings and beliefs and values. The IMCA should also examine any written statements of preferences the person may have made in the past, while they still had capacity to do so.

10.31 To the extent that it is practicable and appropriate to do so, the IMCA must also examine health and social care records relevant to the person.

10.32 Chapter 5 contains further guidance on finding out the views of people who lack capacity. Chapter 3 contains further guidance on helping someone to make their own decision.

Considering alternative courses of action

10.33 The IMCA must check what alternative courses of action are available and should explore whether the decision-maker has considered all options. They should also ask whether there is a proposed option which is less restrictive of the person's rights and freedom of action (chapter 2, principle 5).

10.34 The IMCA may wish to discuss possible options with other professionals or paid care workers directly involved in providing care or treatment for the person. But they must respect the confidentiality of the person they are representing.

Getting a second medical opinion

10.35 For decisions about serious medical treatment, the IMCA must consider whether the person would benefit from a second medical opinion, for example from a doctor with appropriate expertise. This helps put the person who lacks the relevant capacity in an equivalent position to a person who has the relevant capacity, and who can request a second opinion.

Scenario: The IMCA's role in communicating with the person and supporting them to be involved in a decision

Mr F lives with his aunt and has expressed the desire to live independently, continuing to have professional 24 hour care.

The nature of Mr F's impairment as a result of a brain injury, alongside his limited experience of being enabled to make his own decisions, means he gets very anxious expressing his views directly, due to concern about upsetting his aunt. Mr F also gets overwhelmed in meetings, feeling over-stimulated and frightened. He is therefore unable to participate fully, often retracting his expressed wishes and stating he 'doesn't know' what he wants when asked directly.

An IMCA begins to visit him alone each week, in preparation for a meeting to discuss the options for his accommodation. Mr F rates the options in terms of what he'd like about living alone versus living with his aunt. They spend time creating a table that includes his views, his wishes to retain contact with his aunt and excitement for new opportunities. It is agreed that Mr F will not attend the formal meetings and only one person will feed back the outcome to him, so as not to overwhelm him with detail, but rather discuss the next step.

This approach allows for the complexity of taking those next steps (finding property, planning for changes in living arrangements and the way the care provision may alter) to occur. The IMCA ensures Mr F's involvement in the decision, enables his voice to be heard and allows him to be represented without his physical presence at the meeting, to enable the decision to be made in his best interests.

What decisions require an IMCA under sections 37 to 39 of the MCA?

10.36 There are two types of decisions which require an IMCA to be instructed. These are:

- decisions about serious medical treatment
- decisions about the provision of accommodation or changes in accommodation

Decisions about serious medical treatment

10.37 Where a serious medical treatment decision is being proposed, section 37 of the Act imposes a duty on the NHS body to instruct an IMCA if:

- the person concerned does not have the capacity to make a decision about the treatment, and
- there is no-one appropriate to consult about whether the decision is in the person's best interests, other than paid care staff.

10.38 Regulations in England and Wales define 'serious medical treatment' as treatment which involves providing, withdrawing or withholding treatment where:

- if a single treatment is proposed there is a fine balance between the likely benefits to the patient and the burdens and risks to the patient, or
- a decision between a choice of treatments is finely balanced, or
- what is proposed is likely to have serious consequences for the patient.

10.39 'Serious consequences' are those which are likely to have a significant impact on the patient for whom the best interests decision is being made, either from the effects of the treatment itself or its wider implications. This may include treatments which:

- cause serious and prolonged pain, distress or side effects
- have potentially major consequences for the patient (for example, stopping life-sustaining treatment or having major surgery such as heart surgery), or
- have a serious impact on the patient's future life choices (for example, interventions for ovarian cancer).

10.40 It is impossible to set out all types of procedures that are likely to have serious consequences for the patient, and in many cases the same treatment may or may not have serious consequences depending on the circumstances of the case. The IMCA should also consider the benefits, burdens and risks to the person as a result of the treatment and if they are finely balanced it may therefore be considered as a serious medical treatment.

10.41 The following are examples of some treatments that in most cases will have serious consequences:

- chemotherapy and surgery for cancer
- electro-convulsive therapy
- therapeutic sterilisation
- major surgery (such as open-heart surgery or brain/neuro-surgery)
- major amputations (for example, loss of an arm or leg)
- treatments which will result in permanent loss of hearing or sight
- withholding or stopping clinically assisted artificial nutrition and hydration
- termination of pregnancy

Scenario: An IMCA and serious medical treatment

Mr N is knocked off his motorbike and is admitted to ITU in a minimally conscious state with a severe brain injury. His clinical team assess him as having very little chance of any substantive improvement in his condition. As Mr N has no capacity to express himself or make a decision, and no close family, the NHS Trust instructs an IMCA regarding a best interests decision about his treatment.

Mr N's friends say they believe he would not wish to receive clinical artificial nutrition and hydration (CANH) via a PEG (percutaneous endoscopic gastrostomy) feed and would want treatment to be withdrawn. His business partner states he should 'be given a chance', believing withdrawal of CANH would not be ethical, but says that Mr N wouldn't wish for continued treatment if it meant requiring 24 hour care.

The IMCA presents her conclusions to the decision maker, a neurorehabilitation consultant. Mr N's past wishes and expressions are clear from the evidence, namely that he would not wish for ongoing treatment in his situation. The IMCA's report also includes reference to case law outlining the weight to be given to P's wishes. She highlights BMA guidance regarding how to proceed with decisions about withdrawing CANH as well as guidance from the Royal College of Physicians. She also highlights the need for caution in consideration of others' own ethics when they are in direct contrast to Mr N's.

A best interests decision is reached, considering the IMCA's report, independent neurorehabilitation instructions, and palliative care advice. Everyone involved with Mr N's care agree that continuing with CNAH is not in his best interests, so court involvement is not required.

Mr N is transferred to a hospice where treatment is withdrawn.

10.42 It should be noted that in many of these situations the court would make the best interests decision (see chapter 5 and 7). Organisations should still instruct an IMCA in these cases. An IMCA (or possibly the Official Solicitor) may act as litigation friend for the person if they also lack capacity to conduct any litigation in respect of the proposed treatment.

10.43 The only situation in which the duty to instruct an IMCA need not be followed, is when the treatment needs to be provided as a matter of urgency (for example, to save the person's life). This decision should be recorded with the reason for the

non-referral. NHS bodies will however still need to instruct an IMCA for any serious medical treatment that follows the emergency treatment.

10.44 While a decision-maker is waiting for the IMCA's report concerning the proposed serious medical treatment, they must still act in the person's best interests for other acts and decisions (for example, to give treatment that stops the person's condition getting worse but is not serious medical treatment).

Scenario: Using an IMCA for ongoing treatment

Mr J had a fall and suffered serious head injuries. He was taken to hospital in a semi-conscious condition. Mr J needed urgent surgery and lacked capacity at the time to consent to this. Although the hospital staff could not trace any family or friends, they did not involve an IMCA in the decision to operate, because the operation needed to be carried out as a matter of urgency.

After the surgery Mr J was conscious and the hospital assessed him as still lacking capacity to consent to further medical treatment. At this point the hospital appointed an IMCA for Mr J.

The IMCA met with Mr J and was able to ascertain his wishes and feelings as to treatment. The IMCA also looked at Mr J's case notes and reviewed the options for treatment with the consultant. The consultant took into account the IMCA's report when making the decision about Mr Jones' best interests as regards the next steps for treatment.

10.45 If a patient is subject to provisions of the Mental Health Act 1983, but a decision is required for serious medical treatment, NHS bodies cannot instruct an IMCA if:

- the treatment is for mental disorder, and
- it is regulated by Part 4 or 4A of the MHA

In these cases, the patient will qualify for IMHA services. See the MHA Code of Practice in England or Wales for further guidance.

10.46 If serious medical treatment proposed for the detained patient is not regulated by the Mental Health Act, the patient then has a right to an IMCA – if they meet the Mental Capacity Act's requirements. For example, a detained patient who lacks capacity to consent to chemotherapy should normally qualify for an IMCA if there are no family or friends whom it would be appropriate to consult.

Decisions about the provision of accommodation or changes of accommodation

10.47 The Mental Capacity Act imposes similar duties on NHS bodies and local authorities who are proposing arrangements relating to long-term accommodation or changes in such accommodation. These duties apply where a person is being moved into a hospital, care home, or any other residential accommodation that is provided under:

- The NHS Act 2006 or the NHS (Wales) Act 2006
- The Care Act 2014
- The Social Services and Well-being (Wales) Act 2014
- Section 117 of the Mental Health Act 1983

10.48 The duty to instruct an IMCA also applies where an NHS body proposes to make arrangements:

- for the provision of hospital accommodation – or to move the person to another hospital – for longer than 28 days
- for the provision of care home accommodation – or to move them to a different care home – for what is likely to be longer than eight weeks
- If the accommodation is for less than 28 days in a hospital or less than 8 weeks in a care home, then an IMCA need not be appointed

10.49 The duty also applies if a local authority proposes to make arrangements:

- for the provision of care home or residential accommodation, which is likely to be longer than eight weeks, or
- to change the person's care home or residential accommodation for a period likely to exceed eight weeks.

10.50 Sometimes the provision of accommodation will be longer than expected. The responsible body should involve an IMCA as soon as they propose that the stay will be longer than 28 days or eight weeks (as applicable).

10.51 The duty to appoint an IMCA does not apply if the arrangements need to be made as a matter of urgency (for example, an emergency admission to hospital or as a response to the likelihood of homelessness). The decision-maker must involve an IMCA as soon as possible after making an emergency decision, if:

- the person is likely to stay in hospital for longer than 28 days, or
- they will stay in other accommodation for longer than eight weeks.

10.52 The duty to appoint an IMCA does not apply if the person in question is going to be accommodated as a result of an obligation imposed on them under the Mental Health Act 1983. This may occur in hospital or in the community, for

example under a Community Treatment Order or guardianship. However, if a person is under the Mental Health Act but not subject to such an obligation, the duty to instruct an IMCA could apply (if they meet the usual conditions set out in the Mental Capacity Act).

Scenario: An accommodation decision

Ms L has autism and a history of mental health conditions and has lived in a residential home for several years. Her home is going to close.

Ms L becomes very anxious about this but is assessed as lacking capacity to make a decision about her future accommodation. Therefore a best interests decision is necessary.

As Ms L has no friends or family to represent or support her the local authority instructs an IMCA to advocate for her. The IMCA visits Ms L and talks with her about her worries and wishes for her next home. Ms L says that she is worried particularly that her next home will be very noisy as a previous place was. She is also worried about potentially being separated from another resident in the home to whom she is close. The IMCA shows Ms L pictures of some potential homes which are available and discusses them with her. He facilitates visits to them and notes Ms L's preferences about them.

The IMCA also talks to staff who have been involved in Ms L's care and reviews her case notes before writing a report.

A meeting of professionals involved in Ms L's care is held to discuss where Ms L might live from the available options. The IMCA puts forward Ms L's views about the kind of place Ms L wants to live in, the particular home Ms L preferred and why, plus her wish to stay with her friend if possible. The IMCA notes that Ms L and her friend could move together if it is also in the interests of the other resident and places are available. The IMCA also advises that, if living together is not possible, visits should be facilitated for Ms L and her friend, if in both of their best interests. This would help to ease Ms L's anxieties and be consistent with her wishes and feelings.

The local authority decides that it would be in Ms L's best interests to move to the new home she preferred.

Are IMCAs available to people in prisons?

10.53 IMCAs must be appointed for people who are in prison if other criteria are met (see paragraph 10.9-10.16 above), including that they lack capacity to make decisions about serious medical treatment.

How are IMCAs instructed for decisions about serious medical treatment or accommodation (section 37-39 of the MCA)?

10.54 Local authorities or NHS organisations are responsible for instructing an IMCA to represent and support a person who lacks the relevant capacity under sections 37 to 39.

10.55 For decisions about serious medical treatment, where the person is receiving NHS treatment, the IMCA will be instructed by the NHS body proposing to provide or secure that treatment. But if the person is in an independent or voluntary sector hospital and serious medical treatment is being proposed by the NHS, the IMCA will be instructed by the NHS body that has secured that treatment, for example by organising, arranging and funding it. The NHS body should have arrangements in place with the independent or voluntary sector hospital to ensure an IMCA is appointed promptly when securing treatment from these services.

10.56 For decisions about admission to accommodation in hospital for 28 days or more, the IMCA will be instructed by the NHS body making the arrangements. The independent or voluntary hospital must have arrangements in place with the NHS body to ensure that an IMCA can be appointed without delay in relevant cases. If the arrangements amount to a deprivation of liberty the same IMCA may also represent and support the person for the LPS process, if they have had the required training.

10.57 For decisions about moves into longer term accommodation[121] (for eight weeks or longer), or about a change of accommodation, the IMCA will be instructed by either the NHS body or local authority proposing to make the arrangements.

10.58 Sometimes NHS organisations and local authorities will in practice make decisions together about moving a person into long-term accommodation. In these cases, the organisation that has responsibility for instructing the IMCA is normally the one that is ultimately responsible for the accommodation arrangements in question.

[121] This may be accommodation in a care home, nursing home, ordinary and sheltered housing, housing association or other registered social housing or in private sector housing arranged by a local authority or in hostel accommodation.

10.59 Where a local authority or NHS body decides to use their power to apply the IMCA role to a review of the accommodation arrangements, that body will be the appropriate organisation to instruct the IMCA.

10.60 Further detail on appointing IMCAs to act under LPS is provided in paragraphs 10.74 to 10.80.

What are the duties of the organisation instructing the IMCA under section 37-39?

10.61 The organisation, or the decision maker on behalf of the organisation:

- *must* instruct an IMCA to support and represent a person in the situations set out in paragraphs 10.10.
- *may* decide to instruct an IMCA in situations described in paragraphs 10.11
- *must*, in all circumstances when an IMCA is instructed, take into account the information that the IMCA provides when assessing whether the particular decision is in the best interests of the person.

10.62 The organisation should also have procedures, training and awareness programmes to make sure that:

- all relevant staff know when they need to instruct an IMCA and are able to do so promptly, prior to a decision being made
- all relevant staff know how to contact the IMCA service and the procedure for instructing an IMCA
- all relevant staff record an IMCA's involvement in a case and any information the IMCA provides to help decision-making
- all relevant staff record how a decision-maker has taken into account the IMCA's report and information as part of the process of assessing the person's best interests (this should include reasons for disagreeing with that advice, if relevant)
- all relevant staff provide access to relevant records when requested by an IMCA
- the IMCA receives information about changes that may affect the IMCA's role
- decision-makers inform all relevant people when an IMCA is instructed, and
- decision-makers inform the IMCA of the decision taken and the reason for it.

10.63 Sometimes an IMCA and staff working for the organisation which instructed the IMCA might disagree. If this happens, they should try to settle the disagreement through discussion and negotiation as soon as possible. If they cannot do this, they should consider the most appropriate formal method to raise the concern. Please see more information on managing conflict in chapter 24.

10.64 In some situations, the IMCA may challenge an organisation's decision, or they may help somebody to challenge a decision (see more information in chapter 24). If

there is no other way of resolving the disagreement, the decision may be considered by the Court of Protection.

10.65 Information on the duties of the Responsible Body appointing the IMCA under LPS is given in paragraphs 10.74 to 10.80.

What happens if an IMCA acting in a decision about serious medical treatment or accommodation disagrees with the decision-maker (section 37 – 39 of the MCA)?

10.66 The IMCA's role is to advocate for, represent and support the person. They may do this by asking questions, raising issues, offering information and writing a report. They may take part in a meeting involving relevant health care and social care staff to help inform a decision as to what is in the person's best interests. There may sometimes be cases when an IMCA thinks that a decision-maker has not paid enough attention to their report and other relevant information and is particularly concerned about the decision made. They may then need to consider challenging the decision.

10.67 An IMCA has the same rights to challenge a decision as any other person caring for the person or interested in their welfare. This right of challenge applies to any matter, including decisions about lack of capacity and a person's best interests, in relation to the decision on which the IMCA has been instructed.

10.68 Chapter 24 sets out how disagreements can be settled. The approach will vary, depending on the type and urgency of the disagreement. It could be a formal or informal approach.

10.69 Before using formal methods, the IMCA and the decision-maker should discuss the areas they disagree on – particularly those that might have a serious impact on the person the IMCA is representing and supporting. The IMCA and decision-maker should make time to listen to each other's views and to understand the reason for the differences. Sometimes these discussions can help to resolve a disagreement.

10.70 An IMCA service may have a steering group, with representatives from the local NHS organisations and local authorities. These representatives may negotiate between two differing views or clarify policy on a certain issue.

10.71 Where a case cannot be resolved it may need to be referred to the Court of Protection for a decision. The Court can make a decision in the best interests of the person who lacks the relevant decision-making capacity (see chapter 7). An IMCA may seek permission to refer a case to the Court of Protection for a decision or be asked by the Court to act as litigation friend.

10.72 If an IMCA has concerns not directly related to compliance with the MCA, for example a concern about the healthcare or social care provided to the person they are supporting, they may use complaints or safeguarding procedures as necessary – and they can pursue a complaint as far as the relevant ombudsman if needed. The decision may need to be taken to court for judicial review.

10.73 Chapter 5 sets out procedures for safeguarding people who may lack capacity to make decisions for themselves.

When should an IMCA be appointed under the LPS?

10.74 It is the role of the Responsible Body to appoint an IMCA. The Responsible Body must take all reasonable steps to appoint an IMCA for the person as soon as the LPS process has been triggered, if:

- The Responsible Body is not satisfied that there is an Appropriate Person to represent and support the person (see chapter 15 for more information on suitability of the Appropriate Person), and either;
- The person has the capacity to consent to the appointment of an IMCA and makes a request to the Responsible Body; or;
- The person does not have the capacity to consent to the appointment of an IMCA, unless the Responsible Body is satisfied that being represented and supported by an IMCA would not be in their best interests.

10.75 In some cases, the Responsible Body will be satisfied that being represented and supported by an IMCA would not be in the person's best interests. These situations will be extremely rare, such as the person is at the end of their life and the person and the family do not want an IMCA. Where this decision is taken it should be appropriately recorded in the person's records.

10.76 The Responsible Body also has a duty to appoint an IMCA to support the Appropriate Person if the requirements of paragraph Schedule AA1 apply. Further information is provided in paragraphs 10.107 – 10.116.

10.77 Where the Responsible Body has reason to believe that the Appropriate Person is no longer suitable because for example they are either unwilling or unable to fulfil their functions, and no alternative Appropriate Person can be found, then an IMCA must be appointed to represent and support the person instead (if the relevant criteria are met).

10.78 In some cases, an IMCA might be appointed but a suitable individual to carry out the role of the Appropriate Person is identified later in the process. Where this is the case, the Responsible Body should cease the appointment of the IMCA and appoint the Appropriate Person, if they consent to the appointment. Likewise, it may be that

an Appropriate Person who is appointed at the start of the process is no longer able or willing to continue the role. Where this is the case, an IMCA should be appointed as soon as possible (unless another Appropriate Person can be appointed).

10.79 If an IMCA is already involved under another section 37 - 39 of the MCA, or is an advocate under other legislation, and they have the required skills to represent and support the person under the LPS that IMCA can do so provided they have the appropriate training.

10.80 If the authorisation is ceased at any time, then the appointment of the IMCA will also cease.

Out of area arrangements

10.81 In some cases, a Responsible Body will be responsible for authorising arrangements for someone in a setting that is in the area of another Responsible Body. See chapter 14 for further information on identifying the correct Responsible Body.

10.82 Where this is the case, if the criteria set out in paragraph 10.74 above are met and an IMCA must therefore be appointed, the Responsible Body authorising the arrangements must appoint the IMCA. The Responsible Body should, as far as practicable and appropriate, work with the organisations in the area the person is placed in order to identify an IMCA in that area who will be able to meet with the person more easily.

What is the role of an IMCA under LPS?

10.83 When there is not a suitable individual to act as an Appropriate Person, described in chapter 15, for the person, in most cases an IMCA will represent and support the person through the LPS process. In order to represent and support the person, IMCAs should familiarise themselves with the person's circumstances and obtain and evaluate relevant information about the person. IMCAs should take all practicable steps to provide support to the person so that they may participate as fully as possible in any relevant decisions.

10.84 The role of the IMCA in LPS is a continuous one. The person will have an IMCA appointed to them, unless there is someone suitable to be their Appropriate Person, at the beginning of the assessments process. The same IMCA, as far as possible, will continue to represent and support the person once an authorisation is in place, unless someone suitable to act as the Appropriate Person is identified.

10.85 In some cases, there may be someone suitable to act as the Appropriate Person, but they need support from an IMCA to carry out that role. Where this is the case, an IMCA must also be appointed to help the Appropriate Person to represent and

support the person. The role of the IMCA for the Appropriate Person is also a continuous one. Once the authorisation is in place the Appropriate Person and their IMCA do not have to be in continuous communication. However, the Appropriate Person should be able to contact the IMCA for support throughout the duration of the authorisation. Please see paragraphs 10.107 – 10.116 below for more information on the role of the IMCA for the Appropriate Person.

How does the IMCA support and represent the person?

10.86 Once the IMCA is appointed, they should ascertain how they can best support the person as soon as possible. This may include determining the person's communication methods, or perhaps what time of day is best to talk to the person.

10.87 Even though it may be determined that the person does not have the capacity to make a decision about the arrangements that amount to a deprivation of liberty, the person may still be able to express their current wishes and feelings about the arrangements for example, through things that they say or their behaviour. If the person can express their current wishes and feelings, the IMCA should ascertain these.

10.88 In some cases, the person may not be able express their current wishes and feelings, or these cannot be ascertained. In this case, IMCAs must ascertain, as best they can, what the person's wishes, feelings, beliefs and values would be, if they had capacity, regarding the arrangements or proposed arrangements. It is also important for the IMCA to determine the person's previous wishes and feelings about their care or treatment, as although these may have changed, they may still be relevant to the proposed arrangements.

10.89 In order to do this, the IMCA should meet with the person and, help them understand the LPS process, the arrangements being proposed, and what these arrangements mean, as far as is possible. Additionally, where practicable and appropriate, the IMCA may consult with those caring for the person, including in a professional capacity, and others who are likely to know the person and therefore their wishes and feelings well.

10.90 Some people may be unable to communicate their wishes and feelings to the IMCA. In these situations, the IMCA should explore alternative communication methods. If the person is unable to express their wishes and feelings on an issue then the IMCA, as far as possible, should try to work out their likely wishes and feelings from speaking to and observing the person, speaking to other people, accessing records and through observation. The person may use behavioural, or other communication methods, to make their wishes about the arrangements and feelings known.

10.91 If the person does not wish, or it is reasonable to believe that the person does not wish, to reside in the proposed place or to receive care and treatment in that place,

the IMCA should ensure that this is communicated to the Responsible Body as soon as possible. This will trigger the duty for the case to be referred to an AMCP at pre-authorisation review stage. Please see chapter 18 for more information on AMCPs.

10.92 The IMCA should accompany the person, to support and represent them, when they are being consulted by the Responsible Body. This may include supporting the person to communicate, or to understand what is happening during the meetings. If the consultation is not taking place face to face, the IMCA should consider how they can provide this support and representation effectively and appropriately. The IMCA should also help the person name those that they wish to be consulted on the proposed arrangements. See chapter 17 for further information on the consultation.

10.93 The IMCA should also accompany the person, to support and represent them, during the person's assessments, unless the person would prefer to do them alone.

10.94 Ahead of either the consultation or assessments, the IMCA should consider with the person what they may need or wish to tell any of the assessors or the Responsible Body during those meetings. The IMCA should also consider whether they or the person has any concerns about how the assessment or consultations process has been implemented and how they should raise these with the relevant individuals or bodies. It may be appropriate to ask for another assessment to be completed.

10.95 The IMCA should support the person to explore the potential for less restrictive options than the proposed arrangements, and where necessary communicate these to the Responsible Body.

10.96 The functions of an IMCA under the LPS include writing a report on their findings for the Responsible Body. The report may include submissions that are considered appropriate in relation to the person and the act or decision being proposed. If there are alternative arrangements suggested that may better reflect the person's wishes and feelings, the IMCA should communicate these to the Responsible Body in the report.

10.97 In part, the IMCA's role is to represent and support the person in their relationship with the Responsible Body. The IMCA should seek the best outcome for the person, which includes encouraging the Responsible Body to consider all options for the person's arrangements. If an agreement cannot be reached, the IMCA may request than an AMCP considers the case. The role of the AMCP is to provide an additional layer of scrutiny to the LPS process. The AMCP role does not amount to a formal mediation role, but it is a way to resolve a difference of view between the person and those proposing the arrangements. Upon receiving such a request from the IMCA, the Responsible Body should consider the principles set out in chapter 18 when deciding whether the case reaches the threshold for referral to the AMCP service. As with any case, the AMCP team should consider whether they think the threshold for an AMCP is met before accepting the case.

10.98 IMCAs have a right to:

- Be consulted about the person's wishes and feelings about the arrangements.
- Make submissions to assessors, as they consider appropriate, having regard to data protection law and the wishes and feelings of the person.
- Meet the person, including at the place (or places) where their care or treatment is taking place.
- Be provided with a copy of the person's authorisation record.
- Apply to the Court of Protection or provide the person with assistance to do so.

10.99 The Responsible Body should:

- If the IMCA has written a report of their findings, pass this on to the professional undertaking the necessary and proportionate assessment. This is part of the Responsible Body's ongoing duty to disclose relevant information to all those carrying out assessments.
- Provide the IMCA with copies of the assessments under the LPS.
- Keep the IMCA informed throughout the LPS process.
- Notify the IMCA of the outcome of the authorisation and give or send a copy of the authorisation record to the IMCA without delay

How does the IMCA continue to support the person after an authorisation has been granted?

10.100 After the arrangements have been authorised, the IMCA should maintain contact with the person throughout the period of the authorisation as far as it is practicable and appropriate to do so. The IMCA should also represent and support the person throughout any reviews in much the same way that they represented and supported them through the initial authorisation process. If the authorisation is renewed, the same IMCA can continue to represent and support the person without needing to be reappointed.

10.101 The IMCA should work with the person to determine how to continue to best represent and support them.

10.102 The IMCA must have regard to the ascertainable wishes and feelings of the person when making the best interests decision as to how often to meet with them, if the person lacks capacity to decide this themselves.

10.103 When meeting the person, the IMCA should establish the person's wishes and feelings in relation to the arrangements that amount to a deprivation of liberty. The IMCA should ensure that these continue to be understood and respected by the Responsible Body.

10.104 The IMCA may, where appropriate, submit a written report to the Responsible Body when:

- The person or IMCA wishes to raise a concern.
- The person or IMCA wishes to request a review.
- The IMCA is preparing for a scheduled review.

If a report is submitted, the Responsible Body should provide the IMCA with a timely written response to the points raised, setting out the planned action. The Responsible Body should also ensure that any report is filed in the person's health or care records.

10.105 If the IMCA or the person has concerns about the authorisation or the way in which the Responsible Body handled the case, the IMCA can support the person to take certain steps. For example:

- Making a complaint, for example, to the care or treatment provider or the Responsible Body.
- Raising an adult safeguarding concern.
- Requesting a review for the person where an authorisation is in place.
- Making an application to the Court of Protection.

10.106 Once an authorisation is in place, the person and their Appropriate Person or IMCA can make an application to the Court of Protection, for example to challenge the authorisation. The IMCA should, for example, consider whether the person is happy with the arrangements or whether they would like to challenge them in Court and, if so, support them to bring this challenge. Even if the person doesn't wish to challenge the authorisation, it may still be necessary to take the arrangements to Court. If this is the case, the IMCA should make the application themselves. Please see chapter 24 for more information on deciding whether to take a challenge to court, and chapter 7 for more information on the court itself.

How does the IMCA support the Appropriate Person?

10.107 The Appropriate Person represents and supports the person, similar to the IMCA role. However, the Appropriate Person role is unpaid and generally carried out by someone who knows the person well, such as a friend or family member. Please see chapter 15 for more information on the role of the Appropriate Person.

10.108 The Responsible Body must publish information about when an Appropriate Person may need to be supported by an IMCA in an accessible and appropriate place. They should also publish information about what an Appropriate Person can expect from the IMCA service.

10.109 In some cases, the Appropriate Person may request support from an IMCA, in order to best support and represent the person. In other cases, it may be decided that it would be in the person's best interests for their Appropriate Person to have the support of an IMCA. Where this is the case, an IMCA will be appointed to support the Appropriate Person to make sure they are able to support and represent the person, including ensuring that the person's wishes and feelings are understood and communicated.

10.110 The IMCA may also support the Appropriate Person to make sure that they get access to the relevant records they need to carry out the role effectively, and to ensure that the correct information is recorded in the authorisation record.

10.111 Prior to the authorisation of the arrangements, the IMCA should take all practicable steps to meet the Appropriate Person, to support them to understand the LPS process, their role as an Appropriate Person, what the proposed arrangements would mean for the person and what the person's rights are. Where relevant, the IMCA may also support the Appropriate Person to seek less restrictive options for the person. The IMCA should also support the Appropriate Person to ascertain and understand the person's wishes and feelings about the arrangements.

10.112 The IMCA can provide support to the Appropriate Person when they are preparing, with the person, for the consultation process. This may include, providing advice on how best to support the person when they are being consulted. The IMCA can also support the Appropriate Person to identify people that should be consulted and pass this information to the Responsible Body.

10.113 The IMCA should support the Appropriate Person through any meetings they have with the person carrying out the pre-authorisation review, including supporting them to express their wishes and feelings.

10.114 If there is a disagreement between the person or the Appropriate Person and the Responsible Body, the IMCA can support the Appropriate Person to manage that disagreement.

10.115 At any time, the Appropriate Person, or the person, may wish to raise concerns with the Responsible Body about either the authorisation or the process. Where this is the case, the IMCA can support the Appropriate Person to for example:

- Make a complaint to the managing authority or the Responsible Body.
- Raise an adult safeguarding concern.
- Request a review for the person where an authorisation is in place.
- Make an application to the Court of Protection

10.116 Once the authorisation is in place, the person or their Appropriate Person may decide to make an application to the Court of Protection, for example to challenge

the arrangements. The IMCA can help the Appropriate Person to determine if an application would be appropriate and if so, make an application. Please see chapter 24 for more information on deciding whether to bring a challenge to court.

Can the IMCA access all the health and care records of the person?

10.117 As with IMCAs acting under the s37-39 of the MCA, an IMCA acting under the LPS may, at all reasonable times, examine and take copies of:—

- any health record,
- any record of, or held by, a local authority and compiled in connection with a social services function, and
- any record held by a person registered under Part 2 of the Care Standards Act 2000, chapter 2 of Part 1 of the Health and Social Care Act 2008 or chapter 2 of Part 1 of the Regulation and Inspection of Social Care (Wales) Act 2016 which the person holding the record considers may be relevant to the IMCA's investigation.

What is the interface between IMCAs acting under the MCA with other types of advocacy?

10.118 A person who lacks the relevant capacity could also be entitled to other types of statutory advocacy. These include an Independent Mental Health Act Advocate (IMHA) under the Mental Health Act or an independent advocate instructed under the Care Act 2014. In Wales, they may meet the requirements for advocacy under Part 10 of the Codes of Practice for the Social Services and Well-being (Wales) Act 2014 and the Mental Health (Wales) Measure. If the person is a looked after child or care leaver then they are entitled to, and may also have, an advocate appointed under s.26A of the Children Act 1989.

10.119 These advocates are designed to work collaboratively with and not replace IMCAs. The same advocate may be qualified to act as more than one type of statutory advocate, though they are different roles.

10.120 An Independent Advocate appointed under another legislation, such as the Care Act (2014), can also be the IMCA for the person for the LPS if they meet the requirements outlined in paragraphs 10.70 – 10.73.

Other types of advocacy (non-statutory)

10.121 A person who may be deprived of their liberty may be, or may wish to be a member of a self-advocacy or peer advocacy group or service. Where this is the case, advocacy provided through these groups or services should be supported alongside any statutory advocacy, as a way of supporting the person with decision-making.

11. What does the Act say about advance decisions to refuse treatment?

This chapter explains what to do when somebody has made an advance decision to refuse treatment. It sets out what the Act means by an 'advance decision' and has guidance on making, updating and cancelling advance decisions. It also sets out how to check whether an advance decision exists and is valid and applicable in the circumstances; the responsibilities of healthcare professionals when an advance decision exists; and how to handle disagreements about advance decisions.

In this chapter, as throughout the Code, a person's capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

Quick summary

- An advance decision enables anyone aged 18 and over, who has capacity, to refuse specified medical treatment for a time in the future when they may lack the capacity to consent to or refuse that treatment.
- An advance decision to refuse treatment must be valid and applicable to current circumstances. If it is, it has the same effect as a decision that is made by a person with capacity and healthcare professionals must follow the decision.
- Healthcare professionals will be protected from liability if they:
- stop or withhold treatment because they reasonably believe that an advance decision exists, and that it is valid and applicable
- treat a person because, having taken all practicable and appropriate steps to find out if the person has made an advance decision to refuse treatment, they do not know or are not satisfied that a valid and applicable advance decision exists.
- Specific requirements apply for advance decisions which refuse life-sustaining treatment.

How can someone make an advance decision to refuse treatment?

What is an advance decision to refuse treatment?

11.1 It is a general principle of law and medical practice that people have a right to consent to or refuse treatment. The courts have recognised that adults have the right to say in advance that they want to refuse treatment if they lose capacity in the future – even if this results in their death. A valid and applicable advance decision to refuse treatment has the same force as a contemporaneous decision. Sections 24–26 of the Act set out when a person can make an advance decision to refuse treatment. This applies if:

- the person is 18 or older, and
- they have the capacity to make an advance decision about treatment.

11.2 A young person (under the age of 18) cannot make an advance decision, however they can make an advance (written) statement setting out their preferences, which any decision-maker should take into account.

11.3 Healthcare professionals must follow an advance decision if it is valid and applies to the particular circumstances. If they do not, they could face criminal prosecution (be charged with committing a crime) or civil liability (somebody could sue them).

11.4 Advance decisions can have serious consequences for the people who make them. They can also have an important impact on family and friends, and professionals involved in their care. Before healthcare professionals can apply an advance decision, there must be proof that the decision:

- exists
- is valid, and
- is applicable in the current circumstances.

11.5 These tests are legal requirements under section 25(1). Paragraphs 11.47-11.53 explain the standard of proof the Act requires.

11.6 Despite the serious consequences of decisions to refuse life-sustaining treatment, such decisions embody the right to self-determination, and are to be respected provided that such decisions meet the requirements of sections 25(5) and (6) of the Act.

Scenario: Advance decisions and care planning

Mr D receives a cancer diagnosis. As part of the discussion about his cancer with the clinicians Mr D learns about the types of care or treatment that are available and their benefits, harms and risks. He is asked about his preferences, wishes, beliefs, values and feelings about his illness and prognosis, and the types of decisions that may need to be made about his care and treatment in the future. From this discussion, Mr D can anticipate how his condition may affect him in the future. He records his wishes about his care and treatment by making an advance care and support plan.

As part of this plan Mr D makes an Advance Decision to Refuse Treatment. This can be followed by those responsible for Mr D's care or treatment (whether professional staff or family carers) in the event that he loses capacity to decide once his illness progresses.

Who can make an advance decision to refuse treatment?

11.7 It is up to individuals to decide whether they want to refuse treatment in advance. They are entitled to do so if they want, but there is no obligation to do so. Some people choose to make advance decisions while they are still healthy, even if there is no prospect of illness. This might be because they want to keep some control over what might happen to them in the future.

11.8 Others may think of an advance decision as part of their preparations for growing older (similar to making a Will). Or they might make an advance decision after they have been told they have a specific disease or condition, or fluctuating capacity.

11.9 Many people prefer not to make an advance decision, and instead leave healthcare professionals to make decisions in their best interests at the time a decision needs to be made. Another option is to make a Lasting Power of Attorney. This allows a trusted family member or friend to make personal welfare decisions, such as those around treatment, on someone's behalf, and in their best interests if they ever lose capacity to make those decisions themselves (see paragraph 11.42-11.43 below and chapter 8).

11.10 People can only make advance decisions to refuse treatment. Nobody has the legal right to demand specific treatment, either at the time or in advance. So no-one can insist (either at the time or in advance) on being given treatments that healthcare

professionals consider to be clinically unnecessary or inappropriate. But people can make a request or state their wishes and preferences in advance.

11.11 Healthcare professionals should then consider the request when deciding what is in a patient's best interests (see chapter 5) if the patient lacks capacity.

11.12 Nobody can ask for or receive procedures that are against the law (for example, help with committing suicide). As section 62 sets out, the Act does not change any of the laws relating to murder, manslaughter or suicide.

Capacity to make an advance decision to refuse treatment

11.13 For most people, there will be no doubt about their capacity to make an advance decision. Even those who lack capacity to make some decisions may have the capacity to make an advance decision. It may be helpful to get evidence of a person's capacity to make the advance decision (for example, if there is a possibility that the advance decision may be challenged in the future). It is also important to remember that capacity can change over time, and a person who lacks capacity to make a decision now might be able to make it in the future. Chapter 4 explains how to assess a person's capacity to make a decision.

Scenario: Respecting capacity to make an advance decision

Ms L has lived with metastatic breast cancer for some years and two years ago made a written and witnessed advance decision to refuse treatment (ADRT). The ADRT specifies that if the cancer progresses in a way that means Ms L becomes unable to swallow food or drink on her on her own, she does not want to be kept alive by being fed through a feeding tube or drip. It also says that she does not want cardiopulmonary resuscitation if her heart and lungs stop working so that she cannot breathe independently.

Ms L later develops vascular dementia and moves to a care home. She gives the care home staff her ADRT. Her dementia gradually worsens, and she loses capacity to make decisions about her care and treatment, both regarding the cancer and more generally.

In time Ms L's cancer also develops. The care home staff liaise with Ms L's medical team so that her decisions as set out in the ADRT are followed at the appropriate time.

11.14 Healthcare professionals should always start from the assumption that a person who has made an advance decision had capacity to make it, unless they are aware of reasonable grounds to doubt this. If a healthcare professional is aware of such grounds they should consider (usually with legal advice) whether it is possible to

resolve those doubts themselves (see paragraph 11.70-11.71), or whether it is necessary to go to the Court of Protection for a decision as to whether or not the advance decision exists. They can provide life-sustaining treatment or treatment required to prevent a serious deterioration in the person's condition whilst any application is being made to the court (see paragraph 11.80). More detail on retrospective capacity assessments is at paragraph 4.100-4.104.

11.15 Healthcare professionals may have particular concerns about the capacity of someone with a history of suicide attempts or suicidal thoughts who has made an advance decision. It is important to remember that making an advance decision which, if followed, may result in death does not necessarily mean a person is or feels suicidal. Nor does it necessarily mean the person lacks capacity to make the advance decision. Suicidal behaviour can be linked to psychiatric illness which can affect decision-making capacity. If the person has clear suicidal intent at the time the professional is engaging with them, this may raise questions about their capacity to make the advance decision at the time they made it.

What should people include in an advance decision?

11.16 There are no particular formalities about the format of an advance decision. It can be written or verbal, unless it deals with life-sustaining treatment, in which case it must be written and specific rules apply (see paragraphs 11.32-11.37 below).

11.17 An advance decision to refuse treatment:

- must state precisely what treatment is to be refused – a statement giving a general desire not to be treated is not enough.
- may set out the circumstances when the refusal should apply – it is helpful to include as much detail as possible.
- will only apply at a time when the person lacks capacity to consent to or refuse the specific treatment.
- should include a statement of values, for example an individual might want to state whether it is more important to them that they be kept pain free rather than kept alive.

11.18 People can use medical language or everyday language in their advance decision. But they must make clear what their wishes are and what treatment they would like to refuse.

11.19 An advance decision refusing all treatment in any situation (for example, where a person explains that their decision is based on their religion or personal beliefs) may be valid and applicable.

11.20 People who are thinking about making an advance decision may wish to discuss this with:

- healthcare professionals (for example, their GP or the person most closely involved with current healthcare or treatment), or
- an organisation that can provide advice on specific conditions or situations (they might have their own format for recording an advance decision).

11.21 It is for the person to decide whether they want to do this or not. Healthcare professionals should record details of any discussion on healthcare records.

11.22 Some people may also want to get legal advice. This will help them make sure that they express their decision clearly and accurately. It will also help to make sure that people understand their advance decision in the future.

11.23 It is a good idea to try to include possible future circumstances in the advance decision. For example, a woman may want to state in the advance decision whether or not it should still apply if she later becomes pregnant. If the document does not anticipate a change in circumstance, healthcare professionals may decide that it is not applicable if those circumstances arise.

11.24 If an advance decision is recorded on a patient's healthcare records, it is confidential. Some patients will tell others about their advance decision (for example, they might tell healthcare professionals, friends or family). Others will not. People who do not ask for their advance decision to be recorded on their healthcare record will need to think about where it should be kept and how they are going to let people know about their decision.

Written advance decisions

11.25 A written document can be evidence of an advance decision. It is helpful to tell others that the document exists and where it is. A person may want to carry it with them in case of emergency, or carry a card, bracelet or other indication that they have made an advance decision and explaining where it is kept.

11.26 There is no set form for written advance decisions, because contents will vary depending on a person's wishes and situation. But it is helpful to include the following information:

- full details of the person making the advance decision, including date of birth, home address and any distinguishing features (in case healthcare professionals need to identify an unconscious person, for example)
- the name and address of the person's GP and whether they have a copy of the document

- a statement that the document should be used if the person ever lacks capacity to make treatment decisions
- a clear statement of the decision, the treatment to be refused and the circumstances in which the decision will apply
- the date the document was written
- the date when the document should be reviewed (the document must not have a 'valid until' date)
- the person's signature (or the signature of someone the person has asked to sign on their behalf and in their presence)
- the signature of the person witnessing the signature, if there is one (or a statement directing somebody to sign on the person's behalf).

11.27 See paragraphs 11.32-11.37 below if the advance decision deals with life-sustaining treatment.

11.28 Witnessing the person's signature is not essential, except in cases where the person is making an advance decision to refuse life-sustaining treatment. But if there is a witness, they are witnessing the signature and the fact that it confirms the wishes set out in the advance decision. It may be helpful to give a description of the relationship between the witness and person making the advance decision. The role of the witness is to witness the person's signature, it is not to certify that the person has the capacity to make the advance decision – even if the witness is a healthcare professional or knows the person.

11.29 It is possible that a professional acting as a witness will also be the person who assesses the person's capacity. If so, the professional should also make a record of the assessment, because acting as a witness does not prove that there has been an assessment.

Oral advance decisions

11.30 Whilst it is preferable to have a written advance decision to refuse treatment, it is possible to have oral advance decisions. There is no set format for oral advance decisions. This is because they will vary depending on a person's wishes and situation. Healthcare professionals will need to consider whether an oral advance decision exists and whether it is valid and applicable (see paragraphs 11.47-11.53).

11.31 Where possible, healthcare professionals should record an oral advance decision to refuse treatment in a person's healthcare record. This will produce a written record that could prevent confusion about the decision in the future. The record should include:

- a note that the decision should apply if the person lacks capacity to make treatment decisions in the future

- a clear note of the decision, the treatment to be refused and the circumstances in which the decision will apply
- details of someone who was present when the oral advance decision was recorded and the role in which they were present (for example, healthcare professional or family member), and
- whether they heard the decision, took part in it or are just aware that it exists

What rules apply to advance decisions to refuse life-sustaining treatment?

11.32 The Act imposes particular legal requirements and safeguards on the making of advance decisions to refuse life-sustaining treatment.

11.33 Section 4(10) states that life-sustaining treatment is treatment which a healthcare professional who is providing care to the person regards as necessary to sustain life. This decision will not just depend on the type of treatment. It will also depend on the circumstances in which the healthcare professional is giving it. For example, in some situations antibiotics may be life-sustaining, but in others they can be used to treat conditions that do not threaten life.

11.34 Advance decisions to refuse life-sustaining treatment must meet specific requirements:

- They must be put in writing. If the person is unable to write, someone else should write it down for them. For example, a family member can write down the decision on their behalf, or a healthcare professional can record it in the person's healthcare notes.
- The person must sign the advance decision, in the presence of a witness. If they are unable to sign, they can direct someone to do so on their behalf in their presence. It is advisable to note exactly what was done to facilitate the signing by another person.
- The witness must then sign the document in the presence of the person making the advance decision. If the person making the advance decision is unable to sign, the witness can witness them directing someone else to sign on their behalf. The witness must then sign to indicate that they have witnessed the nominated person signing the document in front of the person making the advance decision.
- The advance decision must include a clear, specific written statement from the person making the advance decision that the advance decision is to apply to the specific treatment even if life is at risk.
- If this statement is made at a different time or in a separate document to the advance decision, the person making the advance decision (or someone they

have directed to sign) must sign it in the presence of a witness, who must also sign it.

11.35 Clinically assisted nutrition and hydration (CANH) has been recognised as a form of medical treatment. CANH involves using tubes to provide nutrition and fluids to someone who cannot take them by mouth. It bypasses the natural ability to swallow and requires clinical monitoring. An advance decision can refuse CANH. Refusing CANH in an advance decision is likely to result in the person's death, if the advance decision is followed. It is very important to discuss advance decisions to refuse life-sustaining treatment with a healthcare professional. But it is not compulsory. A healthcare professional will be able to explain:

- what types of treatment may be life-sustaining treatment, and in what circumstances and
- the implications and consequences of refusing such treatment (see also, paragraph 11.4)

11.36 A healthcare professional may also be able to provide confirmation that the person has capacity to make an advance decision to refuse life-sustaining treatment.

11.37 An advance decision cannot refuse actions that are needed to keep a person comfortable (sometimes called basic or essential care). Examples include warmth, shelter, actions to keep a person clean and the offer of food and water by mouth. Section 5 of the Act allows healthcare professionals to carry out these actions in the best interests of a person who lacks capacity to consent (see chapter 6).

When should someone review or update an advance decision?

11.38 Anyone who has made an advance decision is advised to regularly review and update it as necessary. Decisions made a long time in advance are not automatically invalid or inapplicable, but they may raise doubts when deciding whether they are valid and applicable. A written decision that is regularly reviewed is more likely to be valid and applicable to current circumstances – particularly for progressive illnesses. This is because it is more likely to have taken on board changes that have occurred in a person's life since they made their decision.

11.39 Views and circumstances may change over time. A new stage in a person's illness, the development of new treatments or a major change in personal circumstances

may be appropriate times to review and update an advance decision. However, it is imperative that the advance decision does not have a 'valid until' date[122].

How can someone withdraw an advance decision?

11.40 Section 24(3) allows people to cancel or alter an advance decision at any time while they still have capacity to do so. There are no formal processes to follow. People can cancel their decision verbally or in writing, and they can destroy any original written document. Where possible, the person who made the advance decision should tell anybody who knew about their advance decision that it has been cancelled. They can do this at any time. For example, they can do this on their way to the operating theatre or immediately before being given an anaesthetic. Healthcare professionals should record a verbal cancellation in healthcare records. This then forms a written record for future reference.

How can someone make changes to an advance decision?

11.41 People can make changes to an advance decision verbally or in writing (section 24(3)) whether or not the advance decision was made in writing. It is good practice for healthcare professionals to record a change of decision in the person's healthcare notes. But if the person wants to change an advance decision to include a refusal of life-sustaining treatment, they must follow the procedures described in paragraphs 11.32-11.37.

How do advance decisions relate to other rules about decision-making?

11.42 A valid and applicable advance decision to refuse treatment is as effective as a refusal made when a person has capacity. Therefore, an advance decision overrules:

- the decision of any personal welfare Lasting Power of Attorney (LPA) made before the advance decision was made. So, an attorney cannot give consent to treatment that has been refused in an advance decision made after the LPA was signed
- the decision of any court-appointed deputy (so a deputy cannot give consent to treatment that has been refused in an advance decision which is valid and applicable)

[122] See *The X Primary Care Trust .v. XB & Anor* [2012] EWHC 1390, available at: https://www.bailii.org/ew/cases/EWHC/Fam/2012/1390.html.

- the provisions of section 5 of the Act, which would otherwise allow healthcare professionals to give treatment that they believe is in a person's best interests.

11.43 An LPA made after an advance decision will make the advance decision invalid, if the LPA gives the attorney the authority to make decisions about the same treatment. If an advance decision is made after making an LPA, the attorney will not be able to override what is written in the advance decision. In this situation, if a decision needs to be made about something that the individual has not detailed in the advance decision, then the attorney will still be able to act.

11.44 The Court of Protection may make declarations as to the existence, validity and applicability of an advance decision, but it has no power to overrule a valid and applicable advance decision to refuse treatment.

11.45 Where an advance decision is being followed, the best interests principle (see chapter 5) does not apply. This is because an advance decision reflects the decision of an adult with capacity who has made the decision for themselves. Healthcare professionals must follow a valid and applicable advance decision, even if they think it goes against a person's best interests.

Advance decisions regarding treatment for mental disorder

11.46 Advance decisions can refuse any kind of treatment, whether for a physical or mental disorder. But generally, an advance decision to refuse treatment for mental disorder can be overruled if the person is detained in hospital under the Mental Health Act 1983, when treatment could be given compulsorily under Part 4 of that Act. However, even where clinicians may lawfully treat a patient compulsorily under the Mental Health Act, they should, where practicable, try to comply with the patient's wishes as expressed in an advance decision. They should, for example, consider whether it is possible to use a different form of treatment not refused by the advance decision. If it is not, they should explain why to the patient. Advance decisions to refuse treatment for other illnesses or conditions are not affected by the fact that the person is detained in hospital under the Mental Health Act. For further information see chapter 22.

How can somebody decide on the existence, validity and applicability of advance decisions?

Deciding whether an advance decision exists

11.47 It is the responsibility of the person making the advance decision to make sure their decision will be drawn to the attention of healthcare professionals when it is needed. Some people will want their decision to be recorded on their healthcare records. Those who do not will need to find other ways of alerting people that they

have made an advance decision and where somebody will find any written document and supporting evidence[123]. Some people carry a card or wear a bracelet. It is also useful to share this information with family and friends, who may alert healthcare professionals to the existence of an advance decision. But it is not compulsory. Providing the person's GP with a copy of the written document will allow them to record the decision in the person's healthcare records.

11.48 It is important to be able to establish that the person making the advance decision was 18 or over when they made their decision, and that they had the capacity to make that decision when they made it, in line with the test for capacity set out in chapter 3. But as explained in paragraphs 11.14–11.15 above, healthcare professionals should always start from the assumption that the person had the capacity to make the advance decision.

Deciding whether an advance decision is valid

11.49 An existing advance decision must still be valid at the time it needs to be put into effect. Healthcare professionals must consider the factors in section 25 of the Act before concluding that an advance decision is valid. Events that would make an advance decision invalid include those where:

- the person withdrew the decision while they still had capacity to do so
- after making the advance decision, the person made a Lasting Power of Attorney (LPA) giving an attorney authority to make treatment decisions that are the same as those covered by the advance decision (see also paragraph 11.43)
- the person has done something that is clearly inconsistent with the advance decision which suggests that they have changed their mind. The person might have done something inconsistent while there was no reason to doubt their decision-making capacity. However, the wording of the Act also covers situations where the person no longer has capacity to withdraw their decision or make decisions about medical treatment, but is clearly indicating that they want treatment covered by the decision[124].

[123] See *NHS Cumbria CCG.v. Rushton* [2018] EWCOP 41, available at: https://www.bailii.org/ew/cases/EWCOP/2018/41.html.

[124] See *Re QQ* [2016] EWCOP 22, available at: https://www.bailii.org/ew/cases/EWCOP/2016/22.html.

Scenario: Assessing whether an advance decision is valid

Mr A sees a friend die after prolonged hospital treatment. Mr A makes a signed and witnessed advance decision to refuse treatment (ADRT) to keep him alive by means of a ventilator if he loses the ability to breathe by himself. The ADRT includes a statement that this will apply even if his life is at risk.

A few years later, Mr A is seriously injured in a road traffic accident. He is paralysed from the neck down and cannot breathe without the help of a machine.

He has capacity to consent to be treated and takes part in a rehabilitation programme. He also discusses with healthcare professionals, family and friends his wishes and feelings about continuing treatment to maximise his chances of his condition improving. He asks his sister to go to his home to look into how it could be adapted to enable him to return to live there in future and to make arrangements for this.

Shortly afterwards, due to unexpected complications arising from his injuries, Mr A loses consciousness. By chance, at his home his sister finds his written ADRT, which Mr A had not mentioned to her.

Mr A's sister is aware that Mr A's actions before he lost capacity to decide on his treatment are inconsistent with the ADRT. She shows the ADRT to the other family members and his hospital medical team. They agree that Mr A's actions following his accident give reasonable grounds to doubt the validity of the advance decision.

They decide that it is in Mr A's best interests to continue to give him treatment including assistance with his breathing, and to apply to the Court of Protection for a decision with regard to the ADRT.

Deciding whether an advance decision is applicable

11.50 To be applicable, an advance decision must apply to the situation in question and in the current circumstances. Healthcare professionals must first determine if the person still has capacity to accept or refuse treatment at the relevant time (section 25(3)). If the person has capacity, they can refuse treatment there and then. Or they can change their decision and accept treatment. The advance decision is not applicable in such situations.

11.51 The advance decision must also apply to the proposed treatment. It is not applicable to the treatment in question if (section 25(4)):

- the proposed treatment is not the treatment specified in the advance decision

- the circumstances are different from those that may have been set out in the advance decision, or
- there are reasonable grounds for believing that there have been changes in circumstance, which would have affected the decision if the person had known about them at the time they made the advance decision.

11.52 So when deciding whether an advance decision applies to the proposed treatment, healthcare professionals must consider:

- how long ago the advance decision was made,
- whether there have been changes in the patient's personal life (for example, the person is pregnant, and this was not anticipated when they made the advance decision) that might affect the validity of the advance decision, and
- whether there have been developments in medical treatment that the person did not foresee (for example, new medications, treatment or therapies).

11.53 For an advance decision to apply to life-sustaining treatment, it must meet the requirements set out in paragraphs 11.34.

Scenario: Assessing if an advance decision is applicable

Mr M has prostate cancer. He has consented to treatment, but has also made an advance decision to refuse specific clinical trial treatments, saying he doesn't want to be a 'guinea pig' for the medical profession. Five years later, he is admitted to hospital seriously ill, which includes losing consciousness.

The doctors treating Mr M examine his advance decision. They are aware that there have been major developments in prostate cancer treatment in the intervening years. They discuss this with Mr M's partner and all agree that there are reasonable grounds to believe that Mr M may have changed his advance decision if he had known about newer treatment options following successful clinical trials So, the doctors decide the advance decision does not apply to the new treatments, and that giving him the treatment is in his best interests.

If Mr M regains capacity to make decisions about his treatment, he can consider his advance decision and accept or refuse future treatment.

What happens to decisions made before the Act came into force?

11.54 Advance decisions made before the Act came into force may still be valid and applicable, although they will need careful consideration given the time that has elapsed since they were made. Healthcare professionals should apply the rules in the Act to advance decisions made before the Act came into force, subject to the transitional protections that applied to advance decisions that refuse life-sustaining treatment.

What implications do advance decisions have for healthcare professionals?

What are healthcare professionals' responsibilities?

11.55 Healthcare professionals should be aware that:

- a patient they propose to treat may have refused treatment in advance
- valid and applicable advance decisions to refuse treatment have the same legal status as decisions made by people with capacity at the time of treatment
- valid and applicable advance decisions to refuse treatment apply at the start of and through the continuation of treatment
- where a patient is receiving treatment which they have not made an advance decision to refuse, but their condition changes and requires different treatment, they may have made a valid and applicable advance decision to refuse that treatment.

11.56 Where appropriate, when discussing treatment options with people who have capacity, healthcare professionals should ask if there are any specific types of treatment they do not wish to receive if they ever lack capacity to consent in the future.

11.57 If somebody tells a healthcare professional that an advance decision exists for a patient who now lacks capacity to consent, they should make reasonable efforts to find out what the decision is. Reasonable efforts might include having discussions with relatives of the patient, looking in the patient's clinical notes held in the hospital or contacting the patient's GP. The healthcare professional should not rely on second hand accounts of what the advance decision might say but, if it is written, try to obtain a complete copy[125].

[125] NHS Cumbria CCG v Rushton [2018] EWCOP 41 (21 December 2018), available at: - https://www.bailii.org/ew/cases/EWCOP/2018/41.html.

11.58 Once they know a verbal or written advance decision may have been made, healthcare professionals must determine whether:

- it exists, both as a document (if one was created), and as a matter of law, i.e. that the person had capacity to make it (see paragraph 11.47 – 11.48)
- it is valid (see paragraph 11.49), and
- it is applicable to the proposed treatment (see paragraphs 11.50-11.53)

11.59 When establishing whether an advance decision applies to current circumstances, healthcare professionals should take special care if the decision does not seem to have been reviewed or updated for some time. If the person's current circumstances are significantly different from those when the decision was made, the advance decision may not be applicable. People close to the person concerned, or anyone named in the advance decision, may be able to help explain the person's prior wishes.

11.60 If healthcare professionals are satisfied that an advance decision to refuse treatment exists, is valid and is applicable, they must follow it and not provide the treatment refused in the advance decision.

11.61 If healthcare professionals are not satisfied that an advance decision exists that is both valid and applicable, they can treat the person but should be aware that they could be charged with assault. The treatment must be in the person's best interests (see chapter 5). In the case of doubt about existence, validity or applicability, healthcare professionals should always consider (usually with legal advice) whether an application to the Court of Protection is required.

11.62 The Court of Protection can settle disagreements about the existence, validity or applicability of an advance decision (paragraph 11.78). Section 26 of the Act allows healthcare professionals to give necessary treatment, including life sustaining treatment, to stop a person's condition getting seriously worse while the court decides.

11.63 If an advance decision is not valid or applicable to current circumstances:

- healthcare professionals must consider the advance decision as part of their assessment of the person's best interests (see chapter 5) if they have reasonable grounds to think it is a true expression of the person's wishes
- they must not assume that because an advance decision is either invalid or not applicable, they should always provide the specified treatment (including life-sustaining treatment) – they must base this decision on what is in the person's best interests.

Do advance decisions apply in emergencies?

11.64 A healthcare professional must provide emergency treatment in the patient's best interests, unless they are satisfied that there is an advance decision that is:

- valid, and
- applicable in the circumstances

11.65 Healthcare professionals should not delay emergency treatment to look for an advance decision if there is no clear indication that one exists. But if it is clear that a person has made an advance decision that is likely to be relevant, healthcare professionals should assess its validity and applicability as soon as possible. Sometimes the urgency of treatment decisions will make this difficult.

When can healthcare professionals be found liable?

11.66 Healthcare professionals must follow an advance decision if they are satisfied that it exists, is valid and is applicable to their circumstances. Failure to follow an advance decision in this situation could lead to a claim for damages for battery or a criminal charge of assault.

11.67 But they are protected from liability if they are not:

- aware of an advance decision, or
- satisfied that an advance decision exists, is valid and is applicable to the particular treatment and the current circumstances (section 26(2))

11.68 Once they become aware of the advance decision to refuse treatment, the healthcare professional should consider whether to continue treatment.

11.69 Healthcare professionals will be protected from liability for failing to provide treatment if they 'reasonably believe' that a valid and applicable advance decision to refuse that treatment exists. But they must be able to demonstrate that their belief was reasonable (section 26(3)) and point to reasonable grounds showing why they believe this. Healthcare professionals can only base their decision on the evidence that is available at the time they need consider an advance decision.

11.70 Some situations might be enough in themselves to raise concerns about the existence, validity or applicability of an advance decision to refuse treatment. These could include situations when there is:

- a disagreement between relatives and healthcare professionals about whether verbal comments were really an advance decision

- evidence about the person's state of mind raises questions about their capacity at the time they made the decision (see paragraphs 11.13-11.15)
- evidence of important changes in the person's behaviour before they lost capacity that might suggest a change of mind.

11.71 In cases where doubt remains about the existence, validity and/or applicability of an advance decision which cannot be resolved in any other way, the matter should be brought to court as soon as possible (see 11.78-11.81).

What if a healthcare professional has a conscientious objection to stopping or providing life-sustaining treatment?

11.72 Some healthcare professionals may disagree in principle with patients' rights to refuse life-sustaining treatment. They do not have to do something that goes against their beliefs. But they must not simply abandon patients or cause their care to suffer.

11.73 Healthcare professionals should make their views clear to the patient and the healthcare team as soon as someone raises the subject of withholding, stopping or providing life-sustaining treatment. Patients who still have capacity should then have the option of transferring their care to another healthcare professional, if it is possible to do this without affecting their care.

11.74 In cases where the patient now lacks capacity but has made a valid and applicable advance decision to refuse treatment which a doctor or health professional cannot, for reasons of conscience, comply with, arrangements should be made for the management of the patient's care to be transferred to another healthcare professional[126]. Where a transfer cannot be agreed, the Court of Protection can direct those responsible for the person's healthcare (for example, a trust, doctor or other health professional) to make arrangements to take over responsibility for the person's healthcare (section 17(1)(e)).

What happens if there is a disagreement about an advance decision?

11.75 It is ultimately the responsibility of the healthcare professional in charge of the person's care when the treatment is required to decide whether there is an advance decision which is valid and applicable in the circumstances. In the event of disagreement about an advance decision between healthcare professionals, or

[126] *Re B (Adult: Refusal of Medical Treatment)* [2002] EWHC 429 (Fam) at paragraph 100(viii), available at:- https://www.bailii.org/ew/cases/EWHC/Fam/2002/429.html.

between healthcare professionals and family members or others close to the person, the senior clinician must consider all the available evidence. This is likely to be a hospital consultant or GP where the person is being treated in the community.

11.76 The senior clinician may need to consult with relevant colleagues and others who are close to or familiar with the patient. All staff involved in the person's care should be given the opportunity to express their views. If the person is in hospital, their GP may also have relevant information.

11.77 The point of such discussions should not be to try to overrule the person's advance decision but rather to seek evidence concerning its validity and to confirm its scope and its applicability to the current circumstances. Details of these discussions should be recorded in the person's healthcare records. Where the senior clinician has a reasonable belief that an advance decision to refuse medical treatment is both valid and applicable, the person's advance decision should be complied with.

When can somebody apply to the Court of Protection?

11.78 The Court of Protection can make a decision where there is genuine doubt or disagreement about an advance decision's existence, validity or applicability. But the court does not have the power to overturn a valid and applicable advance decision.

11.79 The court has a range of powers (sections 16–17 of the Act) to resolve disputes concerning the personal care and medical treatment of a person who lacks capacity (see chapter 7). It can decide whether:

- a person has capacity to accept or refuse treatment at the time it is proposed
- the person had capacity to make the advance decision at the time
- an advance decision to refuse treatment is valid
- an advance decision is applicable to the proposed treatment in the current circumstances

11.80 While the court decides, healthcare professionals can provide life-sustaining treatment or treatment to stop a serious deterioration in their condition. The court has emergency procedures which operate 24 hours a day to deal with urgent cases quickly[127]. See chapter 7 for guidance on applying to the court.

11.81 Where the court is satisfied that a valid advance decision to refuse treatment exists covering the situation, it cannot then make a best interests decision about the treatment.

[127] Details on making an urgent or emergency application to the Court of Protection, available at: https://www.gov.uk/emergency-court-of-protection.

How do advance statements and advance care and support plans differ from advance decisions?

11.82 Advance statements can be made about any aspect of care or accommodation or lifestyle. They are considered as evidence of the person's wishes when a best interests decision is being made (chapter 5), however, unlike advance decisions, an advance statement is not legally binding.

11.83 Advance care and support plans are used to record treatment and care wishes so that they can be taken into account when a best interests decision is being made. Like advance statements, they are not legally binding. They may however contain details of any advance decision, advance statement or health and welfare LPA.

12. What is the definition of a Deprivation of Liberty?

The Liberty Protection Safeguards (LPS) can only be used to authorise arrangements that give rise to a deprivation of liberty. This chapter introduces and explains what is meant by a deprivation of liberty.

A LPS authorisation should only be sought if a less restrictive alternative is not available. Therefore, it is important to first consider whether arrangements can be put in place which do not amount to a deprivation of liberty.

Further legal developments may occur after this guidance has been issued and health and social care staff need to keep themselves informed of legal developments that may have a bearing on their practice.

Quick summary

Freedom to leave

- ‘Freedom to leave’ means the ability to leave permanently, for example in order to live where, and with whom, they choose.

Continuous supervision and control

- ‘Continuous supervision and control’ means the person not being left alone for significant periods of the day and not being allowed to make decisions about their own life. For example, about the activities they do during the day or where they live.

Consent and capacity

- **A person can only be considered to have been deprived of their liberty if they have not provided valid consent to the confinement in question. If a person does not have the relevant capacity, then consent cannot be given**
- **The test of capacity where the arrangements are being carried out in the person’s own home is likely to be less onerous.**
- **Consent to what would otherwise be a deprivation of liberty can be given in advance in cases where valid consent has been given when the person had the relevant capacity. However, the arrangements must fall within the parameters specified by the advance consent.**

Medical treatment

- Deprivation of liberty will not occur in cases where medical treatment for a physical disorder is being provided, in any setting, which is materially the same as that provided to a person without a mental disorder

What are the three components of a deprivation of liberty?

12.1 The courts have confirmed, in a number of cases, that a deprivation of liberty has three parts:

- the person is being **confined** in a restricted space for a non-negligible period of time ('the objective element')
- the person has not validly **consented** to that confinement ('the subjective element'), and
- the state is **responsible** for the confinement ('state imputability').[128]

12.2 This chapter will explain what each of these means and how, when considered together, they may indicate whether someone is being deprived of their liberty. It is important to remember that all of these three components must be in place in order for a deprivation of liberty to occur.

When does confinement occur?

12.3 In order for a person to be deprived of their liberty, there must be confinement in a restricted space for a non-negligible time period.

12.4 The starting point in assessing whether there is confinement in this sense should always be "the concrete situation" of the person.129 This will require consideration of a whole range of criteria such as:

- the **duration** of the measures,
- the **effects** of the measures, including any hardships the person experiences as a result, and
- the **type** of **measure** and manner of its implementation, including the specific context and circumstances.[130]

12.5 Meeting one of these criteria does not necessarily mean there is a confinement, but the combination of these considered together may have that result. However, if

[128] For example, *Storck v Germany* (2005) 43 EHRR 96 (App No 61603/00) at [74] and [89].
[129] *Guzzardi v Italy* (1980) 3 EHRR 333 (App No 7367/76) at [92].
[130] As above.

one is implemented in a particularly restrictive way, this could mean a confinement arises.

12.6 The difference between confinement and restriction upon liberty is "merely one of degree or intensity, and not one of nature or substance".131 In other words, it is not about the nature of the measures and where they take place; but how they are applied. Section 6 of the Mental Capacity Act 2005 (the Act) provides that the use of restraint – which falls short of confinement – will not attract protection against liability unless the individual taking the action reasonably believes it is necessary to do so in order to prevent harm to the person; the restraint must also be a proportionate response to the likelihood of harm and the seriousness of that harm.

How does duration define confinement?

12.7 For a deprivation of liberty to arise, a person must be confined for more than a negligible period of time. There is no fixed definition of how long such a period would be; it will vary according to the individual circumstances. A person may be confined for a long time and not be deprived of their liberty, whereas a very short confinement may constitute a deprivation of liberty.

12.8 Nevertheless, as a general rule, the longer a confinement lasts, the stronger the case for finding that a deprivation of liberty has taken place; a shorter period requires greater reliance on other factors.

12.9 In deciding whether a confinement for a short period of time will amount to a deprivation of liberty, the following factors in particular will need to be considered. The presence of any of these will make it more likely that a deprivation of liberty will be, or is, occurring:

- the use or threat of force or coercion;
- particularly severe or serious forms of restraint, and;
- the consequences of the restrictions for the person.

12.10 If a deprivation of liberty does not arise because the time period is negligible, then it is likely that the act is a restriction of liberty, and you will be able to rely on section 6 of the Act (see para 12.6), as long as the confinement is necessary and proportionate.

12.11 It is important to note that case law has never suggested a fixed time period for a deprivation of liberty and has always emphasised that it will vary according to individual circumstances.

131 As above at [93].

What is the test for a confinement?

12.12 The leading domestic legal case about the meaning of a confinement is the Supreme Court decision known as "Cheshire West".132 This decision concerned three individuals, all of whom lacked capacity to consent to their care arrangements, whose situation is summarised below.

Mr P

Mr P, aged 37, lived in a staffed bungalow with two other residents. There were normally two members of staff on duty during the day and one 'waking' member of staff overnight. Mr P required prompting and help with all activities of daily living, getting about, eating, personal hygiene and continence. He sometimes required intervention when he exhibited challenging behaviour but was not prescribed any tranquilising medication. He was unable to go anywhere or do anything without one-to-one support. The level of support available meant that Mr P was able to leave the home frequently for activities and visits.

MIG and MEG

MIG and MEG were sisters who had learning disabilities, aged 18 and 17 respectively. MIG had sight and hearing conditions, communicated with difficulty, and required help crossing the road because she was unaware of danger. She lived with her foster mother whom she regarded as 'Mummy'. Her foster mother provided her with intensive support in most aspects of daily living. MIG was not on any medication. She was not restrained or locked in. She had never attempted to leave the home by herself and showed no wish to do so, but, if she had done so, her foster mother would have restrained her. MIG attended a further education college daily during term time and was taken on trips and holidays by her foster mother.

MEG lived with three others in a small NHS residential home. She had occasional outbursts of challenging behaviour towards the other residents and sometimes required physical restraint. MEG was prescribed (and administered) tranquilising medication to control her anxiety. She was not in a locked environment, but had one-to-one, and sometimes two-to-one, support. MEG was accompanied by staff whenever she left the residential home. She attended the same further education college as her sister daily, during term time, and had an active social life. She showed no wish to go out on her own, so there was no need to prevent her from doing so. But it was accepted that if she had tried to leave, she would have been restrained or brought back for her own safety.

[132] *P v Cheshire West and Chester Council* and *P v Surrey CC* [2014] UKSC 19, [2014] AC 896.

12.13 The Supreme Court held by a majority that Mr P, MIG and MEG had all been deprived of their liberty. Lady Hale, giving the leading judgment, set out a view on the key features from the relevant case law when it comes to considering the "concrete situation" of the person. She referred to this as the "acid test", which involved determining whether the person concerned is (1) under continuous / constant supervision and control, and (2) not free to leave. Both conditions must be satisfied for a situation to be considered a deprivation of liberty.

12.14 Lady Hale also confirmed that the following were not relevant to the question of whether a person is deprived of liberty:

- the person's **compliance** or lack of objection,
- the relative **normality** of the placement (whatever the comparison made), and
- the **reason or purpose** behind a particular placement.

Freedom to leave

12.15 In order to be deprived of liberty, the person must not be free to leave. The starting point for determining the person's ability to leave should be whether the person can leave permanently. Freedom to leave does not simply mean the ability to leave the place in question for the purpose, for example, of a trip or visiting the shops, although this may be relevant. It refers to leaving in the sense of the person being able to permanently remove themselves. For example, in order to live where and with whom they choose or to permanently remove themselves from some a place or situation.

12.16 It is important not to conflate "freedom to leave" with "ability to leave" or "attempts to leave". This means, for example, that if the person does not attempt to leave or express a wish to leave, it does not automatically mean that they are free to leave. The focus instead should be the actions (or proposed actions) of those around the person, rather than the person themselves. For example, decision makers may need to consider the following questions:

- What does the person's care and support plan say about what would happen if the person tried to leave or expressed a desire to leave, or if a friend / relative wanted to remove the person?
- Would steps be taken to stop the person if they attempted to leave the accommodation (including calling the police to return them)?
- Are there any concrete plans in place to deal with situations where, for example, a friend or family member might attempt to assist the person to leave?
- What assistance (if any) is available to the person to support them to leave?
- Have family or friends been told not to remove the person from the accommodation?
- Has the person been told they will not be permitted to go home?

12.17 You will also need to consider the practical, concrete options that are available, as well as the person's existing care regime. For example, if the person is in hospital, the viability of a return home – including what support would be available –may need to be considered.

12.18 A person also may not be considered free to leave if the options available to them are constrained or prescribed by someone else. For example, if a care home resident is only being offered one or more alternative care home placements, this does not necessarily mean they are free to leave in the sense that they can choose to live where they wish. But this depends on there being suitable alternative options available; if the person does not have a "home", then offering alternative care homes may mean that the person is in fact free to leave.

12.19 In Cheshire West, the dispute was about the long-term living arrangements where there was no question of the adults being able to leave the accommodation on their own. However, not all deprivations of liberty will involve questions of residence or living arrangements, and the "ability to leave" limb of this test will need to be adjusted accordingly. For example, in relation to transport arrangements you will need to consider whether the person could refuse the transport altogether (i.e., walk away and not be transported). When it comes to day centre arrangements, you will need to consider whether the person can leave the day centre and do when and if they choose, something else instead.

12.20 Determining freedom to leave will also be particularly challenging where the person lives in their own domestic or family home, which is perhaps where they have lived happily for a considerable period of time. In such cases, it may not make sense to consider whether the person is free to leave their home permanently. Instead, the consideration should be what would happen if they tried to leave temporarily. For example, would they be stopped in order to prevent them from walking into the road and putting themselves at risk.

Scenarios: Freedom to leave

Mr W is a 21-year-old with severe learning disabilities, autism, and complex needs. He lives in a residential home and is not objecting to his placement. Mr W is unable to acknowledge and absorb information relating to his accommodation or his care and treatment. Due his high level of need, the family are unable to look after him at home and there is no other placement suitable to meet his complex needs. He cannot leave his home permanently, as his needs could not be met elsewhere. The care and support plan indicates that he would be prevented from leaving the home if he tried to leave, including through the use of restraint. Mr W is not free to leave.

Miss Y is a 22-year-old with learning disabilities. She lives in supported living and is not objecting to her placement. Miss Y has also been offered a range of alternative accommodation. However, she prefers living where she is because of the location of the accommodation (it is near her family and the shops) and she gets on well with the other residents. Miss Y can leave her accommodation and would be supported to move to alternative accommodation if she indicated that she wanted to do this. Miss Y is free to leave.

Continuous Supervision and Control

12.21 To be deprived of their liberty, a person must be under continuous supervision and control. Both elements must be present in order for a confinement to occur; if not, there is no confinement.

12.22 It is important to note that there is a considerable degree of overlap between supervision and control. For example, the purpose of the supervision can often be to control the person (and vice versa). The two concepts can also interact with each other: a great degree of one with less of the other may still be a deprivation of liberty. Someone may not appear at first glance to be under constant supervision, but the level of complete control they are under means that this impacts on the supervision, and there may be a deprivation of liberty.

12.23 In some decisions, the courts refer to either “continuous” or “constant” in relation to the supervision and control; but in other decisions, both terms are used interchangeably (as in the Cheshire West judgment). In practice, there is little difference in the meaning of “continuous” and “constant”. As a general rule, decision makers should avoid focusing on one term at the expense of the other; for example, looking at “continuous” on its own might lead to unnecessary and unhelpful focus on periods of time.

12.24 It is very important to bear in mind that supervision and control should not be downplayed inappropriately as support. For example, in relation to MIG (see scenario above) the constant/continuous supervision and control included attending college and going out on trips accompanied. One person's support could be another person's supervision and control, and much will depend upon whether the person is being provided with support in order to facilitate something they have expressed a wish to do (see paragraphs 12.36 to 12.38 for more information).

What is continuous supervision?

12.25 Supervision means the 'monitoring' or 'observation' of the person in order to keep them safe or protect them from harm. This would include direct 'eyes on' supervision, or indirect supervision where the person was being monitored 'remotely', and where there would be intervention if the person appeared to be at risk of harm.

12.26 One way to answer the question of whether the person is subject to continuous supervision is to ask whether the individual or body responsible for the person have a plan in place which means that:

- at all times they know where the person is, and
- at all times they know what the person is doing, and
- they would intervene to protect the person if they were at risk of harm.

12.27 If all three are present, then the person may be under continuous supervision. This is particularly likely to be the case if the plan sets out what the individual or body responsible for the person will do in the event that they do not know where the person is and what they are doing.

12.28 The three points in para 12.26 may also be relevant to the level of control the person is under. For example, if those responsible for the person always know what the person is doing, it may be that that is for the purpose of controlling what the person is doing. See paragraphs 12.31 to 12.38 for more information on continuous control.

12.29 Whether or not a person is subject to continuous supervision is something that will have to be assessed on a case by case basis. In doing so, it will be relevant to consider the setting that the person is in. In a care home, for example, any the following will often be relevant in assessing the level of supervision (as well as being potentially relevant to control):

- Does the person have time alone in their room whenever they want?
- Are they free to make choices about actions or activities?
- Is the person temporarily locked in their room?

- Is the person subject to being checked frequently (at least once every half an hour)?

12.30 In domestic and community settings it is important to bear in mind the reality of the situation. A person living in their home may well be accompanied by someone most of the time purely by the nature of living together, but this does not necessarily amount to continuous supervision. In particular, decisions makers may need to consider if the person has time alone in a room, for example a bedroom or a living room, if they go there of their own volition and are they free to leave that room and move to another room if they wish. If the answer to these questions is yes, the person is not necessarily under continuous supervision. On the other hand, if the carer/family member is in the same room as the person for the purposes of supervision, or if the person is always followed by the carer/family member when they move from one room to another, this might amount to continuous supervision.

What is continuous control?

12.31 Control can be defined in terms of another making decisions of importance in the person's life, including the place they live, activities the person undertakes, who they are in contact with, and their care and treatment. The individual making the decisions may be a family member, a paid or unpaid carer, or a professional.

12.32 In particular, the following should be considered.

- **Location:** has the person decided (either in the past when they had capacity or now) where they want to live, or indicated that they are happy or unhappy with their residence?
- **Activities:** In the place that they live, how much of a say do they have over what they do each day?
- **Contact:** are there any restrictions over who they see and visit?
- **Restraint:** are they **medicated** or **physically** restrained to an extent which deprives them of the ability to carry out their own wishes over a certain matter and have freedom over it?

12.33 In some cases, the level of care that the person receives can be directly related to the level of control. For example, a person may need 24-hour care and help with all activities of daily living, getting about, eating, personal hygiene and continence.

12.34 However, this in itself does not mean that the person is continuously controlled, if they are making decisions which facilitate their own wishes and feelings, such as when to eat or what they want to do each day. Decision makers should consider how far they are supporting the person to carry out these tasks in accordance with the person's views and preferences, as opposed to controlling when, where or how they carry out these tasks. If the person is being provided with support in

order to facilitate something they have expressed a wish to do, such as help going on an outing, then this may not on its own amount to continuous control.

12.35 Similarly, most care environments will have a predetermined schedule as part of care, for example, set mealtimes and bedtimes. It would be highly unlikely that any of these alone would count as control, particularly if the person has freedom around these scheduled events. As a general rule, measures which are applicable to all residents and intended to facilitate the proper management of the premises should not be regarded as control. However, if large parts of the day are pre-planned in terms of the person not being allowed to go out or choose to do something different with their day as there would be no one available to watch them, then this could constitute control.

12.36 The person's ability to come and go from their home temporarily – on a regular basis – is sometimes linked to the level of control they are under. It is important to consider whether they are free to make their own choices or whether for large parts of the day they are under the control of another and are not able to choose activities, locations and/or timings.

12.37 There may be times when a carer does not allow a person to leave for their own safety, for instance because the person is drowsy having received medication. This will not necessarily mean that the person is under continuous control and may amount to a mere restriction of the person's liberty in their best interests. This will have to be assessed on a case-by-case basis.

12.38 However, somebody who needs assistance to leave a place and who may require support when they have left their home, can still be considered not subject to control. For example, a person may not be able to leave immediately because there is no carer available. This would not necessarily be confinement, but decision makers should consider how long the delay would be and how frequently this situation would occur.

Continuous control: scenarios

Mrs B is an 83-year-old with dementia. She lives in a residential home and is not objecting to her placement. She regularly asks to go to the shops and the care staff will accompany her at least once a week at a time agreed by Mrs B and the care staff. This is not by itself continuous control

Mr C is an 87-year-old man and has dementia. He lives in a supported living facility and is not objecting to his placement. Mr C is not allowed to go out

without permission and must tell staff where he is going. He is generally able to go out two or three times a week at a time determined by staff. At all other times he spends his time as he wishes. This is control, but does not amount to continuous control.

Devices for indirect monitoring

12.39 Technology put in place to enhance a person's well-being would not normally on it's own count as supervision or control. Examples of these devices would be:

- wearable tech to monitor the person's health, e.g. heart rate and insulin checkers, and
- monitoring devices in the kitchen such as a fridge monitor or an oven/gas monitor.

12.40 In other cases, the technology may have been put in place to exert some degree of supervision or control over the person, and decision makers should consider whether, in the circumstances of the case, this amounts to continuous supervision and control. For example, the following – on their own – are unlikely to amount to constant supervision and control:

- CCTV is being used some parts of the person's accommodation,
- if the person has a GPS tracker to monitor where they are, but it is not known what they are doing;
- if the GPS tracker is taken off or turned off at certain times, or the data is not being reviewed; or
- if an alarm is triggered when the person leaves their residence.

12.41 However, if the purpose of the CCTV, the tracker or the alarm is to enable staff or carers to react and intervene if the person was at risk of harm, then this is more likely to be constant supervision and control.

12.42 Therefore, decision makers should always consider the purpose of the use of technology. The true effect of such devices on liberty depends not on the information conveyed, but what action is taken in response to them. For example, the supervision and control is unlikely to be constant if the purpose of the devices is to ensure a person can be located (without forcing their return), or ensure that if they go to a place of potential danger, authorities are at least aware of the situation and the person is encouraged, though not forced, to return.

Supervision and control in domestic settings

12.43 As in the case of determining the level of supervision (see above), in domestic and community settings it is important to bear in mind the reality of the situation. The following scenario is an example where the person is unlikely to be confined.

Mrs L

Mrs L is a 93-year old woman with Alzheimer's disease who has lived in a flat (which she also owns) for nearly 40 years. She has a strong sense of belonging in her home. Care and safety arrangements have been set up for her by her adult daughters and the local authority. These arrangements include:

- a fence and two gates have been erected in order to enclose her garden,
- the front door which leads into the garden, is locked, but Mrs L can operate it so she can access the garden when she wishes,
- door sensors would be activated if Mrs L were to leave the property at night, and an alarm call would be automatically be made to one of her daughters nearby and, if not available, to emergency services. This would enable Mrs L to be guided safely back home, and
- a local authority arranged care package consisting of three visits a day by specialist dementia carers

Mrs L has ample time to spend as she wishes, she is orientated in her home, and her home environment gives her considerable pleasure and stimulation. The carers' visits are the minimum necessary for her safety and well-being, being largely concerned to ensure she is eating, taking liquids and coping generally in other respects. This is not continuous supervision and control.

12.44 In determining cases such as Mrs L, you will need to consider the fact that the person is living in their own home as a relevant factor to be considered. In other words, this should be one of the factors to be considered in looking at the concrete situation of the person.

Scenarios: continuous supervision and control

Jennifer

Jennifer is in her 80s and lives in a care home. She is in the early stages of dementia. Whilst in the care home, she can freely come and go from communal areas and into her room. The care home has staff that conduct a routine check of all the areas, but there is not a member of staff present at all times. The care home has a large garden which Jennifer can use freely, although it has an alarm which is triggered if a resident tries to leave the premises. Jennifer usually goes out once a week with a family member when they visit (without permission from staff) and sometimes on excursions organised by the care home.

Conclusion: This in itself is not a deprivation of liberty: the LPS do not apply. There is some supervision as would be expected in a care home, but it is not continuous in either the communal areas or in her private room. She is also able to leave temporarily.

Edward

Edward has severe dementia and has been placed by his local authority in a nursing home. He has nowhere else to live. Edward is on a locked ward and he is not allowed to leave without permission and one-to-one staff support. He spends most of his day in a communal day room where a member of the care staff is always present. He goes to his bedroom sometimes during the day and is in his room during the night. When he is in his bedroom, the care team check on him roughly every half an hour.

Conclusion: Edward is not free to leave, and subject to continuous supervision and control. The acid test is met and the LPS should be applied.

Marsha

Marsha is a woman in her 40s with schizophrenia. The care home normally keeps her in the care home until mid-morning to ensure that she does not go out when she is overly drowsy or disorientated following her morning medication. After this she is able to go out unescorted for as long as she wishes, provided she returns by 9pm. She does this reliably but, if she did not return, the care home would notify the family to see if they knew her

whereabouts and would bring her home. If her whereabouts were not known, they would report the matter to the police.

Conclusion: This – in itself – is not a deprivation of liberty and the LPS do not apply. Marsha is not continuously supervised and is not subject to complete control. Not being permitted to go out before 11am is a restriction (in place for her safety) rather than a deprivation of liberty.

Jack

Jack has dementia and lives in a care home. He chooses to spend about half of the day in his room where he likes to watch classic films. Otherwise, he stays in the living or dining room, both of which have staff going in and out of to check on the residents. He can go out into the garden, but if he attempts to leave the garden he will be guided back. He goes on one group excursion a week. There is nowhere else for him to live and he would not be allowed to move out permanently.

Conclusion: Jack is not free to leave the garden, but importantly the level of supervision is not continuous. The acid test is not met

Karim

Karim is 30 years old and has autism, cerebral palsy, hearing and visual impairments, and a learning disability. He resides in a one-bedroom adapted flat with 1:1 support at all times. Members of staff look after him there to ensure he does not place himself in danger. He requires permission to go out and, when he does, must always be accompanied by a member of staff (such support is normally available on two or three afternoons each week). Whilst content in his flat, Karim would prefer to move back to live with his parents. However, the local authority does not think this is appropriate, mainly because his parents would be unable to cope, and it is not willing to provide alternative accommodation.

Conclusion: As Karim is under continuous supervision and control on a 1:1 basis at all times, and is not free to leave permanently, he is deprived of his liberty.

Tom

Tom is a 30-year-old man with a learning disability. He goes out to college three days per week. A carer escorts him and collects him but does not stay with him. When in his shared accommodation he is often accompanied by his

carer but not supervised all the time. He has access to his bedroom and other rooms in the house when he is alone. At college he is supervised whilst in class but has free time at breaks.

Conclusion: This – by itself – is not a deprivation of liberty and the LPS do not apply. This is because Tom is not subject to continuous supervision or control as he is able to choose where to go and what to do both inside and outside the house.

Jake

Jake lives with his wife and has dementia. The front door is always locked to stop him wandering out into the road. When his wife goes to the shops, she leaves Jake at home with the door locked, but he is still able to wander around the house. She tries to time this with when a carer is scheduled to check in on him too. But this is not always possible. During the day, Jake is able to choose what to do in the house and, for example, likes to paint and draw. Jake is unable to go out often, mainly because his wife does not feel capable of looking after him when outside. The local authority is not willing to provide additional carers.

Conclusion: Jack is under some degree of control, but he is not subject to continuous supervision. The acid test is therefore not met.

Mina

Mina is 71 years old and has dementia. She lives in a care home and needs assistance with all aspects of her care and treatment. She is able to use the garden as she wishes, and there are no locked doors or any other barriers to prevent her from leaving the care home. On most community outings she is escorted by staff. She is allowed to go out by herself to the shops or to do other errands for about 30 minutes per day, with the agreement of the care home manager, as long as it is safe to do so. Mina also spends two nights per week with her daughter every fortnight. She is unhappy at the care home and wants to return to her home; her family, care home staff, and other professionals are agreed that she is not able to look after herself at home.

Conclusion: Mina is not subject to constant supervision and control and therefore is not deprived of her liberty.

Young people and the acid test

12.45 The LPS apply to 16- and 17-year-olds as well as adults aged 18 and over. Case law has indicated that when it comes to 16- and 17-year-olds different considerations will often need to be applied when it comes to the acid test; namely, that the comparator for the young person is not a fully matured adult, but rather a person of the same age and relative maturity who does not have a disability.[133] However, in practice, a person of the same age and maturity will be very similar, for the purposes of the comparator, as an adult. This means there may be very little difference, in reality, between the approach towards young people and adults. But it is important to proceed on a case-by-case basis, having regard to the actual circumstances of the young person.

Jason

Jason lives at home with his parents. He has a learning disability and attends a day special school from Monday to Friday. He is in year 11 and has just turned 16. At school, Jason has a level of need that requires supervision at all times. He stays with a support worker during break times, who is also supervising other young people, which therefore limits how Jason can spend his break. He is also unable to go to a different school, as there is not another school in his local area able to meet his needs.

At home, Jason's parents do not supervise him all times. Jason can move around his house freely and do what he wants, for example, he often decides to watch TV in his bedroom. He is not allowed to leave the house on his own, unlike his brother who is 15 and does not have a learning disability.

Conclusion: Jason is deprived of his liberty at school. As he is now 16, an LPS authorisation would be required. At home, Jason is not deprived of his liberty. Whilst he is not free to go out on his own, his parents are not continuously supervising what he does in the house.

[133] *Re D (A Child)* [2019] UKSC 42.

Sophia

Sophia is 17 and lives with her foster family, whom she has lived with for 5 years. She has a learning disability and a neurological condition which restricts her physical movement. Sophia's foster parents must therefore be with her at all times in case she needs anything. Sometimes, her foster parents are doing something else whilst watching her, such as cooking dinner or helping their other foster children – Sophia is therefore not able to move rooms or choose to do something else. Sophia's foster parents have cared for her a long time and have become family to her. They are also trained to care for Sophia. It would be possible for Sophia to be moved to another foster placement, but it would be disruptive to her care and she is happy with her foster family.

However, every two weeks, Sophia goes to a respite service for a long weekend. At the respite service, Sophia has a dedicated carer who supports her over the weekend. This carer is with Sophia at all times, however, she is able to spend her time how she chooses and the carer would support her to change activity or rooms when she wants to. Sophia is not able to refuse respite care and would not be free to go home whenever she chose.

Conclusion: Although Sophia could leave the foster placement, she would be placed into another foster placement and is therefore not free to leave. She is also continuously supervised and controlled at home. Sophia is therefore deprived of her liberty at home.

When Sophia visits the respite services, she is not free to leave. However, she is not continuously controlled as she is able to spend her day how she chooses. Sophie is therefore not deprived of her liberty in her respite service.

What does it mean to give valid consent?

12.46 This part of the guidance should be read alongside chapter 4 on assessing capacity (including the discussion on fluctuating capacity).

12.47 A person can only be considered to have been deprived of their liberty if they have not provided "valid consent" to the confinement in question. The courts have

considered that, if a person does not have mental capacity to consent to the confinement, then consent cannot be given by the person.134

12.48 The consent must be that of the person; so for example a donee under a lasting power of attorney, or a deputy appointed by the Court of Protection, cannot consent on behalf of the person to the arrangements. It is important to ensure that consent has been given freely and the person has not been coerced or pressured into giving it. Wherever possible the person should be supported to make the decision for themselves.

12.49 A parent cannot consent to arrangements that would otherwise amount to a deprivation of liberty of a 16 or 17-year-old.135 In such cases the LPS would normally be needed to authorise the deprivation of liberty.

12.50 When it comes to assessing a person's capacity to consent to the arrangements, decision makers must apply sections 2 and 3 of the Act, and the principles in section 1. Section 2 provides that

> "… a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain."

12.51 Section 3 provides that a person is unable to make a decision if they are unable to:

- understand the information relevant to the decision;,
- retain that information;
- use or weigh that information as part of the process of making the decision, or;
- to communicate their decision.

12.52 It is therefore important for the decision maker to be able to identify the information relevant to the decision to consent to the arrangements in question. Decision makers must also give or provide the information to the person themselves. When it comes to arrangements, the starting point would be the following information:

- what type of arrangements are being proposed;
- who will be carrying out the arrangements;
- where and how will the arrangement be implemented, and;
- what will happen if the arrangements are not put in place.

12.53 When it comes to arrangements being carried out in the person's own home, the test of capacity will normally be less onerous compared to – for example –

[134] *HL v UK* (2005) 40 EHRR 32 (App No 45508/99).
[135] *Re D (A Child)* [2019] UKSC 42.

arrangements carried out in a hospital or care home. In particular, the following points may need to be considered:

- In many cases the person can recognise the types of arrangements, since they will be very similar to those that have been in place for some time.
- Often the person will already know those carrying out the arrangements; people such as loved ones or long-term private carers,
- Where and how the arrangements are implemented may be very similar to those that have been in place for some time.
- The notion of what will happen if the arrangements are not put in place might be less relevant to consider in a domestic setting, unless there are concrete plans for alternative arrangements such as a care home placement.

12.54 Therefore, when it comes to domestic settings, the person may be more likely to be able to consent to the arrangements. This approach might also be relevant in other settings, such as a care home or supported living where the person had chosen to live in the accommodation before losing capacity to consent, have lived for some period of time, and have shown strong sense of belonging.

Advance consent

12.55 A deprivation of liberty does not arise if the person has capacity to, and gives, consent to the care or treatment arrangements. This applies even if the person lacks capacity to make decisions on other matters. Such consent is normally provided at the time when the arrangements need to be put in place. But in some cases, a person can consent in advance to specific arrangements that would otherwise amount to a deprivation of liberty. This is often referred to as advance consent.

12.56 If advance consent has been provided, then the person is not being deprived of their liberty. Accordingly, the Responsible Body is not required to authorise the arrangements through the LPS.

12.57 The ability to provide advance consent should always be an important aspect of care planning. It ensures that the person can plan ahead and have a say in the provision made for their future care or treatment and avoid unnecessary and potentially distressing assessments.

12.58 There is no limit on the use of advance consent in particular settings, although there are some settings in which it may be more appropriate, such as end-of-life care. It would also, for example, be possible to use advance consent for the following:

- a set of arrangements for mental health care and treatment in hospital, which would mean that consideration could be given to informal admission in accordance with section 131 of the Mental Health Act 1983, and;

- the period following elective surgery under general anaesthetic, in order to deal with a period of likely post-operative delirium.

12.59 It may be that the person loses capacity temporarily, or their capacity fluctuates. In these cases, it is possible for the person to consent to being deprived of their liberty when they lose capacity, as long as the consent was provided while they had the relevant capacity. Where appropriate, the person should be supported to make this decision. However, the person should never have an LPS authorisation in place at the point at which they have, or regain, capacity to give valid consent.

Deciding whether the advance consent is valid

12.60 Any person aged 16 or over who has capacity to consent to the arrangements, can provide advance consent. In order to give advance consent, the person should clearly articulate the particular arrangements to which they are consenting. The advance consent would not be valid if, for example, the person simply made a general declaration that they consented to any future care or treatment arrangements which would give rise to a deprivation of their liberty.

12.61 The ability to consent, as defined by the Act, is decision specific. This means that the ability to consent to a deprivation of liberty will vary depending on the circumstances. For example, the decision to continue living in a home environment, while having restrictions in place such as the door being locked overnight, is less onerous than deciding to move permanently to a care home or hospital. The decision maker should therefore consider the nature of the decision when determining whether or not a person has capacity to consent to the arrangements.

12.62 Evidence should be provided to demonstrate that advance consent has been given. The following information should be included:

- Full details of the person providing advance consent, including date of birth, and home address.
- The name and address of the health and care professionals involved in the person's care or treatment and whether they have a copy of the document.
- A statement that the document should be used if the person ever lacks capacity to consent to the arrangements in question.
- A clear statement of the arrangements to which the consent applies, and the circumstances in which it will apply.
- The date the document was written (or reviewed).
- The person's signature (or the signature of someone the person has asked to sign on their behalf and in their presence).
- The signature of the person witnessing the signature, if there is one (or a statement directing somebody to sign on the person's behalf) confirming that the person has capacity at that point to make the advance decision.

12.63 If the person has given advance consent to specified arrangements then, it would not remain valid if:

- the person withdraws their consent when they have capacity to do so;
- there are reasonable grounds to believe that circumstances exist which the person did not anticipate when giving advance consent and which would have, if anticipated, affected their decision.
- the person does anything else clearly inconsistent with the advance consent remaining their fixed decision. Depending on the circumstances of the case, this might include where the person has made a further statement which is plainly incompatible with the advance consent, or where the arrangements clearly cause the person a level of distress; or
- evidence emerges which shows that the person was coerced or pressured into giving advance consent.

12.64 Consideration needs to be given to how long ago the consent was given and if there has been any significant change in the person's circumstances. Decision makers should also be satisfied that the person has not been pressured into giving consent. Consent given in advance does not necessarily have to be written, but it cannot be implied or assumed.

12.65 In addition, advance consent would not be valid if the advance consent contains a time period within which it is valid, and that period has expired. For example, the person may consent in advance to specified arrangements in a hospital for up to a week, in order to reflect the expected length of treatment. The advance consent would come to an end at the end of the period specified.

Deciding whether the advance consent is applicable

12.66 Advance consent only applies to arrangements that are put into effect while the person who had given the consent does not have the capacity to give or withhold consent. The arrangements must fall within the parameters specified by the advance consent.

12.67 Advance consent can only be used for arrangements which enable care or treatment to be delivered and which would otherwise give rise to a deprivation of liberty. It cannot, for example, serve as consent to particular medical treatment or treatments or a demand for a particular form of care or treatment.

12.68 The Court of Protection would have the power under section 15(1)(c) of the Act to declare whether an advance consent exists, is valid, or is applicable to particular arrangements, either proposed or put in place.

Lasting powers of attorney and court appointed deputies

12.69 Under the Act, a donee under a lasting power of attorney, or a deputy appointed by the Court of Protection, cannot consent on behalf of a person to arrangements which give rise to deprivation of liberty that would otherwise be a deprivation of that person's liberty. However, a lasting power of attorney or deputyship could co-exist with advance consent. Therefore, a donee or deputy could consent on the behalf of the person to their admission to the relevant care setting. If the person had also given valid advance consent which was applicable to the arrangements made for their care or treatment, the result would be that any confinement to which they were subject would not amount to a deprivation of their liberty, and would not require authorisation under the LPS.

Monitoring

12.70 Where a decision maker is relying on advance consent in circumstances where they would otherwise be applying for authorisation under LPS, they should inform the body who would otherwise be the Responsible Body immediately. In cases where a different body is involved in arranging the care or treatment, that body should be informed at the same time. The Responsible Body should ensure that regular reviews of the person's care and treatment take place, to satisfy itself that the advance consent remains valid and applicable. If staff or family members/friends have concerns about the misuse of advance consent in individual cases, they should contact the local authority to initiate a safeguarding enquiry under section 42 of the Care Act, section 47 of the Children Act 1989, or section 126 of the Social services and Well-being (Wales) Act 2014.

State responsibility

12.71 A confinement must be imputable to the State in order for a deprivation of liberty to arise. This means that, to some degree, the State -in this case an NHS body or local authority - has some level of responsibility for that confinement. The State will be directly responsible if the confinement takes place in a hospital or care home which is run by a public authority (such as the NHS), or if the person has been placed in a care home by a body such as a local authority.

12.72 But the responsibility of the State may arise even without this.

- First, it will arise if there are court proceedings taking place and the court in question has not applied Article 5 of the ECHR properly, and
- Second, under Article 5 there is a positive obligation on the State to protect all of its citizens against interferences with their liberty, whether by public bodies or by private individuals. Public authorities are therefore obliged to take action

to protect individuals, including reasonable steps to prevent a deprivation of liberty of which the authorities have or ought to have knowledge.[136]

12.73 This means the arrangements may be imputable to the State as a result either of the State's "direct involvement" in the person's detention or of the State's positive obligations to protect the person against interferences with their liberty carried out by private persons (i.e. indirect responsibility). Below is an example of indirect state responsibility for a deprivation of liberty.

Mr K

Mr K is aged 38 and as a result of a road traffic accident, suffered significant brain injury and other disabilities. He lacks capacity to make decisions relating to his care and treatment, and financial affairs. Mr K was awarded substantial damages which was approved by the court in civil proceedings. A deputy (a trust corporation) has been appointed by the Court of Protection to manage Mr K's finances and make all decisions regarding his property and affairs.

Mr K requires assistance with all aspects of personal care and daily living. He requires 24-hour care and assistance seven days a week. He has very limited communication. His 24-hour care regime – including the adaptation of his accommodation - has been arranged by his deputy and means that he is under constant supervision and control and is unable to leave his home.

His accommodation and care package were arranged and is provided without any input from the local authority or NHS. The care is supervised by a private specialist brain injury case manager and is provided by private carers. The situation has not been drawn to the attention of a local authority or NHS body.

[136] *Storck v Germany* (2006) 43 EHRR 6 (App No 61603/00) at [102].

12.74 In this case the State is indirectly responsible for the confinement. This is because of the involvement of the court in awarding damages, the Court of Protection in appointing the deputy, and the role of the deputy.

12.75 The arrangements will not be imputable to the state, where the state is not directly or indirectly involved in the arrangements or is not aware (or should not be aware) of the confinement. This is more likely to occur in private domestic settings where the arrangements are being carried out without the knowledge of public authorities.

What should public authorities do if they become aware of a "private" deprivation of liberty?

12.76 Where an NHS body or a local authority knows or ought to know that a person is subject to restrictions that might give rise to a deprivation of liberty, then its positive obligations under Article 5 are triggered. These are as follows:

- to investigate the situation and determine whether there is, in fact, a deprivation of liberty,
- if so, it must take reasonable and proportionate measures to bring that situation to and end (for example through the provision of services), and
- if it cannot bring the deprivation of liberty to an end, the LPS should be considered.[137]

[137] *A Local Authority v A* [2010] EWHC 978 (Fam).

Mrs F

Ms F has severe learning disabilities. Following a severe deterioration of her physical health, she was admitted to hospital and treated for pneumonia and heart problems. When her condition worsened, she was transferred to the hospital's intensive care unit. She was intubated, heavily sedated and on a mechanical ventilator. She has a mitt on one of her hands to stop her removing the tube.

Ms K

Ms K has dementia and has been placed into a care home following a severe stroke. She lacks capacity to consent to her care and treatment. Her muscle tone and strength has been weakened by the stroke, and so she needs constant one-to-one support at all times to help her get about. Staff are present to check her progress throughout the day. She is not allowed to leave the care home unless a member of staff is available. She is also given strong medication to help prevent the risks of a future stroke. This makes her feel lethargic and tired.

Medical treatment for physical health problems

12.77 A deprivation of liberty will not occur if the person is treated for a physical illness and the treatment is given under arrangements that are the same as would have been in place for a person who did not have a mental disorder. In other words, the restrictions on the person are caused by physical health problems and the treatment being provided. The root cause of any loss of liberty is the physical condition, not any restrictions imposed by others (for instance health and care professionals). This approach should be applied to any form of medical treatment for physical health problems and in whatever setting the treatment is being delivered. It should not be limited to hospital settings, but could include any setting where medical treatment is being provided.

12.78 The following scenarios are examples of where a person should not be considered deprived of their liberty.

12.79 In these cases, the restrictions on the person could be categorised as “commonly occurring restrictions on movement” and, since the treatment is materially the same as would have been provided to someone without a mental disorder, it is unlikely to be a deprivation of liberty.

12.80 Decision makers will need to consider carefully the real reason that the arrangements have been put in place:

- Are they a result of the administration of medical treatment for a physical health condition?
- Would they be put in place for any other person, without mental disorder?

If the answer to the above questions is yes, the person is not being deprived of their liberty. If any of the answers are no, then deprivation of liberty might be occurring.

12.81 If the person requires treatment for a physical health condition but due to their mental disorder they require additional significant restrictions – which would not be provided to others who do not have a mental disorder – then it is possible that they are being deprived of their liberty and will need an authorisation under the LPS.

13. What is the process for authorising arrangements under the Liberty Protection Safeguards?

The LPS include a process by which arrangements that may amount to a deprivation of liberty for a person's care or treatment, are considered and may be authorised. If an authorisation is given, the next stages of the process are regular reviews of the authorisation and, where appropriate, the renewal of an authorisation. This chapter covers this process.

Quick summary

Freedom to leave How to recognise the need for an LPS authorisation and how to trigger the process

- **If the proposed arrangements around the person's care or treatment may amount to a deprivation of liberty, then the LPS process should be triggered. Anyone can trigger the process.**

How LPS interacts with other health and care planning

- **If the person's care or treatment is being arranged under a different legal framework, it may be the case that the LPS assessments and reviews should be carried out alongside the person's main health or care and support plan processes.**

The actions required by the Responsible Body once the LPS have been triggered

- **Once the Liberty Protection Safeguards have been triggered the Responsible Body must; Once the LPS have been triggered the Responsible Body should:**
  - consider whether the case is suitable for the LPS
  - establish if it is the correct Responsible Body
  - consider representation and support for the person by an Appropriate Person or IMCA

- commission the medical, capacity, and necessary and proportionate assessments and determinations
- carry out the consultation to establish the person's wishes and feelings.

- **Once the consultation and assessments and determinations have been completed, the pre-authorisation review must take place. The pre-authorisation review is followed by the final authorisation, carried out by the Responsible Body.**

Once an authorisation is in place

- **There are limited occasions on which the Responsible Body may vary an authorisation, where the arrangements themselves are not fundamentally changing.**
- **The Responsible Body must set out a schedule for reviews in the authorisation record.**
- **Authorisations can be renewed, where appropriate, for the first time for up to 12 months. Thereafter an authorisation can be renewed for a period of up to 36 months.**

What are the Liberty Protection Safeguards?

13.1 Sometimes, it may be appropriate to propose arrangements that amount to a deprivation of liberty for a person's care or treatment. If the person lacks the relevant mental capacity to consent to those arrangements, they can only be authorised in accordance with a procedure prescribed by law. When these arrangements are being considered, a number of safeguards should also be put in place to protect the person. This is because liberty is a human right protected by Article 5 of the European Convention of Human Rights.

13.2 The LPS are the process in England and Wales for considering whether such arrangements should be authorised. The LPS also provides a number of safeguards for the person. These include:

- comprehensive assessments and determinations as to whether the authorisation conditions are met,
- the right to representation and support,
- the right to review of an authorisation, and
- the right to challenge the authorisation or arrangements in court.

13.3 In addition to the formal safeguards provided by the scheme, the LPS also puts the person, and their wishes and feelings at the centre of the process. This aims to ensure that the person is involved in decisions about their care and treatment arrangements, and they are aligned as far as possible with the person's preferences. The LPS helps to ensure this through the consultation process. See paragraphs 13.31 to 13.34, and chapter 17.

Integrating the LPS with statutory health and social care processes

13.4 The need to deprive a person of liberty may be identified when a person is being assessed, care planning is taking place, or their care or treatment is being reviewed under other legislation such as the Care Act 2014 or the Social Services and Well-being (Wales) Act 2014. If so, the LPS process may need to be triggered (see para 13.13 to 13.23 below).

13.5 In these scenarios, the LPS process should be carried out alongside other assessment, planning and review processes as far as practicable and appropriate. This helps to reduces unnecessary bureaucracy and the number of processes the person, and their family, have to go through. It will also help to ensure the person's care or treatment plan is closely aligned with the LPS. This chapter sets out how each stage of the LPS process should be carried out alongside these other, statutory processes.

13.6 Some people may not have a statutory health or care plan, and instead may be receiving care either from family and friends or through privately arranged care. Where this is the case, Responsible Body staff should work with the carers to ensure that the person's arrangements going forward are lawful and respect any particular considerations regarding how the carer delivers care to their friend or family member, as far as is practicable and appropriate.

Deciding whether to trigger the LPS process

13.7 The circumstances preceding triggering the LPS process will differ from person to person. Decision makers should always follow the principles of the Mental Capacity Act 2005 (the Act), set out in chapter 4. As far as practicable, the person should be supported to make their own decisions about the arrangements for their care or treatment.

13.8 Where the person is undergoing health or care assessments, planning, or reviews, staff should be alert to anything that may indicate that the LPS process should be triggered. It may be, for example, that considering the appropriate arrangements for the person in the planning process, the staff member has a reasonable belief that the arrangements may amount to a deprivation of liberty because they are clearly

very restrictive, and the person lacks the relevant mental capacity. Where this is the case, an LPS referral will normally be needed.

13.9 In many cases it will be appropriate for the staff member to explore the arrangements and whether there are less restrictive options, prior to triggering the process. Where this is the case, it is likely that a capacity assessment has been completed and a best interests decision made in respect of the person's care or treatment. It is important to note that capacity is decision and time specific, and therefore in the majority of cases a new capacity assessment and determination will need to be completed. However, in some circumstances, it will be possible for the Responsible Body to rely on an earlier assessment and determination or an assessment carried out for a different purpose. This is discussed further in chapter 16.

13.10 Triggering the LPS process does not necessarily affect any health or care assessment, planning or review processes; these can continue alongside the LPS process. There are specific things that need to happen when the process is triggered, see paragraphs 13.13 to 13.23 below.

13.11 If the person is not undergoing formal health or care planning or reviews, those caring for the person should still follow the principles of the Act and support the person to make their own decision as far as practicable. Responsible bodies should encourage anyone caring for or with an interest in the person's welfare to inform the body if the individual has a reasonable belief that the arrangements may amount to a deprivation of liberty. This should include ensuring information that explains when a deprivation of liberty may be occurring and how to report it to the Responsible Body is published and accessible.

13.12 There may also be situations where it is known in advance that certain arrangements will need to be put in place for a person in the future, and that these arrangements may amount to a deprivation of liberty. For example, a young person who lives in a residential education setting and has certain arrangements that amount to a deprivation of liberty in place that will not change when they turn 16. Where this is the case, the Responsible Body may be able to prepare for the authorisation process in advance, with those involved in the person's care and treatment and the person themselves, and the court where relevant.

Triggering the LPS process

13.13 A Responsible Body should also have mechanisms in place to help identify when arrangements may amount to a deprivation of liberty. This includes mechanisms for members of staff who may not be involved in the person's care or treatment, but who interact with the person in other ways. For example, a housing officer who is

involved in identifying suitable accommodation for the person. Responsible Bodies should have internal processes to allow for referrals from across the organisation.

13.14 If the person's health or care plan is being developed or reviewed, the LPS process can be triggered at any time during the assessment, planning or review process. For example, it may be that initially the person's needs assessment did not require the provision of arrangements amounting to a deprivation of liberty, but a review picks up that their condition has deteriorated and becomes apparent that such arrangements may be necessary. Likewise, it may not be clear what arrangements will be required when the care planning process starts, but as the staff member learns more about the person's needs they believe more restrictive arrangements are required and therefore triggers LPS.

13.15 Where arrangements may amount to a deprivation of liberty the staff member developing or reviewing the plan should ensure the next steps in the process are followed as soon as possible (see paragraph 13.24 below). This may also include a different professional taking over the case to enable the assessments to be aligned.

13.16 If the person is not undergoing health or care assessments planning or reviews, but staff from the Responsible Body either know or come into contact with a person who may be being deprived of their liberty, that staff member should trigger the process (or take any other appropriate action) as soon as practicable. Additionally, staff members should work with those providing care and treatment to ensure that the person is not deprived of their liberty without legal authority, while the LPS process is being carried out. In exceptional circumstances, it may be possible for the decision maker, such as the care provider, to rely on section 4B when taking steps that amount to a deprivation of liberty. See chapter 19 for more information on section 4B.

13.17 All health and social care professionals, staff members and care providers – irrespective of whether or not they are employed by the Responsible Body – have a responsibility to be aware of the potential for a deprivation of liberty to arise and take appropriate action, including making an LPS referral.

13.18 In some cases, the person may not be in contact with formal services, for example, if they or their family have arranged their care or treatment privately. Where this is the case, the Responsible Body will normally need to be informed by third parties about any arrangements that may amount to a deprivation of liberty in order to trigger the LPS process.

13.19 Anybody can inform the Responsible Body of the possibility of a deprivation of liberty. For example, care home staff, domiciliary care workers or family members may become aware that it may be necessary to put arrangements around their care or treatment that could amount to a deprivation of liberty, or that a deprivation of liberty is already taking place.

13.20 The person themselves, their family, or others with an interest in the person's welfare, may raise general concerns about the care and treatment being provided. This could prompt the Responsible Body to determine whether a deprivation of liberty is occurring and if the LPS process should be triggered, or whether an alternative measure is required.

13.21 Responsible Bodies must publish information which sets out how to trigger the LPS process. This should include how the person themselves, their family, or others with an interest in the person's welfare can inform the Responsible Body about a potential deprivation of liberty. The Responsible Body should ensure that this information is in accessible formats. Chapter 14 sets out the information that the Responsible Body must publish.

Providing relevant information

13.22 In many cases, the Responsible Body will already have the person's relevant information because they are assessing or providing services to them. However, if the person has not had contact with services prior to the LPS process being triggered, this information may not be known to the Responsible Body already and will need to be collected.

13.23 The individual informing the Responsible Body should be encouraged to give as much information as possible and appropriate, such as the person's name, date of birth, the care and treatment arrangements and contact details of carers and others interested in the person's welfare. Health and care providers may be able to provide additional information, such as evidence of capacity assessments or best interests decisions relating to the person's care and treatment arrangements.

Actions required by the Responsible Body following a referral

13.24 Once the LPS process has been triggered, there are three immediate tasks that should be undertaken by the Responsible Body:

- Consider whether the case is suitable for the LPS, or whether it would be more appropriately dealt with under a different legal framework, such as the Mental Health Act 1983. If another legal framework is more appropriate, the person's case should be redirected as quickly as possible. If it is not immediately known, the Responsible Body should be alert to any information that suggests that a different legal framework might apply, at any time during the LPS process, and be ready to cease the process and make the necessary referral as appropriate.
- Establish if it is the correct Responsible Body to authorise the arrangements that amount to a deprivation of liberty. If not, under the 'no wrong door' principle, the case should be referred to the correct Responsible Body. For

more information on how to establish which is the correct Responsible Body and the ‘no wrong door principle’, and what to do if there is a disagreement, see Chapter 14.

- Consider representation and support for the person: check if there is someone suitable to be appointed as the Appropriate Person, or whether an IMCA is required. Where a person already has an independent advocate for example, under the Care Act 2014 or the Social Services and Well-being (Wales) Act 2014, this advocate could take on the LPS IMCA role if they are qualified to do so. The Responsible Body should record decisions about appointing, or not appointing, an Appropriate Person or IMCA in the person’s records. It should also monitor the suitability of the Appropriate Person or IMCA during the whole LPS process, including after authorisation. For further information on the role and appointment of an Appropriate Person see Chapter 15, and on the role and appointment of an IMCA see Chapter 10.

13.25 The Responsible Body should inform the referrer, as far as practicable, within five working days that the referral has been accepted. If the case has been referred to be considered under a different legal framework, or to another Responsible Body, then the Responsible Body should inform the referrer as soon as practically possible. The role and responsibilities of the Responsible Body are set out in detail in Chapter 17.

13.26 The assessments process, i.e. from triggering the process to a decision being made as to whether to authorise the arrangements, should not exceed 21 days. This is to ensure that the person is not left in potentially unlawful and/or unsafe arrangements, and they have access to the safeguards they are entitled to. This is important as it protects the person’s Article 5 rights. In exceptional circumstances, however, this may not be possible. Where this is the case, the Responsible Body should ensure this is recorded in the person’s records and shared with the person and their Appropriate Person and/or IMCA.

The Liberty Protection Safeguards assessments and determinations required

13.27 Once the LPS process has been triggered, the Responsible Body should determine whether the authorisation conditions are met. This will mean arranging the following:

- a capacity assessment and determination on whether the person has the relevant mental capacity to consent to the arrangements,
- a medical assessment and determination on whether the person has a mental disorder, and

- an assessment and determination on whether the arrangements are necessary to prevent harm to the person and proportionate in relation to the likelihood and seriousness of harm to the person.

13.28 If the person is undergoing other health and care assessments, planning or reviews, the LPS assessments and determinations should be carried out alongside that process. If the same type of assessment is required for both processes (such as capacity assessment or an assessment of the person's mental disorder) then these should be combined as far as practicable and appropriate. For example, it may be that the capacity assessor for the purposes of the LPS may carry out any capacity assessment that is required for the purposes of the person's care review. Also, if an assessment was carried out for an earlier assessment, plan or review, and is still relevant, it may be possible to use this for the purposes of LPS.

13.29 When undertaking the necessary and proportionate assessment and determination, this should be combined with, for example, the person's needs assessment or NHS continuing health care assessment. It may be that a professional who meets the requirements to carry out the necessary and proportionate assessment and determination for LPS can carry out the other assessments, planning or review as well. However, it may be appropriate for a staff member who doesn't meet the requirements in the relevant regulations but who works with the person and/or is carrying out assessment, planning or review to assist with the LPS assessment and determination, to ensure that both processes are aligned. For example, if an unqualified social worker is carrying out a needs assessment under the Care Act 2014, it may be appropriate for them to assist the LPS assessor in undertaking the necessary and proportionate assessment and determination. This may also be the case for the capacity and medical assessments. See chapter 16 for more information.

13.30 The relevant regulations in England and Wales determine which professionals can carry out each of these assessments and determinations. Further detail about the three required assessments and determinations, and who can carry them out, can be found in chapter 16.

Consultation

13.31 Consultation is an important part of the LPS process and must be carried out during the initial authorisation and when a renewal of an authorisation is being considered. The person, and certain others, must be consulted as far as practicable and appropriate. The main purpose of the consultation is to ascertain the person's wishes and feelings.

13.32 When consultation is taking place as part of the initial assessment process, the Responsible Body should ask the professional carrying out the necessary and proportionate assessment and determination to undertake consultation on its behalf.

13.33 Where an Approved Mental Capacity Professional is carrying out the pre-authorisation review, they must also carry out additional consultation with the person and certain others. See chapter 18 for more information.

13.34 See paragraphs 13.104 to 13.113 for further information on consultation at renewal stage and Chapter 17 for more information about consultation generally.

The authorisation record

13.35 Before an authorisation can be given, a draft authorisation record should be completed. The draft authorisations record can be drafted by anyone, including the individual carrying out the necessary and proportionate assessment and the individual undertaking the pre-authorisation review. It is for the Responsible Body to identify who is best placed to put the draft record together and should agree this role with them. The Responsible Body ultimately has 'ownership' of the authorisation record and can alter it before it comes into force. However, as far as possible, this should be agreed with the person who put together the draft record.

13.36 The draft authorisation record must set out all the arrangements to be authorised. However, the level of detail about the arrangements will vary according to the individual circumstances.

13.37 The draft authorisation record must also specify:

- When the authorisation is due to come into effect. An authorisation can begin 28 days after the authorisation is given.
- The length of time for the authorisation. A person's first and second authorisations can be up to 12 months, and thereafter authorisations can last for up to 36 months. The length of each authorisation should be determined by the person's individual circumstances.
- The conditions for the authorisation. For example, contact arrangements, issues relevant to the person's culture or any other issues related to the deprivation of liberty which – if not dealt with – would mean that the deprivation of liberty would not be justified.
- A programme for reviews. This may for example specify that a planned review takes place on fixed dates or that reviews will take place at certain intervals. See paragraphs 13.79 to 13.98 for more information on reviews.

13.38 The draft authorisation record should also specify who is representing and supporting the person during the authorisation, either an Appropriate Person or an

IMCA, and how to contact them. If the Appropriate Person is being supporting by an IMCA, the draft authorisation may also note this.

13.39 If the draft authorisation record has been completed during the assessments and determinations, it should be shared with the individual carrying out the pre-authorisation review to consider along with the other relevant evidence. The individual can also make recommendations in respect of the contents of the draft authorisation record, if they have not drafted it.

13.40 Ultimately it is the Responsible Body's decision whether or not to agree the draft authorisation record. See paragraphs 13.59 to 13.66 below.

The Authorisation Process

13.41 Once the consultation and assessments and determinations have been completed, there are two stages that must be followed for an authorisation to be given.

13.42 The first is the pre-authorisation review. In some cases, this will require an individual to determine whether it is reasonable for the Responsible Body to believe that the authorisation conditions are met. Alternatively, where an Approved Mental Capacity Professional carries out the pre-authorisation review, they will decide whether the authorisation conditions are met.

13.43 The second stage is the final authorisation. This is the final decision whether or not to give the authorisation. If this results in the decision to authorise arrangements, the authorisation can come into effect immediately or at any time in the next 28 days.

Who undertakes the pre-authorisation review in non-AMCP cases?

13.44 The individual carrying out the pre-authorisation review in non AMCP cases does not need to be a health or social care professional. However, they should have an applied understanding of the Mental Capacity Act 2005 and the LPS process.

13.45 Additionally, the individual that undertakes the pre-authorisation review must not:

- be involved in the day-to-day care of the person,
- be involved in providing any treatment to the person, or
- have a connection, as defined in the relevant regulations, with a care home (in relevant cases involving care homes).

13.46 It is ultimately for the Responsible Body to decide who carries out pre-authorisation reviews in non-AMCP cases. See paragraphs 13.49 to 13.58 for further information on pre-authorisation reviews.

13.47 However, the Responsible Body is responsible for protecting the Article 5 human rights of the person. It should therefore consider the independence of the assessors, pre-authorisation reviewer in non-AMCP cases, and authorisation roles. It is important that each of these roles have a degree of independence between them to reduce the possibility of actual or perceived bias or conflict of interest and provide an appropriate level of scrutiny.

13.48 The same individual should therefore never carry out all three of these roles. It is also unlikely to be appropriate for the same individual to carry out an assessment and determination and the pre-authorisation review. However, it may be appropriate for the individual carrying out the pre-authorisation review to also give the final authorisation. See paragraphs 13.59 to 13.60 for further information.

When must the pre-authorisation review be undertaken by an AMCP?

13.49 The pre-authorisation review must be undertaken by an AMCP in the following specific circumstances:

- if it is reasonable to believe that the person does not wish to reside in the place that is proposed,
- if it is reasonable to believe that the person does not wish to receive care or treatment in the place proposed,
- if the arrangements to be authorised are mainly in an independent hospital,
- any case that the Responsible Body refers to an AMCP, and the AMCP accepts.

13.50 The Responsible Body should not refer cases directly to an individual AMCP. In England, there should be an AMCP team that considers referrals and decides who carries out pre-authorisation reviews. This is to ensure the independents of the AMCP. This team may be organised by the local authority, based within a Responsible Body, or organised across several Responsible Bodies in a local area or across local areas. In Wales, arrangements for AMCPs will be decided locally. The Responsible Body is responsible for deciding who carries out the assessment and determinations and who gives the final authorisation. See chapter 18 for further information on AMCP teams.

13.51 If an AMCP has carried out any of the person's assessments or determinations under a different role, then they should not carry out the pre-authorisation review.

13.52 However, it may be appropriate for the AMCP carrying out the pre-authorisation review to also give the final authorisation, acting on behalf of the Responsible Body. It is important to note that the AMCP is able to turn this request down if they do not think it's appropriate, though.

13.53 The AMCP should not be the individual considering the authorisation in particularly complex cases. Additional scrutiny from another individual ahead of authorising might be particularly beneficial for the complex cases that AMCPs typically consider. See further information on AMCPS in chapter 18.

What is a pre-authorisation review?

13.54 The pre-authorisation review considers the assessments and determinations, information from the consultation, and other evidence, to determine whether the authorisation conditions are met or that it is reasonable for the Responsible Body to conclude that the authorisation conditions are met. The authorisation conditions are that:

- the person lacks capacity to consent to the arrangements,
- the person has a mental disorder, and
- the arrangements are necessary to prevent harm to the person and proportionate in relation to the likelihood and seriousness of harm to the person.

13.55 The individual carrying out the pre-authorisation review should scrutinise the evidence presented, ensuring that there is sufficient evidence for them to make a determination. If the individual carrying out the pre-authorisation review believes further evidence is needed, they should seek this evidence from the individual who carried out the relevant assessment and determination, or any other relevant individual. For example, it may be that the necessary and proportionate assessment and determination lacks detail about the risk of harm, and therefore the individual carrying out the pre-authorisation review could request a copy of the risk assessment that informed the determination.

13.56 If it is not being undertaken by an AMCP, the individual carrying out the pre-authorisation review does not have to meet the person or carry out consultation. However, these steps may be appropriate if the individual decides that the evidence from consultation carried out during the assessment stage is not clear and that a visit or consultation is necessary.

13.57 Where an AMCP is carrying out the pre-authorisation review, they must meet with the person and consult relevant others, if practical and appropriate to do so.

13.58 When the individual carrying out the pre-authorisation review has gathered the relevant evidence, they should consider this against the authorisation conditions.

13.59 AMCPs have specialist knowledge and have undertaken relevant training in order to make this determination. However, the final decision on whether to authorise the arrangements remains the Responsible Body's. See chapter 18 for further information on the role of an AMCP.

13.60 If a previous or equivalent assessment has been used, and the individual carrying out the pre-authorisation review is not satisfied that it was appropriate to rely on this, they will not be able to conclude that the authorisation conditions are met or that it is reasonable for the Responsible Body to reach this conclusion. If this occurs, an authorisation cannot be given, and the Responsible Body may need to consider whether to arrange a new assessment and determination.

13.61 If the pre-authorisation review concludes that the authorisation conditions are not met, or that it is reasonable for the Responsible Body to reach this conclusion, the authorisation process must not continue. For example, if the person does not have a mental disorder, or they do not lack the relevant capacity, then LPS is not the correct framework for their care or treatment arrangements. An alternative framework may be more appropriate, such as the Care Act 2014 or the Social Services and Well-being (Wales) Act 2014.

13.62 If the individual carrying out the pre-authorisation review identifies alternative arrangements that may be more appropriate for the person, and they are available, that may mean the proposed arrangements are not necessary and proportionate. In most cases, this will ultimately be for the relevant commissioning body to consider. In the meantime, the Responsible Body may decide to proceed with the authorisation while a decision is made, or it may wait until the commissioning body or someone arranging care for the person has made a final decision.

Authorising the deprivation of liberty

13.63 Once the pre-authorisation review is complete and the appropriate determination made, the Responsible Body may authorise the arrangements. If the individual authorising the arrangements on behalf of the Responsible Body is the same person as the individual who carried out the pre-authorisation review, they must be able to show a degree of separation between the roles. This means they should act independently when carrying out the pre-authorisation review and as the Responsible Body when authorising.

13.64 The role of the individual considering the authorisation is to decide whether the Responsible Body should authorise the proposed arrangements. The individual is therefore acting on behalf of the Responsible Body in this role, making it a fundamentally different role to the pre-authorisation review. Whilst the same individual can carry out both roles, they must be able to differentiate their decisions at each stage in order for the two processes to remain impartial of each other. For example, if at pre-authorisation review stage, the individual determined it was reasonable for the Responsible Body to conclude that the authorisation conditions are met, when they are considering an authorisation, then they must consider from the Responsible Body's perspective whether there is sufficient justification to give the authorisation.

13.65 The Responsible Body must decide whether or not to authorise the proposed arrangements. The fact that an individual undertaking the pre-authorisation review has decided that the authorisation conditions are met does not obligate the Responsible Body to authorise the arrangements. The Responsible Body should always, for example, consider less restrictive arrangements around the person's care and treatment.

13.66 If the Responsible Body agrees with the draft authorisation record, and decides that an authorisation should be given, it should authorise the arrangements. The authorisation record should be signed and dated. Once the arrangements have been authorised, the draft authorisation record becomes the authorisation record. This may be included in any health or care plan prepared under a different legal framework, such as Continuing Health Care or the Social Services and Wellbeing (Wales) Act 2014, or simply included with any relevant files.

13.67 However, the Responsible Body may disagree with the pre-authorisation review or the draft authorisation record, see paragraphs 13.65 to 13.67 below for more information. If the Responsible Body decides not to authorise the arrangements, it may decide to take further actions. These may include urgently requesting a review of a best interests decision about care and treatment, or initiating a safeguarding enquiry.

13.68 The Responsible Body must ensure that a copy of the authorisation record is arranged to be given or sent without delay to the person and the AP or IMCA (or both). If this does not happen within 72 hours the responsible body must review and record why. This information should also be shared with the person and their IMCA or Appropriate Person.

What happens if the Responsible Body disagrees with the pre-authorisation review?

13.69 It may be that the individual considering the authorisation does not agree with the pre-authorisation review. For example, they may disagree on parts of the draft authorisation record or that the authorisation conditions are met. Ultimately, it is the Responsible Body's decision whether to give an authorisation and agree the draft authorisation record.

13.70 In some cases, the individual considering the authorisation may not agree with one of the conditions recommended for the arrangements in the draft authorisation record. In this scenario, the individual considering the authorisation should talk to the individual who carried out the pre-authorisation review to understand the reasons for their recommendations before making a final decision. Where the individual considering the authorisation decides to make changes to the draft authorisation record, the changes should be clearly stated and justified/explained on the record. This is important for the Appropriate Person or IMCA to understand the final decision, and to best consider how to support and represent the person. A

written explanation should also be given to the individual who caried out the PAR, if it is a different person.

13.71 If an AMCP carried out the pre-authorisation review and the individual considering the authorisation disagree, the individual should discuss this with the AMCP. AMCPs are specialists and the individual considering the authorisation should therefore respect their professional status when considering their decision. It may be, for example, that discussions the position with the AMCP may give the individual more insight to the AMCPs view and they decide to reconsider their position.

When does an authorisation end?

13.72 An authorisation ceases for one of the following reasons:

- It is the end of the period of authorisation specified by the Responsible Body at the time of authorisation and it has not been renewed.
- It is earlier than the end of the original authorisation or renewal period, but the Responsible Body has decided that the authorisation should end.
- The Responsible Body believes or ought to believe that the authorisation conditions are no longer met.
- In relation to arrangements that are either in relation to a mental health Community Treatment Order and the LPS would conflict that treatment. Or, where the person is subject to the Mental Health Act 1983 for treatment of a mental disorder.

13.73 If a decision maker considers the authorisation conditions are no longer met, they should notify the Responsible Body and, for example, suggest a termination of the authorisation or ask for a review.

13.74 The Responsible Body must make every effort to ensure that any person who is likely to be carrying out the arrangements that amount to a deprivation of liberty is notified that the authorisation has ceased (as well as others implementing the arrangements), so that the person is not deprived of their liberty unlawfully.

13.75 Once an authorisation has ceased to have effect, it cannot be renewed. If a new authorisation is required again in the future, the LPS process must be triggered from the beginning.

Challenging an authorisation

13.76 The person, or their Appropriate Person or IMCA, or anyone else, can seek to challenge an LPS authorisation in the Court of Protection. This may be because the person themselves wishes to challenge or another reason, such as the person's

Article 5 rights are at risk, or it is in the person's best interests. See chapter 24 for further information on challenging arrangements.

Variation

13.77 There are limited occasions where the Responsible Body may vary an authorisation. A variation could be used to make changes to an authorisation which do not amount to a fundamental change in arrangements. A variation could be used to remove arrangements from an authorisation or to make small amendments to the arrangements, such as if an additional staff member is required to escort a person on their daily walk. A variation should not be used to add new settings to an authorisation, or to authorise new arrangements without applying the proper legal process – and therefore undermining the person's Article 5 rights.

13.78 As a general rule, where changes of setting, either short or long-term, can be reasonably foreseen, such as regular respite, or a planned move, these can be included in the authorisation record. By covering the different settings in the authorisation, this will avoid the need to give new authorisations each time the person moves settings. For example, if a person is residing in a care home under Continuing Healthcare arrangement, meaning that the CCG is therefore the Responsible Body, and they have a planned hospital stay, this could be built into the authorisation from the CCG. In this situation the hospital manager would not need to give a new authorisation for the person's time in hospital.

13.79 If a person has a change of setting that was not predicted or built into the planned arrangements described in the authorisation record, such as an unforeseen admission to an NHS hospital, and arrangements amounting to a deprivation of liberty are required for the person's care and treatment in this setting, a new authorisation would be required. In this example, the Responsible Body would change to the Hospital Manager (NHS Trust or Local Health Board) of the hospital for this authorisation.

13.80 If appropriate, the authorisation in place for the original setting could be paused and could resume when the person returns provided the authorisation conditions are still met and there are no changes to the arrangements. The original authorisation could remain in place but would in effect be suspended. The Responsible Body for that authorisation should end that authorisation if it becomes clear that the arrangements will need to change when the person returns to the original setting.

13.81 Similarly, if a person has to move from their family home to a care home (but is not eligible for NHS continuing health care) for a period of unplanned care and treatment, because a family carer became ill, and the person could not stay at home, a new authorisation might be required, even though the Responsible Body

would not change. As above, if appropriate, the original authorisation could in effect be suspended until a time when it can be reinstated (if that is appropriate).

13.82 Variations can only be made if it is reasonable to do so and if those who were consulted in the initial authorisation process, and any relevant others, are consulted about the person's wishes and feelings.

13.83 If a variation of the authorisation is proposed, a review should be carried out. If there is no time to do the review before the variation is made, it must be done as soon as practicable once a variation has been made to the authorisation.

Reviews

13.84 To ensure that the arrangements continue to be appropriate for the person, the Responsible Body must review the authorisation in accordance with the programme specified in the authorisation record. The nature and number of reviews will depend on a number of different individual factors, some of which will be known when the authorisation is given, and others which will arise during the authorisation.

13.85 The Responsible Body must set out a schedule for reviews in the authorisation record. The individual who sets this schedule should consider how restrictive the arrangements are, any conditions on the authorisation, the person's wishes and feelings, the length of the authorisation, and whether there is any potential for changes to the person's behaviour or condition. The Responsible Body should consider this when it is deciding whether to authorise the arrangements.

13.86 If the Responsible Body decides not to give effect to the programme of reviews set out in the draft authorisation record, and decides to draft it's own schedule, it should state the reasons in writing to the individual who carried out the pre-authorisation review.

13.87 If the person also has a health or care and support plan then the Responsible Body should seek to carry out the review of the authorisation as part of any reviews of the relevant plan. This approach ensures that the entire care or treatment plan, inclusive of the health or care provision and the arrangements around that, are aligned. This will help to deliver a streamlined and comprehensive service to the person.

When may a review that is not part of the regular programme in the authorisation record take place?

13.88 In some cases, something may happen whilst the authorisation is in place, which means the Responsible Body needs to schedule a review that was not outlined in the authorisation record. These circumstances are:

- If a variation is proposed (more information on variations at para 13.27-13.79),
- If a reasonable request is made by someone with an interest in the arrangements,
- If the person becomes subject to mental health arrangements (e.g. they are detained under the MHA),
- If the person becomes subject to mental health requirements (e.g. a condition is imposed on the person's Community Treatment Order under the MHA),
- If the Responsible Body becomes aware that the person does not wish to reside or receive care or treatment in that place and an AMCP has not reviewed this case previously,
- If the Responsible body becomes aware of a significant change in the person's conditions or circumstances.

13.89 Anyone may contact the relevant Responsible Body to explain why they think a review is required. The Responsible Body should then consider the relevant information presented by the individual who requested the review, to determine whether the request is a reasonable one and/or if one of the other grounds listed above, applies. If it is, or it does, the Responsible Body must carry out a review. Responsible Bodies should ensure that they have appropriate and accessible channels for someone to request a review, and that every request is considered appropriately.

13.90 The Responsible Body should ensure that there are appropriate and accessible channels for someone to raise concerns about the person's arrangements, including whether they align with the person's wishes and feelings. Where the person does not wish to reside or receive care or treatment in the place, and an AMCP has not previously been involved in the case, the review should be referred to an AMCP who should carry out the review and must also determine if the authorisation conditions are met (see paragraphs 13.95-13.99 below for further information).

13.91 Where one of the circumstances outlined in para 13.84 takes place, the Responsible Body should inform the person, their IMCA or Appropriate Person, and any other individual involved in the review that the review is taking place.

What happens in a review?

13.92 Reviews are a process by which the Responsible Body considers whether the deprivation of liberty should continue, and whether the arrangements are still appropriate. However, there may be some occasions when reviews are required to assess certain specific issues, such as whether the conditions are still appropriate and being complied with.

13.93 The format of the review depends on the reason for the review. For example, a review of a more complex nature, such as when the person no longer wishes to

reside in the place, is likely to require a more in-depth review. This is likely to include a face to face meeting and/or case conference. A review to check the progress of the conditions on the authorisation may simply require a phone or video call, or a brief meeting.

13.94 At the very least, the Responsible Body should speak to those involved in the person's care and treatment, and the person themselves if appropriate, to get an understanding of how the arrangements are impacting the person.

13.95 Where the Responsible Body is reviewing a complex authorisation, it should aim to speak to as many people involved in the person's care as possible, including the person themselves. A case conference should also be arranged, which includes the person, the IMCA or their Appropriate Person, anyone the person would want to be present and those involved in the person's care and treatment and carrying out the arrangements. The reviewer should chair the meeting and make the record of it which is shared with others. It may also be appropriate and necessary to arrange a further assessment to determine whether the authorisation conditions continue to be met, for example, if the person's mental capacity has changed.

13.96 Once the Responsible Body has carried out the review, it should consider whether there is an indication that a change to the authorisation is needed. Changes may range from a variation to the authorisation through to ceasing the authorisation if the authorisation conditions are no longer met. If no changes to the authorisation are required or the authorisation only needs to be varied (see paragraphs 13.72 to 13.78 above), the authorisation may continue. Regardless of the outcome of the review, the decision should be stated on the documentation for the review and copies should be shared with everyone who received the initial copy.

13.97 If the review concludes that the authorisation conditions are no longer met, e.g. the person is no longer assessed to have a mental disorder or they have regained the relevant capacity, the authorisation must be ceased immediately. Likewise, if the arrangements are no longer assessed as being necessary and proportionate the authorisation should be ceased immediately. If, however, the arrangements are no longer necessary and proportionate but other arrangements amounting to a deprivation of liberty are still necessary, a new authorisation may be needed.

13.98 The Responsible Body should decide who is best placed to carry out the review and whether the individual is sufficiently independent, for example, of the Responsible Body and the care and treatment providers.

When should a referral be made to an AMCP for a review and what is an AMCP's role in a review?

13.99 If the Responsible Body becomes aware that the person does not wish to reside or receive care or treatment in the place once the authorisation is in place, and the

pre-authorisation review was not undertaken by an AMCP, a review by an AMCP should take place. A review by an AMCP should also take place if a person engaged in caring for the person or interested in their welfare informs the Responsible Body that the person does not wish to reside or receive care or treatment in the place once the authorisation is in place, and makes a reasonable request for a review.

13.100 In the first case, the Responsible Body should consider the person's wishes and feelings, including past wishes and feelings as far as they are relevant.

13.101 Additionally, in the first case above, the Responsible Body should consider the circumstances around the arrangements, including any changes, to get a full understanding of how the person is feeling. For example, it may be that the person is residing in a hospice and was happy when the arrangements were first authorised, however, since the authorisation more people have moved into the ward and have made the person feel uncomfortable.

13.102 The AMCP should carry out the review, by reviewing the authorisation, meeting with the person as far as appropriate and practicable and, consult as far as appropriate and practicable all who were consulted in the initial authorisation process. The AMCP may also decide it is necessary to consult with some other individuals who were not consulted before the authorisation was given.

13.103 The AMCP must determine whether the authorisation conditions continue to be met. Please see more information on how AMCPs carry out reviews in chapter 18.

Renewals

13.104 The maximum initial period of an authorisation is up to 12 months. When the end of the initial authorisation period is drawing near a renewal decision can be made. The authorisation can be renewed for the first time for up to 12 months. Thereafter an authorisation can be renewed for a period of up to 36 months. A renewal for 36 months would normally only be appropriate when it is clear the person's circumstances and wishes and feelings are unlikely to change.

13.105 When an authorisation is renewed, the existing authorisation is continued, and the end date is extended. The Responsible Body should update the authorisation record and share this with the same people who received the initial record, and any other relevant parties.

How does the Responsible Body decide when a renewal is appropriate?

13.106 When the authorisation is coming to an end, the Responsible Body should consider whether a renewal is appropriate or whether other action may be necessary.

13.107 In order to renew an authorisation, the Responsible Body must be satisfied that the authorisation conditions continue to be met. In some cases, where the person's arrangements have been stable for some time and their condition has not changed, the Responsible Body may be confident that the conditions are met without any further action. Where this is the case, further assessments and determinations may not be required.

13.108 If the person's relevant capacity has declined or remained the same, it may not be necessary to carry out a further capacity assessment and determination, as they have not regained the relevant capacity.

13.109 However, in some cases, there will be reasons to believe that the authorisation conditions may no longer be met, for example if it is reported that the person now has capacity to consent to the arrangements. The authorisation must cease if the Responsible Body believes or ought reasonably to suspect that any of the authorisation conditions are not met. Where this is not the case, the Responsible Body should arrange for further assessments and determinations to be carried out in order to determine whether the conditions are still met and therefore whether the same authorisation can be renewed.

13.110 If the authorisation conditions are met, but changes to the arrangements are needed, then a new authorisation may be needed. However, in many cases, previous assessments and determinations can be used. In the case of the necessary and proportionate assessment and determination, it may be that only a brief assessment and determination is needed and the Responsible Body only needs to make a small amendment to the authorisation record. Where this is not the case, the authorisation must be ceased and the LPS process triggered again, in order to put in place a new authorisation following all of the relevant assessments and determinations.

13.111 Whether or not further assessments are being carried out, the Responsible Body must carry out consultation with everyone who was consulted in the initial authorisation process and any other relevant others where it is practicable and appropriate to do so. Consultation at renewal stage is important amongst other matters to see if the person's wishes and feelings have changed in relation to the arrangements.

13.112 If the person's wishes and feelings have changed, it may be that the arrangements are no longer necessary and proportionate. It may therefore be appropriate to carry out a new necessary and proportionate assessment and determination.

13.113 If the person has a health or social care and support plan, the Responsible Body should seek to carry out the consultation for renewal as part of any health or care and support plan review where appropriate and possible. This will streamline relevant processes by keeping the person's LPS authorisation closely linked to their

health or care and support plan and will also reduce the number of processes the person needs to go through.

14. What is the role of a Responsible Body in the Liberty Protection Safeguards process?

The Responsible Body is the organisation that oversees the LPS process.

This chapter describes the responsibilities of a Responsible Body and provides information on how to decide which organisation is the Responsible Body. This chapter also provides information on arrangements made regarding cross-national borders in the United Kingdom.

The details of the overall LPS process are set out in chapter 13. This chapter provides information on the role of the Responsible Body within the LPS system.

Quick summary

Which organisations can be a Responsible Body?

- **The term "Responsible Body" generally refers to an organisation, rather than an individual.**
- **Examples of organisations that will be eligible to be Responsible Bodies include: NHS Trust or NHS Foundation Trust, Local Authority, Clinical Commissioning Group (CCG), Local Health Board or others.**

How to work out who the Responsible Body is.

- **There can only be one Responsible body for any authorisation The rules for identifying the responsible body vary according to whether the arrangements are being carried out mainly in hospital, or the person is in receipt of NHSCHC, or other cases.**
- **The 'No Wrong Door' principle means that if a referral is made to an organisation that is not the correct organisation to act as the**

Responsible Body, the organisation should pass this referral on to the correct Responsible Body.

Duty of Responsible Body to provide information.

- **Each responsible body has a general duty to publish information about the following:**
    - the effect of an authorisation
    - the process for authorising arrangements
    - when an IMCA should be appointed
    - the role of the Appropriate Person
    - when an Approved Mental Capacity Professional (AMCP) may get involved in a case
    - the right to make an application to the Court of Protection
    - reviews of an authorisation.

Which organisations can be a Responsible Body?

14.1 In most cases, the Responsible Body will be one of the following:

- NHS Trust or NHS Foundation Trust
- A local authority
- A Clinical Commissioning Group (in England)
- A Local Health Board (in Wales)

14.2 In some situations, the Responsible Body could also be:

- A Special Health Authority
- The Secretary of State
- The Welsh Ministers

How to work out which organisation is the Responsible Body

14.3 There can only be one Responsible Body for any authorisation. Schedule AA1 of the Mental Capacity Act 2005 (MCA) establishes a hierarchical list for the purposes of determining who the Responsible Body is. In many cases this will be straightforward. In other cases, such as where the authorisation covers different

settings, the identity of the Responsible Body needs to be determined by reference to the criteria in Schedule AA1 to the MCA. The list of questions below is provided to assist with working out who the Responsible Body is. The questions should be worked through, starting at the top, and once the answer to the question is "yes", the Responsible Body has been identified. These questions are as follows:

1. Are the arrangements being carried out mainly in an NHS hospital? If so, in England the Responsible Body is the NHS Trust or NHS Foundation Trust. In Wales, it is the Local Health Board.
2. Are the arrangements being carried out mainly in an independent hospital in England? If so, the Responsible Body is either the local authority who is meeting the person's needs or the local authority within whose area the hospital is situated in.
3. Are the arrangements being carried out mainly in an independent hospital in Wales? If so, the Responsible Body is the Local Health Board for the area in which the independent hospital is situated.
4. Are the arrangements being mainly carried out through the provision of NHS Continuing Healthcare in England or Continuing NHS Healthcare in Wales? If so, the Responsible Body is the Clinical Commissioning Group (CCG) in England or the Local Health Board in Wales.
5. In all other cases the Responsible Body is a local authority.

What does "mainly" mean?

14.4 In some cases, the identification of the Responsible Body will depend on where the arrangements are "mainly" being carried out, or how the person's care or treatment needs are "mainly" being carried out. The meaning of the word "mainly" will be particularly relevant when the arrangements being authorised apply in different settings.

14.5 In considering the meaning of the word "mainly", emphasis should be placed on time considerations and where the arrangements are taking place for the majority of the time. For example, if the authorised arrangements are commissioned as part of a care and support plan under the Care Act 2014 or the Social Services and Well-being (Wales) Act 2014 and cover a person living in a care home for seven days a week, which has been arranged by a local authority, however on two mornings they visit the hospital for regular treatment, the Responsible Body would be the local authority.

Who is the Responsible Body for arrangements in an NHS Trust or NHS Foundation Trust or Local Health Board?

14.6 For all cases where arrangements are being carried out mainly in an NHS hospital, the Responsible Body is the "hospital manager" of that hospital. This term is given a specific meaning for the purpose of the Liberty Protection Safeguards. In England, in most cases it means the NHS Trust or NHS Foundation Trust responsible for that hospital. In Wales, in most cases it means the Local Health Board for that hospital in Wales.

Who is the Responsible Body for arrangements in an Independent Hospital?

14.7 In England, if the arrangements are mainly in an independent hospital, the Responsible Body is a local authority. In broad terms, either the local authority meeting the person's needs or otherwise the local authority for the area in which the hospital is located. If the hospital is situated across different local authority areas, and the person's needs are not being met by a local authority, the local authority for the greater part of the hospital is the Responsible Body. This also applies where a person is in an independent hospital setting, even if the service is being funded or commissioned by the NHS, and in the case of private wings or buildings on NHS sites. This applies unless the person's needs are being met by a local authority, see paragraphs 14.9 and 14.10 below.

14.8 In Wales the Responsible Body for independent hospitals is always the Local Health Board for the area where that independent hospital is located. If the hospital is situated across different local authority areas, the Local Health Board for the greater part of the hospital is the Responsible Body. . Again, this also applies where a person is in an independent hospital setting, even if the service is being funded or commissioned by the NHS, and in the case of private wings or buildings on NHS sites.

Which local authority is the Responsible Body when a person is in an independent hospital, if the person's needs are met by a local authority, in England?

14.9 In England, where the arrangements are mainly in an independent hospital, if the person's needs are being met under the relevant social care legislation, the Responsible Body will be the local authority meeting the person's needs under that legislation. For adults this will be an Educational Health and Care (EHC) plan under Part 4 of the Children and Families Act 2014 or care and support needs under Part 1 of the Care Act 2014. For young people in England, the relevant legislation will be an EHC plan under Part 4 of the Children and Families Act 2014, accommodation under section 20 of the Children Act 1989, or where the person is subject to a care or interim care order under the Children Act 1989.

14.10 If more than one local authority is meeting the needs of a person for care and support under Part 1 of the Care Act 2014, the Responsible Body is the local authority for the area in which the person is ordinarily resident for the purposes of that Part of that Act.

Who is the Responsible Body for a Hospice?

14.11 Most hospices will meet the relevant definition of an independent hospital. Where this is the case, in England the Responsible Body would be a local authority; in Wales it would be the Local Health Board.

14.12 Many hospice services and end of life care services are delivered outside of hospices and hospitals, for example in care homes, and in people's own homes. In these cases, the Responsible Body would be the CCG or the local authority in England, or the Local Health Board in Wales.

Who is the Responsible Body for Continuing Healthcare in England and Continuing NHS Healthcare in Wales?

Who is the Responsible Body for Continuing Healthcare in England?

14.13 In England, the CCG is the Responsible Body when the arrangements are carried out mainly through the provision of NHS Continuing Healthcare (NHS CHC). The CCG commissioning the NHS CHC is the Responsible Body, regardless of where the person is residing.

14.14 NHS CHC is a package of care arranged and funded solely by the health service in England for a person aged 18 or over to meet physical or mental health needs which have arisen as a result of disability, accident or illness.

14.15 If a person is assessed as eligible for NHS CHC, the NHS is responsible for commissioning a care package that meets the individual's primary health and associated social care needs, including accommodation, if that is part of the overall need. In such cases the CCG responsible for the provision of NHS CHC will be the Responsible Body.

14.16 If a person is in receipt of NHS CHC and they also need to visit hospital regularly for treatment, the Responsible Body would depend on where the arrangements were mainly carried out. If the arrangements are not being carried out mainly in a hospital, the CCG would be the Responsible Body. For example, if the person lives in a care home which is being provided under CHC four days of the week but needs to stay overnight in a hospital for three days a week then the CCG would be the Responsible Body. The CCG would therefore be responsible for considering and, where appropriate, authorising arrangements across both settings.

14.17 The National Framework for Continuing Healthcare sets out the respective responsibilities of the NHS and local authorities in respect to both NHS Continuing Healthcare and joint packages of health and social care. For more information on NHS Continuing Healthcare please see the framework, available on GOV.UK.

Who is the Responsible Body for Continuing NHS Healthcare in Wales?

14.18 The provisions of Continuing NHS Healthcare in Wales (equivalent to NHS CHC in England) are the responsibility of the NHS in Wales, delivered through Local Health Boards (LHBs). These arrangements are set by Welsh Ministers through *Continuing NHS Healthcare - The National Framework for the Implementation in Wales*.

14.19 If a person is assessed as eligible for Continuing NHS Healthcare, the NHS is responsible for commissioning a care package that meets the individual's health and associated social care needs, including accommodation, if that is part of the overall need. In such cases the LHB that is responsible for the provision of the Continuing NHS Healthcare will be the Responsible Body.

14.20 The Framework stipulates that LHBs have the lead responsibility for CHC in their local area. They must, however, work with local authorities, other NHS organisations and independent/voluntary sector partners to ensure effective operation of the Framework. As such the Responsible Body will be the LHB.

Who is the Responsible Body when a person is receiving NHS Continuing Healthcare or Continuing NHS Healthcare out of area?

14.21 Where, in order to meet an individual's continuing care needs, the placing CCG or Local Health Board in Wales arranges to provide them with:

- accommodation in a care home; and
- at least one planned healthcare service (other than simply NHS-funded nursing care (NHS FNC)) connected with the provision of that accommodation,

then the placing CCG in England or Local Health Board in Wales retains commissioning responsibility for that person, in respect of those services, regardless of which GP the individual is registered with. This continues for as long as the individual requires a continuing care package (that is, they remain resident in accommodation and continue to require services), whether this is provided in the same physical location or another. In such cases the placing CCG or Local Health Board in Wales is the Responsible Body.

Who is the Responsible Body when a person's needs are being met by more than one organisation?

14.22 If a person is in receipt of NHS CHC, then it is normally the case that the CCG would be responsible for the entirety of the care package. This is because it is

responsible for the person's health and associated social care needs. However, it is possible that a local authority could still be meeting that person's "non-associated" social care needs; in other words, needs that are not connected to the person's primary health needs. For example, a person may have additional support needs which it could be appropriate for the local authority to address through property adaptations.

14.23 In all cases, the legal test is whether the arrangements are carried out mainly through the provision of NHS CHC. Given that the person has a primary health need and is in receipt of NHS CHC, it almost by definition follows that in such cases the CCG or LHB would be the Responsible Body.

14.24 If a person is not eligible for NHS CHC, they may potentially receive a joint package of health and social care. This is where an individual's care or support package is funded by both the NHS and the local authority. In these cases, the Responsible Body is the local authority.

14.25 If a person is not eligible for NHS CHC but has a need for care from a registered nurse and their overall needs would be most appropriately met in a care home with nursing, they may be eligible for NHS-funded Nursing Care. All other care needs may be subject to an assessment under social care legislation such as the Care Act. Irrespective of whether or not their needs are being assessed or met by a local authority, in such cases the Responsible Body will be the local authority is (assuming that the arrangements are not being carried out mainly in an NHS hospital).

Who is the Responsible Body for all other situations?

14.26 In all other circumstances, where the arrangements are not taking place mainly in a hospital or through NHS CHC, a local authority will be the Responsible Body. Which local authority is the Responsible Body will, broadly speaking, depend on whether the person's care and support needs are being met by a local authority and which local authority are meeting the person's needs.

14.27 If a person is aged 18 or over, the Responsible Body will be:

- If there is an EHC plan, the local authority responsible for that plan (England).
- If there is an Individual Development Plan (IDP), the local authority responsible for that plan (Wales).
- Otherwise if the person has needs being met under the Care Act 2014 or the Social Services and Well-being (Wales) Act 2014 (SSWBA), the local authority responsible for meeting those needs.

14.28 If a person, aged over 18, is entirely self or privately funded for their care and does not have an EHC plan or IDP in place and is not having their needs met under the Care Act 2014, the SSWBA or the Children Act 1989, and the arrangements require them to reside in a local authority area, the Responsible Body will be the local authority where the person is residing.

14.29 If the person is aged 16 or 17, and their care is funded by a local authority, then deciding which local authority is the Responsible Body is different. The Responsible Body will be:

- If there is an EHC plan (in England), the local authority responsible for that plan;
- If there is an IDP (in Wales), the local authority responsible for that plan;
- If there is no EHC plan or IDP in place, and the person is being provided with accommodation under section 20 of the Children Act 1989, or section 76 of the SSWBA, the local authority providing that accommodation.

Otherwise, if the person is subject to a care or interim care order under the Children Act 1989, the local authority with parental responsibility under the order for that person's care.

14.30 In all other cases (for all ages) the following points determine who the correct Responsible Body is:

- If the arrangements provide for the person to reside in one place, the local authority for the area in which that place is situated.
- If the arrangements provide for the person to reside in more than one place, the local authority for the area in which the main place of residence is situated. Or,
- In any other case, the local authority for the area in which the arrangements are mainly carried out.

14.31 In some cases, a local authority may determine that a person's needs can only be met in specified accommodation, and that accommodation is being provided out of area. For example, care home accommodation, supported living and shared lives in England and care home accommodation in Wales. In such cases, the first local authority will continue to meet the person's needs and will normally remain the Responsible Body.

Who is the Responsible Body when more than one local authority is involved in meeting needs?

14.32 If more than one local authority is meeting the needs of the person under either the Care Act 2014 (for England) or the SSWBA, the area where the person is ordinarily resident will be the Responsible Body.

14.33 If more than one local authority is meeting the needs of the person under the Care Act 2014 (for England) and the Social Services and Well-being Act (Wales) 2014, the following points determine who the correct Responsible Body is:

- If the arrangements require the person to reside in one place, the local authority for the area in which that place is situated.
- If the arrangements require the person to reside in more than one place, the local authority for the area in which the main place of residence is situated. Or,
- In any other case, the local authority for the area in which the arrangements are mainly carried out.

What is the 'No Wrong Door' principle?

14.34 If an individual or a health or care provider contacts a Responsible Body about arrangements that may give rise to a deprivation of liberty, and that organisation is not the correct organisation to act as the Responsible Body, the organisation should pass this referral on to the correct Responsible Body. The Responsible Body should inform the individual or organisation who contacted them that the referral has been passed to the correct Responsible Body.

14.35 The correct Responsible Body should acknowledge receipt of the referral to the person or organisation who made it within five working days of the original referral being made. The correct Responsible Body should begin as soon as possible taking the relevant steps to determine whether an authorisation is needed and appoint an IMCA or Appropriate Person.

What should be considered during cross-border working?

14.36 The legal frameworks governing UK cross-border placements can be complicated and may vary between jurisdictions. When the use of the LPS is being considered, it is important, as in all cross-border cases, to ensure a person-centred approach is taken throughout and that authorities should work together.

14.37 The UK Governments have agreed a number of principles that should be applied to all cross-border placements. Guidance on cross-border placements can be found in Chapter 21 of the Care and Support Statutory Guidance (which has been agreed by the four UK Governments) and in the SSWBA, Part 11 Code of Practice (Miscellaneous and General).

14.38 For good practice on cross border working, the Social Care Institute for Excellence (SCIE) has published guidance that has been agreed across the four Governments. The Cross-Border Placements guidance is available on their website https://www.scie.org.uk/.

14.39 Paragraph 14.3 set out guidance on establishing the Responsible Body under the Liberty Protection Safeguards. When working out who is the Responsible Body, decision makers may need to take into account cross border arrangements for example between England and Wales.

14.40 For example, a local authority in England may have assessed a person under the Care Act 2014 and decided that their care and support needs can only be met through accommodation of a certain type (such as a care home) and is proposing to provide that accommodation in Wales and in circumstances that amount to a deprivation of liberty. In such a case the local authority in England will be the Responsible Body.

14.41 The Responsible Body can negotiate with the local authority, NHS body, or LHB for the area into which the person has moved, to see whether local staff could undertake LPS assessments and/or reviews on its behalf. For example, this might be appropriate if the English or Welsh Responsible Body is a long distance from the area where the person will be living or currently lives.

14.42 For AMCPs, there are separate regulations in England and Wales which outline the eligibility requirements in order to practice as an AMCP. However, AMCPs are eligible to practice as an AMCP in either England or Wales if they meet the requirements to be eligible for approval and to practice in the other country (either England or Wales). For example, if an AMCP from Wales wishes to be approved to carry out the role by a local authority in England, they will need to demonstrate knowledge of the relevant English legislation. For further information on AMCPs, see chapter 18

What happens when a person from England moves to a service in Wales?

Care homes in Wales (local authority funded or self-funded)

14.43 An English local authority may decide under the Care Act 2014 (or the Children Act 1989) that a person's care and support needs can only be met through care home accommodation in Wales, and the arrangements will amount to a deprivation of liberty. In such cases the local authority in England will normally continue as the Responsible Body.

14.44 This principle can in some cases also apply to people who "self-fund". For example, if a person who is privately or self-funded for their care moves from England to a service in Wales and their care and support is being arranged by an English local authority, the English local authority will normally continue to be the Responsible Body.

14.45 If a person from England who “self-funds” and lacks the relevant capacity is moved into a care home in Wales by their family without the involvement or knowledge of any local authority, the local authority in Wales where the person is situated that will be the Responsible Body if that person’s care amounts to a deprivation of liberty.

Own home/domestic settings/supported living/extra care housing/shared lives in Wales

14.46 Where an adult has moved from England to supported living or shared lives accommodation in Wales, the English local authority will sometimes remain the Responsible Body. This will be the case if the English local authority, upon assessment, has determined that their needs can only be met through a supported living or shared lives arrangement in Wales.

14.47 This arrangement would not apply when the person moves or is moved from England into a domestic setting, a family setting or extra care housing (which is not supported living or shared lives) in Wales. In these circumstances, the Responsible Body will be the local authority or LHB in Wales. It is therefore essential that all relevant authorities in England and in Wales work closely together when a move and authorisation is being considered.

Care homes in Wales (arranged under NHS CHC arrangements funded by an English CCG)

14.48 Where the care arrangements are being carried out mainly through NHS CHC, funded by an English CCG, but delivered in Wales (e.g. via funding the person’s accommodation in Wales), the CCG will normally be the Responsible Body. This is the case where the arrangements include the accommodation and at least one planned healthcare service (other than simply NHS FNC) connected with the provision of that accommodation. In some cases, this will not apply, for example where the LHB has agreed to take over the case or where the move has been arranged by a local authority. For further clarification the relevant ‘Who Pays?’ guidance should be referred to.

NHS hospitals in Wales

14.49 In cases where the arrangements are carried out mainly in an NHS hospital in Wales, the LHB in the area where the hospital is situated in Wales would be the Responsible Body. This will normally apply even if the person is living in England or has been placed in that hospital by an English NHS Trust or Foundation Trust.

Independent hospitals in Wales

14.50 If the arrangements are being carried out mainly in an independent hospital in Wales, the LHB in the area where the hospital is situated is the Responsible Body. This includes anyone from England placed in an independent hospital in Wales.

What happens when a person from Wales moves to a service in England?

Care homes in England (local authority funded or self-funded)

14.51 Where the person that has been assessed by a Welsh local authority as having needs that can only be met under the SSWBA 2014 within care home accommodation in England, then the Welsh local authority is the Responsible Body.

14.52 If a person from Wales who "self-funds" and lacks the relevant capacity is moved into a care home in England by their family without the involvement or knowledge of any local authority, the local authority in England where the home is situated that will be the Responsible Body if that person's care amounts to a deprivation of liberty.

Own home/domestic settings/supported living/extra care housing/shared lives in England

14.53 Where a person moves or is moved from Wales into a domestic setting, a family setting, extra care housing, supported living or shared lives in England, and needs to be deprived of their liberty, the Responsible Body will be the local authority in England (assuming they are not in receipt of NHS CHC). It is therefore essential that all relevant authorities in England and in Wales work closely together when the move and the authorisation is being considered.

Care homes in England (funded by Continuing NHS Care)

14.54 If the arrangements are being carried out mainly through the equivalent of Continuing NHS Healthcare, funded by an LHB in Wales and are being delivered in England (e.g. a hospital or care home in England) the LHB funding the residential arrangement will normally be the Responsible Body.

NHS Hospitals in England

14.55 In all cases where the arrangements are being carried out mainly in an NHS hospital in England, the "hospital manager" (normally the NHS Trust or NHS Foundation Trust responsible for that hospital) is the Responsible Body, regardless of who funds the services in the NHS hospital or if the person is living in Wales.

Independent hospitals in England

14.56 In the case of a person from Wales being deprived of liberty mainly in an independent hospital in England, a local authority in England will be the Responsible Body. The English local authority for the area in which the hospital is situated, will normally be the Responsible Body.

What happens when a person from Scotland or NI moves to a service in England or Wales?

14.57 If a person from either Scotland or Northern Ireland is moved to England or Wales and needs to be deprived of their liberty in order to receive care or treatment, then the Liberty Protection Safeguards can be considered. The same rules for identifying the Responsible Body apply to any such person moving from Scotland or Northern Ireland. For example, if the arrangements are taking place in an NHS hospital the Responsible Body will be the "hospital managers (normally the NHS Trust or NHS Foundation Trust in England, or LHB in Wales, responsible for that hospital). If the arrangements are taking place outside of a hospital and the person is not eligible for NHS CHC, the Responsible Body would be a local authority, normally the 'hosting' authority in either England or Wales – that is the local authority for the area in which the arrangements are taking place.

14.58 The Responsible Body should work closely with the placing authority who will be likely to know the person well. This may include using assessors or, if necessary, a professional trained as an AMCP from the placing authority in Scotland or Northern Ireland. Assessors and AMCPs will need to meet the requirements as set out in the relevant regulations in either England or Wales. AMCPs based in Scotland or NI will also need to be approved by a local authority in England or Wales and have relevant knowledge of care arrangements in England or Wales. For more information, please see chapter 16 for assessments and chapter 18 for AMCPs.

What happens when a person from England or Wales moves to a service in Scotland or Northern Ireland?

14.59 If a person subject to an LPS authorisation is moved from England or Wales to a service in Scotland or Northern Ireland, then the LPS will no longer apply. Where this is the case, the local authority and NHS services involved in the person's care or treatment should ideally liaise with the relevant services in Scotland or Northern Ireland to ensure appropriate measures are being put into place.

14.60 Please refer to the relevant legislation and processes for people who lack mental capacity in the relevant nation.

How should disputes be resolved?

14.61 In some cases, it may not be clear who the correct Responsible Body is, and two or more organisations may disagree on which is the Responsible Body. Where this is the case, it is essential that the person is not disadvantaged while the disagreement is resolved. Therefore, the Responsible Body that received the initial referral (assuming they are party to the dispute) or the first Responsible Body that is part of

the dispute that received the referral should begin the LPS process. This includes identifying whether there is someone suitable to act as the Appropriate Person or, if there is not, appointing an IMCA to allow the person to be represented and supported as soon as possible. Please see more information on the Appropriate Person at chapter 15 and more information on IMCAs at chapter 10.

14.62 Assessments may also need to be commissioned if the dispute may take some time to resolve. In this case, the Responsible Body that first received the referral and is party to the dispute should commission these assessments. For more information on assessments please see chapter 17.

14.63 In order to settle a disagreement on which Responsible Body is the correct Responsible Body, the body that first received the referral and is party to the dispute should:

- Identify an individual who will act as the point of contact within that Responsible Body in relation to the dispute and provide the other Responsible Bodies with the contact details of that individual.
- Collect evidence regarding where the person receives care or treatment, and which organisations commission and/or pay for that care or treatment. This includes evidence both from the lead organisations and all other organisations involved.
- Share all evidence with all involved organisations.
- Facilitate a discussion between the relevant organisations to discuss the evidence and agree a final outcome.
- Provide the person and their Appropriate Person or IMCA a written statement to inform them of the final position.

14.64 All organisations involved should engage with the dispute process including, providing all relevant evidence when requested to and engaging in constructive dialogue to reach a conclusion. If at any stage in the process the evidence that has been requested changes, then the lead organisations should be informed immediately.

14.65 All organisations have a responsibility, in order to uphold the human rights of the person, to ensure that any dispute is resolved as quickly as possible.

14.66 If a dispute cannot be resolved by the organisations involved, the matter may have to be resolved by a court.

14.67 If it is agreed that a new organisation will take over the role of Responsible Body from the initial organisation that received the referral, then costs associated with assessments and advocacy should be transferred to the new Responsible Body.

What is the Responsible Body's duty to provide information?

14.68 Each Responsible Body has a general duty to publish information about the following:

- **The effect of an authorisation.** Information under this requirement should include the types of care and treatment arrangements, restrictions and acts that may be put in place under an authorisation, and the circumstances in which a person can be considered deprived of their liberty. This could include examples of the arrangements for care or treatment which may amount to a deprivation of liberty and could be authorised by an LPS authorisation.

- **The process for authorising arrangements.** Information under this requirement should set out the process the Responsible Body must follow to assess whether the person is deprived of their liberty. This will include information about the assessments and determinations, consultation, and the pre-authorisation review stages. It should also explain how referrals can be made.

- **When an IMCA should be appointed.** Information under this requirement should set out the situations in which either the person or their Appropriate Person may need to be supported by an IMCA. Responsible Bodies should also consider including information about the role of an IMCA and what the person or their Appropriate Person can expect from the IMCA service. For more information on IMCAs see chapter 10.

- **The role of the Appropriate Person.** Information under this requirement should set out what an Appropriate Person will be expected to do throughout the LPS process, who may act as the Appropriate Person, and some useful resources for the Appropriate Person to improve their knowledge of the LPS process and their role. For more information on the Appropriate Person see chapter 15.

- **When an Approved Mental Capacity Professional (AMCP) may get involved in a case**. AMCPs provide enhanced oversight to those cases that need it most. Information under this requirement should set out the role of the AMCP and when a Responsible Body must or may refer a case to an AMCP. The Responsible Body should also consider including information about what steps they may take before referring a case to an AMCP. For more information on AMCPs see chapter 18.

- **The right to make an application to the Court of Protection.** Information under this requirement should explain the rights of the person and others to make applications to the Court of Protection. It should also include advice on

how to make an application, what sort of decisions can be the subject of an application, what are the powers of the court and how to access legal aid.

- **Reviews of an authorisation.** Information under this requirement should set out how reviews must be scheduled in the person's authorisation record, how someone can request a review of a person's authorisation, and the situations when an unscheduled review must take place. It should also include what will happen when a review is carried out, what the person and others can expect in terms of involvement and the sort of decisions that can be made following a review. It should also set out what a review may involve and when an AMCP will need to be involved.

14.69 Responsible bodies should consider working together in producing such information and materials for their local area. The Responsible Body must publish this in a place and format which is accessible and appropriate for the needs of the person and their Appropriate Person. The Responsible Body should also ensure that contact details for an appropriate contact on these matters within the Responsible Body are published alongside this information and are correct.

14.70 As soon as practicable after a referral has been received, the Responsible Body has a duty to take practicable steps to ensure the person and any Appropriate Person understand the nature of the proposed arrangements as they apply to the person. This should include information being provided in an accessible format to the person and their Appropriate Person, or meeting face to face if appropriate and practicable. The Responsible Body should also make sure that the person and any Appropriate Person have the opportunity to ask questions about this information. This process should also be carried out if a new Appropriate Person is appointed at any point during the assessment process or when an authorisation has been given.

14.71 The duty to take practical steps in relation to a particular matter does not apply if the steps needed are not practical. For example, if the person does not have the capacity to understand the information through any appropriate means, then it may not be appropriate to take such steps as described above.

14.72 Chapter 24 provides further information on the information rights of the person.

What is the Responsible Body's role in making sure data sharing is lawful?

14.73 Responsible Bodies must consider and meet their duties under all applicable information sharing and data protection legislation, common law duties and relevant guidance when sharing data as part of the LPS process. Responsible Bodies should also make sure that the Appropriate Person, AMCP and IMCA are aware of and understand their data responsibilities.

14.74 Responsible Bodies have a number of statutory and common law duties and obligations with respect to information sharing (including the Data Protection Act 2018, the UK GDPR and the common law duty of confidence) and must consider all requests to share data in accordance with such duties.

14.75 In addition to the powers and duties that a Responsible Body already has to share information (such as for the purposes of direct care, on a best interests basis or under relevant legislation such as s251B Health and Social Care Act 2012, as amended) Schedule AA1 of the MCA provides authority to the Responsible Body to disclose relevant documents on an implied basis. Provided that in each case sharing is appropriate, proportionate and limited to what is necessary, this would include sharing, as soon as practicable:

- relevant information to ensure the Appropriate Person understands the arrangements which are proposed;
- the assessments, determinations and outcome of the pre-authorisation review with the Appropriate Person, provided such a step is considered practicable and that the information is accessible to and appropriate to their needs;
- the information on which the Responsible Body relies in order to determine whether the authorisation conditions are met, with the AMCP at the pre-authorisation review stage;
- the relevant information that the appointed AMCP needs to consider in order that they may conduct a review.

How does the Responsible Body interact with the Court of Protection?

14.76 The Responsible Body is ultimately accountable to the courts. The Responsible Body's implementation of its duties, or non-implementation, under the LPS process and its authorisation decisions and can be challenged in court. If a case is brought before the court, anyone who has acted on behalf of the Responsible Body could also expect to be called to present evidence.

14.77 When a case has been considered by the Court of Protection, the Responsible Body should ensure that those involved in the arrangements are made aware of any decision of the court that changes the authorised arrangements or terminates the authorisation.

14.78 For further details about the Court of Protection see chapter 7.

What is the Responsible Body's role in monitoring and reporting?

14.79 Responsible Bodies are responsible for notifying the relevant monitoring bodies regularly of certain matters relating to the LPS, such as when an authorisation is given and when it ends. Please see chapter 20 for more information on the notification duty and monitoring bodies.

14.80 The monitoring bodies may also require access to records relating to the care and treatment of individuals subject to an LPS authorisation from the Responsible Body.

14.81 Additionally, Responsible Bodies have a responsibility for safeguarding people from abuse or neglect. If at any point a safeguarding concern is identified, this should be dealt with through the appropriate processes, including a safeguarding referral for an investigation under the Care Act 2014 or Social services and Well Being (Wales) Act 2014. All Responsible Bodies should have safeguarding policies and procedures already in place. Responsible Bodies should ensure those carrying out elements of the LPS process are trained in identifying safeguarding concerns and know how to escalate with any issues they identify.

15. What is the role of the Appropriate Person in the Liberty Protection Safeguards?

This chapter describes the Appropriate Person role in the LPS.

The Appropriate Person is a statutory role. The Appropriate Person must provide representation and support for the person during the LPS process and during any authorisation.

The Appropriate Person role is normally carried out by someone who is close to the person. When an individual is identified for the role, the relevant Responsible Body must determine if the individual is suitable for the role before appointing them. The individual should not receive remuneration for fulfilling the Appropriate Person role, and the individual must consent to being appointed to the role.

Quick summary

Who can be an Appropriate Person?

- **It is the Responsible Body's responsibility to determine if there is someone suitable to fulfil the requirements of the Appropriate Person role. The identified individual must consent to taking on the role before they are appointed.**
- **The person must consent to the individual being appointed to the role of Appropriate Person. If they lack the capacity to consent, the**

Responsible Body should make a best interests decisions for the person.

- **If there is not an individual suitable to undertake the Appropriate Person role, in most cases, the Responsible Body must appoint an Independent Mental Capacity Advocate (IMCA).**

What is the role of the Appropriate Person?

- **The Appropriate Person will need to understand the LPS process to help ensure that the person's wishes and feelings are properly considered. The Appropriate Person has the right to access certain information to help them with this.**

- **The Appropriate Person provides representation and support for the person and supports them throughout the LPS process. The Appropriate Person should ensure that the person is supported to understand the different stages of the authorisation process and the authorisation itself.**

The Appropriate Person's rights.

- **The Appropriate Person also has the right, in certain circumstances, to be supported in the role by an IMCA.**

Who can be an Appropriate Person?

15.1 The Appropriate Person is a suitable individual that can represent and support the person and, importantly, consents to carry out the role. It is an unpaid role, and the individual who undertakes it must not be engaged in providing care or treatment for the person in a professional capacity. Professional capacity means any person who is paid to carry out the person's care or treatment, either privately or publicly funded. It is unlikely that friends or family members will be providing care in a professional capacity, even if they are compensated for the care they deliver, for example through carer's allowance.

15.2 The relationship between the Appropriate Person and the person will vary in each case. However, those who are likely to act as an Appropriate Person can include (but are not limited to) the following:

- A family member

- A friend of the person
- The person's unpaid carer(s)
- A volunteer who provides support to the person in non-professional capacity (this can include via organisations that both do and do not provide care or treatment to the person)
- An attorney acting under a Lasting Power of Attorney or Court Appointed Deputy.

15.3 In some cases, the most suitable individual for this role will be a volunteer who provides support to the person and who knows the person well. For example, an active volunteer visitor from a local befriending scheme who has visited the person many times, and therefore knows them well, may be suitable and agree to take on the role. Alternatively, it might be appropriate to appoint an advocate or helper at a day centre or club which the person attends. In such cases, individuals could be appointed as long as they are not involved in carrying out the arrangements amounting to a deprivation of liberty. They must also meet the other suitability requirements for being an Appropriate Person which are set out throughout this chapter. See paragraph 15.23 for further information on when the individual being considered for the role of Appropriate Person lives with the person.

15.4 An attorney under a lasting power of attorney or a court appointed deputy should not be appointed to the Appropriate Person role if they are a professional deputy or attorney. The only exception to this would be if the person has specified, when they had capacity to do so, that they wanted the individual who is now their professional deputy or attorney to be their Appropriate Person. This could, for example, be recorded within the lasting power of attorney instrument or another document signed and dated by the person.

15.5 Where the attorney or deputy is directly involved in the arrangements amounting to a deprivation of liberty, for example, agreeing to a care home placement where the person is to be deprived of liberty, they should not be appointed as the Appropriate Person. The attorney or deputy cannot be paid for carrying out the Appropriate Person role. They must also fulfil the other criteria set out in the following paragraphs.

15.6 Ultimately, the role of the Appropriate Person is to support the person's active involvement in the Liberty Protection Safeguards (LPS) process and represent the person, and their wishes and feelings, to ensure that their human rights are protected. The Appropriate Person therefore needs to be able to act truly independently from their other interests in the person's care.

15.7 The Appropriate Person should know the person well and, in most cases, understand their communication style – for example speech, sign language and body language. This is important to be able to support the person with expressing

their views and to advise the Responsible Body about the person's communication needs – for example recommending the use of interpreters and alternative formats for information. However, if this is not the case, this should not in itself prevent anyone from taking on the role and learning more about the person to represent and support them.

15.8 If someone is identified as a suitable individual to be the Appropriate Person, they are not obligated to take on this role. They must expressly consent to the appointment. The Responsible Body should give the individual identified all the relevant information about LPS and the role of the Appropriate Person so they can make an informed decision about whether they wish to take on the role. The Responsible Body should be satisfied that the individual is able and willing to take on this role before they are appointed.

15.9 The Responsible Body should consider the support needs that the Appropriate Person may have and whether they need support to carry out the role. If so, the Responsible Body should consider how best it can support them in the role. If an individual would be suitable to be appointed as the Appropriate Person role, but needs additional support or training, the Responsible Body should consider how and whether this can be provided. See paragraphs 15.63 to 15.67 for more information.

How does the Responsible Body determine if there is a suitable individual to act as the Appropriate Person?

15.10 In order to appoint someone as the Appropriate Person, the Responsible Body must be satisfied that the individual is suitable to represent and support the person. There are a number of considerations the Responsible Body will need to take into account in making this decision.

15.11 An individual cannot be regarded as suitable unless:

- The person has capacity to consent to being represented and supported by that individual, and consents, or
- the person lacks capacity to consent to being represented and supported by that individual, and being represented and supported by the individual would be in the person's best interests.

15.12 This means that the starting point should always be the wishes and feelings of the person when it comes to appointing the Appropriate Person (irrespective of whether the person has the relevant capacity to consent to the appointment). The Responsible Body should take all practical steps to ascertain the person's views about who should be appointed as their Appropriate Person. If the person is able to

express a view on who they may want to represent them, then the Responsible Body should consider this individual.

15.13 If the person has an attorney or deputy with relevant authority, they should be asked to nominate someone to be the Appropriate Person (including themselves if appropriate).

15.14 The Appropriate Person should only be considered suitable if they are:

- 16 years of age or over;
- able to keep in contact with the person;
- not financially interested in the care and treatment providers who are carrying out the arrangements;
- not a relative of a person who is financially interested in those providers;
- not employed by, or providing services to, the person's care and treatment providers who are carrying out the arrangements; and;
- not employed to work in the Responsible Body in any other role related to the person's case.

15.15 In selecting the Appropriate Person, the Responsible Body must consider:

- Does the individual have satisfactory skills relevant for carrying out the role?
- Has the person got any relevant experience to perform the role, such as carrying out a similar formal or informal advocacy role under the Mental Capacity Act 2005, Care Act 2014 or the Social Services and Well-being (Wales) Act 2014.
- Does the person have a preference, if there is more than one suitable individual?
- Is there a written statement indicating their preference?
- Will the proposed individual be able to keep in contact with the person and, if appointed, maintain that contact?
- Does the person appear to trust and feel comfortable with the proposed Appropriate Person?
- Would the proposed Appropriate Person be able to represent the person effectively?
- Is the proposed Appropriate Person likely to comply with the obligations of being an Appropriate Person, including representing the person and supporting their involvement in the LPS process?

15.16 The Responsible Body should always consider the individual circumstances of the potential Appropriate Person when considering their suitability for the role. This includes considering how their age may affect their ability to carry out all the requirements of the role. For example, when considering whether a young person aged 16 or 17-years-old is a suitable Appropriate Person, the Responsible Body

should in particular consider their ability to represent and support the person and the views of the person, including in the Court of Protection.

15.17 The person may have expressed this view and given consent for a specific individual to act as their Appropriate Person when they had the mental capacity to do so. If this is the case, the Responsible Body should take this into account when making the best interest decision regarding who should be the Appropriate Person.

15.18 The Appropriate Person is expected to represent and support the person and to facilitate their involvement in the LPS process. Some individuals may be unable to fulfil this role easily, for instance a family member who lives at a distance and who only has occasional contact with the person, a spouse who also finds it difficult to understand the local authority processes, or a friend who expresses strong opinions of their own (about what a person's care needs are) prior to finding out those of the person concerned. It is not sufficient to know the person well or to love them deeply; the role of the Appropriate Person is to support the person's active involvement with the LPS processes and represent them effectively.

15.19 Responsible Bodies have a safeguarding role, and therefore should consider whether there are any safeguarding concerns about the individual before making the appointment. The Responsible Body should be alert to any factors that may indicate the person does not feel comfortable, or is overpowered by the individual, such as a change in their behaviour or communication when the individual is present. The Responsible Body should continue to consider safeguarding concerns throughout the appointment of the Appropriate Person, as a change to their relationship with the person could occur at any time.

15.20 As noted above, someone who is involved in the person's care or treatment in a professional capacity cannot be the Appropriate Person (e.g. doctor, nurse, social worker, support worker, personal assistant etc.). However, this does not prevent someone who works for a health or care provider but does not specifically provide care and treatment professionally to the person from becoming the person's Appropriate Person. Such an individual may still be suitable to carry out the role, providing they are willing to do so, meet requirements set out in paragraph 15.14, and the Responsible Body does not see any conflict of interest in their case.

15.21 The Appropriate Person must not be someone who would financially benefit from the person being deprived of their liberty in a specific location. For example, if a family member would financially benefit from the sale of the person's home if they were to move into a care home where they would be deprived of their liberty, that family member would not be suitable to act as the Appropriate Person. This would not exclude family members who sell the property to pay for social care and do not financially benefit directly from the sale from being the Appropriate Person.

15.22 As outlined in paragraph 15.6, the Appropriate Person must be able to act truly independently of their own views or interests in the person's care. For example, if a person is being placed into a setting that is not their usual home and the potential Appropriate Person agrees with the arrangements or the potential Appropriate Person is involved in providing care that includes significant restraint, the Responsible Body should exercise caution when considering their suitability for the role.

15.23 If the proposed arrangements take place mainly at the person's usual home, and a family member is the primary carer, they may still be suitable to carry out the role of the Appropriate Person. The Responsible Body should consider whether it would be in the person's best interests for that individual to be the Appropriate Person, including whether there are any safeguarding concerns with that individual carrying out the role.

15.24 In certain circumstances, the Appropriate Person will be expected to challenge the arrangements in the Court of Protection, so the Responsible Body should be satisfied that the individual would be able to bring this challenge if required, before appointing them.

15.25 If the Responsible Body has reason to believe that the person may not have the capacity to consent to the appointment of the Appropriate Person, then they must carry out a capacity assessment. If the outcome of that assessment is that the person does not have the capacity to consent to the appointment, then the Responsible Body can still appoint the Appropriate Person if it is in the person's best interests to do so. See chapter 5 for further information on best interest decisions.

Does the identified individual need to consent to their appointment as the Appropriate Person?

15.26 In order to be appointed as an Appropriate Person, the individual must consent to representing and supporting the person. If the person does not consent or lacks the relevant mental capacity to consent to taking on the role, then the Responsible Body should determine whether there is anyone else suitable and who will consent to undertake the role. If there is not an alternative individual suitable to undertake the Appropriate Person role, in most cases, the Responsible Body must appoint an Independent Mental Capacity Advocate (IMCA). An IMCA is a professional advocate who is trained in Mental Capacity legislation, including LPS. See chapter 10 for more details on the role of an IMCA.

15.27 A Responsible Body should never pressure an individual to consent to taking on this role. It should always be made very clear that the individual can refuse to consent,

and this will not affect their other rights, for example to be involved in the person's care and treatment and to be consulted prior to an authorisation.

15.28 In order for the individual to give valid consent, they should be given the relevant information about the Appropriate Person role, so they are able to make an informed decision. The relevant information includes, but is not limited to:

- What a deprivation of liberty means and the impact on the person,
- The role of the Appropriate Person and what is expected from the individual who undertakes the role (see paragraphs 15.47 - 15.59 below for more information),
- How to carry out the role, such as meeting the person regularly and challenging decision makers,
- The Appropriate Person's rights for support, including from an IMCA,
- Information on the person and Appropriate Person's rights to challenge an authorisation and how to challenge.

15.29 An individual who lacks capacity to consent to representing and supporting the person, cannot be appointed as the Appropriate Person. However, a Responsible Body must not treat the individual as unable to make this decision unless all practical steps have been taken to help them to do so without success. An individual must not be excluded from taking on the role simply on the basis they have or have had a mental health condition in the past, if they have capacity to consent to the appointment and are otherwise suitable for the role. It may be appropriate for them to be a supported by an IMCA in order to allow them to carry out the role. Please see paragraphs 15.64 – 15.67 for further information on IMCAs supporting the Appropriate Person.

Who identifies whether there is an Appropriate Person available?

15.30 The Responsible Body is required to determine if there is someone who is suitable to fulfil the requirements of the Appropriate Person, and that they are willing to take on that role.

15.31 There are many ways in which the Responsible Body may identify a potential individual to carry out the role of the Appropriate Person. Someone may be identified through other health and social care process such as assessments and reviews under Continuing Health Care/NHS Continuing Care, the Children Act 1989, the Care Act 2014/Social Services and Well-being Act (Wales) 2014, or other relevant legislation.

15.32 If the person's care is privately funded and has no relationship with health and care services, then it may not be immediately apparent if there is a potential Appropriate Person. In such cases the individual who raises the case with the Responsible Body

may be able to identify potential individuals (including themselves, if appropriate) to take on this role. The Responsible Body should explore whether anyone who is recommended, or anyone else, is suitable for the role.

15.33 An individual may have been considered by the Responsible Body and subsequently been identified as unsuitable to be the Appropriate Person or is unable or unwilling to take on the role. Where this is the case, they may be able to suggest someone else who may be able to be the Appropriate Person.

15.34 If an individual is identified and consents to be the Appropriate Person but the Responsible Body is not satisfied that they are suitable, this decision should be recorded, and the reasons clearly stated. The individual or someone else may decide to challenge this decision and the Responsible Body should have appropriate channels for such challenges. The Responsible Body should be able to clearly demonstrate the basis for their decision.

At what stage is an Appropriate Person appointed?

15.35 The Responsible Body must determine whether there is someone who is suitable to be appointed as an Appropriate Person as soon as the LPS process is triggered, for example where it has been identified in the care planning process that a deprivation of liberty may be necessary for the person's care or treatment. This ensures that the person is represented and supported from the start of the process.

15.36 In some instances, the Responsible Body will not be able to identify someone who is suitable to undertake the role of Appropriate Person at the beginning of the process. If this is the case, an IMCA may be appointed in the first instance while the Responsible Body determines whether there is a suitable Appropriate Person. If there is, the IMCA can be replaced by the Appropriate Person. There should not be a delay between the end of the IMCA's appointment and the start of the Appropriate Person's appointment. This could happen at any point, either during the initial authorisation process or once the authorisation is in place.

15.37 If the Responsible Body cannot find a suitable individual who consents to take on the role of Appropriate Person, it must in most cases appoint an IMCA to represent and support the person. The person may have capacity to consent to the appointment of an appropriate person and indicate that they do not want to be represented and supported by anyone other than an IMCA. In this situation, the duty to appoint an IMCA would be triggered. Please see more information about IMCAs in chapter 10.

What can someone do if an IMCA or an Appropriate Person is appointed but they believe there is someone else more suitable to be the Appropriate Person?

15.38 If someone thinks they, or anyone else, would be more suitable to be the Appropriate Person, but they have not been considered, they can raise this with the Responsible Body. The Responsible Body should consider the suitability of the individual in question to take on the role. This can take place at any time in the process, including once an authorisation is in place.

15.39 Once the Responsible Body becomes aware that there is someone else who may be able to carry out the Appropriate Person role, they should decide whether that individual should be appointed. In most cases this would be expected to be resolved through discussion with the person, the current Appropriate Person and the prospective Appropriate Person.

15.40 The Responsible Body should follow the steps outlined in paragraphs 15.10 – 15.25 to determine if the proposed individual is suitable. If so, it should consider the relevant factors of each individual to determine which would be the most suitable to continue in the role. Ultimately, the decision should focus on what is best for the person and, crucially, what the person themselves wants or would want if they had the capacity to consent.

15.41 If the Responsible Body decides the new individual is the most suitable individual to be the Appropriate Person, then provided they consent and the person consents, that individual should be appointed. If the person lacks the capacity to consent to the arrangements, then the Responsible Body must decide whether the appointment is in their best interests before making it.

15.42 If an IMCA had been appointed prior to the Appropriate Person being identified, the Appropriate Person will replace the IMCA. If needed, they should be supported by the IMCA as they transition into their role, with a view to deciding at a later stage whether the IMCA is needed for a longer period.

What can be done if someone thinks the Appropriate Person is not representing the views of the person they support?

15.43 The Responsible Body has an ongoing duty to ensure that the Appropriate Person remains suitable in the role. If concerns arise that the Appropriate Person is not representing and supporting the person, or that there may be a conflict of interest that was not previously noted, the Responsible Body should contact the Appropriate Person to clarify the position before deciding next steps. The Appropriate Person may not have realised that they were not carrying out their role effectively and may be able to change their approach to represent and support the person more effectively. In some cases the Appropriate Person would be entitled to support from

an IMCA. Otherwise it may be necessary to appoint another Appropriate Person or an IMCA to represent and support the person.

15.44 In some cases, the Appropriate Person may disagree with the Responsible Body's decision. Ideally the issue will be resolved through discussion and negotiation among the relevant parties. If the Appropriate Person is unhappy with the Responsible Body's decision, ultimately this may need to be resolved by a court.

Confirming Appointment to the Appropriate Person

15.45 When the Responsible Body identifies and appoints an Appropriate Person, it should inform the Appropriate Person in writing. This letter should provide a point of contact, with a name and contact details if they have any queries about the process or wish to communicate with the Responsible Body.

15.46 The appointment should be clearly recorded in the person's records, so that if anyone carrying out a role within the authorisation process, such as an assessment, can contact them if needed. If an authorisation is given, the Appropriate Person should be recorded on the authorisation record to ensure those involved in the person's care and treatment are made aware of the appointment and, for example, can contact the Appropriate Person if there is an issue to discuss about the person's case.

What is the role of the Appropriate Person?

15.47 The Appropriate Person provides representation and support for the person and supports them throughout the LPS process. It is an ongoing role, which means the Appropriate Person must provide representation and support throughout the period while the person is being assessed, and during the authorisation period. This may include representing the person at a review meeting or supporting the person to raise a concern about the authorisation. This will require being in regular contact with the person and liaising with decision makers to help them to understand the person's circumstances, and their wishes and feelings about the arrangements.

15.48 This will involve understanding the LPS process and what the person's rights are, which will be contained within the information the Responsible Body must provide to the Appropriate Person. Please see chapter 14 for a full list of the information a Responsible Body must provide.

15.49 In order to appropriately represent and support the person in the process, the Appropriate Person will need to discuss the process and the proposed arrangements with the person, and as far as possible help them understand what is being proposed. It is important for the Appropriate Person to ascertain whether the person understands why the arrangements are being proposed, and what they

would mean if authorised. The Appropriate Person should support the person to understand this information as far as possible so that, if they are able to, they can express their views.

15.50 The person should always be kept at the centre of the LPS process, to ensure that their wishes and feelings are properly considered when deciding whether to authorise the arrangements. The Appropriate Person must therefore ensure, as far as possible, that the person is involved at every stage, and they are supported to understand the different stages of the authorisation process and the authorisation itself. The Appropriate Person should ensure that they are in regular contact with the person and, if possible and appropriate, meet them face-to-face.

15.51 During the LPS process itself, there will be many times when professionals will need to meet with the person. This includes assessments, consultation, and reviews of the authorisation. It is the role of the Appropriate Person to ensure that the person is represented and supported in these engagements with professionals. It may be that, in some cases, the Appropriate Person will not be present during the assessments (for example if the person wishes to meet the professional on their own). If this is the case, the Appropriate Person can still play an important role for example by ensuring that the Responsible Body, or their representative, has a good understanding of the person's support needs (for example, communication methods). Additionally, the Appropriate Person should challenge any assumptions made about the person to ensure for example that the assessments carried out are fair and the professional carrying out the assessment and determination understands the person and their wishes and feelings accurately.

15.52 If the person is unable to communicate their wishes and feelings, the Appropriate Person should ensure, as far as possible, that the Responsible Body is aware of them. For example, if the reason the person cannot communicate their wishes and feelings is because a professional carrying out and assessment and determination is unable to understand the person's communication methods, the Appropriate Person could support the person in the meeting to put their views across. Alternatively, the Appropriate Person may want to write to the Responsible Body to provide a record of the person's wishes and feelings.

15.53 Whilst the authorisation is being considered by the Responsible Body, where relevant, the Appropriate Person should support the person or make representations to the Responsible Body and those delivering the person's care to consider less restrictive options. The Appropriate Person may also want to contact the professional carrying out the necessary and proportionate assessment and determination to make them aware of any less restrictive options or encourage the assessor to explore them.

15.54 If at any point the person has a concern about the proposed arrangements or process, or the Appropriate Person has reason to believe that the person would want them to raise a concern, the Appropriate Person should support the person to do so or represent the person's wishes and feelings. The concern should be raised with the relevant parties, such as an assessor, the person's allocated worker, or the Responsible Body directly. If the concern is regarding the quality of care, the relevant regulator should be told as soon as possible. If it is reasonable to believe that the person does not wish to reside or receive care or treatment in the place where they are being deprived of liberty, and the arrangements provide for that, then the Appropriate Person will need to make sure that the Responsible Body is aware because this would trigger the duty to refer the case to an Approved Mental Capacity Professional (AMCP). Please see chapter 18 for more information on AMCPs and chapter 13 for more information on the pre-authorisation review.

15.55 The person's wishes and feelings about whether they want to reside or receive care or treatment in the place may change at any time, either during the assessment stage or once an authorisation is in place. The Appropriate Person therefore needs to be alive to changes in the person's wishes and feelings and, where they arise, inform the Responsible Body. Where this is the case once an authorisation is in place, this would trigger a review, which would be carried out by an AMCP.

15.56 Once an authorisation has been given, the Appropriate Person is able to make a request for a review of the authorisation at any time. If a request is made and it is a reasonable one, then the Responsible Body must carry out a review. The Appropriate Person should represent and support the person through any review, to ensure that their wishes and feelings continue to be understood by decision makers. This may include meeting with the reviewer and supporting the person through further assessments and consultation.

15.57 The Appropriate Person can also make an application to the Court of Protection, for example to challenge the authorisation. They may also need to support the person who is seeking to challenge the authorisation in the court, for example, by helping them to explain their views to their legal representative, ensuring that the legal representative understands the person's wishes and feelings, supporting the person in court, and making a representation in court. They may also need to act as a litigation friend in some cases. See more information on challenging arrangements in chapter 24.

15.58 The role of the Appropriate Person helps to ensure that the person's Article 5 rights under the European Convention on Human Rights are being protected and upheld by the Responsible Body and those carrying out the arrangements. Article 5 protects a person's right to liberty and security and entitles the person to take proceedings to challenge his or her detention and have it decided speedily by a

court. Please see chapter7 for further information on the role of the Court of Protection and chapter 24 for information on challenging arrangements.

15.59 Prior to the authorisation record being signed, the Appropriate Person should ensure that the Responsible Body has indicated a schedule for reviews during the authorisation period. That schedule will reflect the individual circumstances of the case, and the Appropriate Person should work with the Responsible Body to decide how often to review the authorisation. Once reviews are scheduled, the Appropriate Person should both ensure that they take place as planned and where appropriate, represent and support the person during the review. See more information on reviews at chapter 13.

What are the Appropriate Person's rights?

15.60 The Appropriate Person has the right to be informed about the LPS process and the nature of the particular arrangements proposed for the person. The information provided must be accessible to and appropriate to the needs of the Appropriate Person and the Responsible Body must take steps to ensure the Appropriate Person understands the relevant matters as set out in the above paragraphs (e.g. the effects of an authorisation, the process for authorisation etc.). See chapter 14 about the information the Responsible Body must provide.

15.61 The Appropriate Person should be kept up to date with the person's case. If there are any developments in the person's case that would impact upon the authorisation of arrangements, the Appropriate Person should be informed as soon as possible. This includes any concerns raised by someone engaged or interested in the person's care or treatment, or any information which may mean the case is referred to an AMCP.

15.62 If an individual does agree to the role of Appropriate Person, they have the right to be supported to fulfil the role. This ranges from communication support through to formal support from an IMCA. Please see below for further information.

What support is available to the Appropriate Person?

15.63 The Responsible Body should consider the Appropriate Person's communication needs, such as spoken language or British Sign Language. As far as is practically possible, the Responsible Body should provide the relevant information in the Appropriate Person's required communication method. The Responsible Body should also consider the format of the documentation it provides so that it is accessible to and appropriate to both the needs of the person and the Appropriate Person.

15.64 The Appropriate Person has the right, in certain circumstances, to be supported in the role by an IMCA. It is important that the Appropriate Person is informed of the support available which can help them perform this statutory role. Responsible Bodies have a duty to provide certain information, and this must include information on situations in which an Appropriate Person should be supported by an IMCA.

15.65 If the Appropriate Person would like to be supported by an IMCA, they can make a request to the Responsible Body to appoint one. The Responsible Body has a duty to take reasonable steps to appoint an IMCA for an Appropriate Person if they have capacity to consent to being supported by an IMCA and they make a request. An IMCA may be appointed to support the Appropriate Person for a short period(s) or may be appointed for the full period of the assessment process and any subsequent period of authorisation.

15.66 If the Responsible Body thinks an Appropriate Person may need the support of an IMCA, but they have not made a request, they may speak to the Appropriate Person about the benefits an IMCA would offer to them in representing and supporting the person.

15.67 If the Appropriate Person lacks capacity to consent to being supported by an IMCA, an IMCA should be appointed if this would be in the best interests of the person. It would be rare that an Appropriate Person would be suitable to carry out this role if they were unable to consent to being supported by an IMCA. However, where this is the case it will be important for the Responsible Body to monitor the situation and ensure the Appropriate Person is carrying out their role effectively and is engaging with advocacy support. If, despite it being in the person's best interests, the Appropriate Person refuses to work with the IMCA, then they would not be suitable to carry out the role.

What information does the Appropriate Person have access to?

15.68 The role of Appropriate Person does not allow them to access all of the person's health and care records. However, as the Appropriate Person supports and represents the person in the LPS process, they will need to understand the nature of the arrangements, the effect of the authorisation as set out in the authorisation record, and relevant information about the LPS process. Therefore, the Appropriate Person should have access to relevant information. This includes the outcomes of any assessments and determinations, or consultation, in order to best understand the process and the effects on the person. This is an important safeguard to protect the person's Article 5 rights under the European Convention of Human Rights. This also applies whenever a review or renewal occurs, when further assessments or consultation is carried out.

15.69 The information that the Appropriate Person should have access to includes the assessment and determinations. This is in order to enable the Appropriate Person

to understand the reasons for the arrangements being made and any subsequent authorisations. This ensures that the Appropriate Person can effectively support and represent the person to express their wishes and feelings with respect to the arrangements or express them on the person's behalf. The person's consent should be sought in the first instance before sharing this documentation with the Appropriate Person. However, the person's lack of capacity to consent to sharing the relevant information should not prevent the sharing of this information.

15.70 The person has the right to decline permission for the Appropriate Person to receive certain information. If the person lacks the relevant capacity to make such a decision, the sharing of information, beyond that which is required for the Appropriate Person to carry out their functions, should be done on a best interest basis.

15.71 During the consultation, the person may not wish for the Appropriate Person to see certain statements made by them. The professional undertaking the consultation should be made aware of this and may decide not to record such points in documents that will be shared or redact such documents accordingly. However, the person's objection to the sharing of relevant information with the Appropriate Person may indicate the need to reconsider whether the Appropriate Person remains suitable in the role.

15.72 There may be some cases where professionals will choose not to share confidential information with an Appropriate Person. In this case, the Appropriate Person can request the Responsible Body to arrange for the relevant information to be shared. The Responsible Body may do so if it is considered to be lawful and in the person's best interests to do so. If it is not considered lawful or in the person's best interests for the information to be shared with the Appropriate Person, they can request support from an IMCA, who has the right to access certain records as stipulated in regulations and may use this information to support the person even if they may not share it with the Appropriate Person.

15.73 If the LPS process is not going to be completed within 21 calendar days, the Appropriate Person should be made aware of this as soon as the Responsible Body has established it is not possible. The Responsible Body should also record the length of time that the authorisation process has taken and the reasons for this and share this with the Appropriate Person as soon as is practicable.

15.74 If the individual undertaking the pre-authorisation review requests that further work is undertaken, this fact and details of what is required should be shared with the Appropriate Person. This should take place at the same time as those involved in undertaking the assessments and determinations and consultation and those involved in delivering the proposed arrangements receive the information.

15.75 Once the arrangements have been authorised, the draft authorisation record becomes the authorisation record. The Responsible Body has a duty to provide a copy of the authorisation record to the Appropriate Person and the person without delay. If this is not done within 72 hours, the Responsible Body is required to record the reason for this. This information should also be shared with the person and their IMCA or Appropriate Person.

15.76 If the proposed arrangements are not recommended for authorisation, the reasons for this should be shared with the Appropriate Person at the same time as those involved in delivering the proposed arrangements.

What happens if the Appropriate Person decides they can no longer fulfil this role?

15.77 If an Appropriate Person wants or needs to step down from the role for whatever reason, they can do so at any stage. They should notify the Responsible Body as soon as possible so that a decision can be made about whether there is another person to take on this role, or if an IMCA would be required. If it is possible to have a period of handover, this would enable continuity of representation and support for the person. A handover period may include the Appropriate Person introducing the person to the IMCA and meeting them together a few times in order for the person to get to know the IMCA. The Appropriate Person should also ensure that the IMCA understands all the relevant information, including information about the arrangements and the person's wishes and feelings.

15.78 If the Appropriate Person becomes aware of a conflict of interest that may mean they are no longer suitable to carry out the role they should tell the Responsible Body so that another Appropriate Person or an IMCA can be identified and appointed. This can happen at any time throughout the process or during the authorisation period. If an Appropriate Person is uncertain about whether there is a conflict of interest, they should discuss it with the IMCA, if they are supported by one, or with the Responsible Body if not, so that they can be advised on whether they should stand down.

16. What are the assessments and determinations required for the Liberty Protection Safeguards?

There are three assessments and determinations which must be carried out to determine whether the authorisation conditions are met. The Responsible Body needs this information when it is considers whether or not to authorise a case.

The relevant regulations in England and Wales set out the qualifications and experience that a professional is required to have in order to undertake each of the three assessments.

The person must be assessed against the authorisation conditions. In order to accept that authorisation, a determination must be made on whether the assessment has shown the LPS authorisation conditions are met.

Quick summary

LPS Assessments and Care or Treatment assessments and reviews

- A person who is being assessed under the LPS may also be eligible for an assessment or review under other legislation, such as the Care Act 2014. Where this is the case, assessments should be carried out together, as far as practicable and appropriate.

Assessments and determinations required for the LPS

- Three assessments and determinations must be carried out by no less than two professionals before a Responsible Body can consider an authorisation to deprive someone of their liberty. These are:
    - the capacity assessment and determination of whether the person lacks capacity to consent to the arrangements,
    - the medical assessment and determination of whether the person has a mental disorder, and
    - an assessment and determination of whether the arrangements are necessary to prevent harm to the person and proportionate in relation to the likelihood and seriousness of harm to the person.

- For a Responsible Body to give an authorisation, these authorisation conditions must be met.
- Detailed guidance on the capacity assessment and determination, the medical assessment and determination, and the necessary and proportionate assessment and determination is set out below.

What happens to assessments at renewal or when there is a substantial change in the person's circumstances?

- When the authorisation period is coming to an end and if the Responsible Body is satisfied that the authorisation conditions continue to be met, the authorisation may be renewed without further assessments.
- However, if, depending on the circumstances of the case, the Responsible Body is not satisfied that the authorisation conditions are still met, further assessments may be needed.
- A review must be carried out if the Responsible Body becomes aware that a person's condition or circumstances have significantly changed, and a new authorisation may be needed.

LPS Assessments and Care or Treatment assessments and reviews

16.1 A person who is being assessed under the Liberty Protection Safeguards (LPS) may also be eligible for an assessment or review under other legislative frameworks, such as:

- a needs assessment or review under the Care Act 2014, or the Social Services and Well-being (Wales) Act 2014,
- an assessment under the Mental Health (Wales) Measure 2010,
- an assessment or review under Continuing Health Care (England) or NHS Continuing Care (Wales),
- an assessment or review of eligibility for NHS-funded nursing care,
- an assessment or review under section 117 of the Mental Health Act 1983, or,
- an assessment or review under the Children Act 1989 (England).

16.2 Care and treatment options should be considered carefully, with the aim of reducing restrictions if possible, before considering arrangements that amount to a deprivation of liberty. When carrying out any assessment or review under these legislative frameworks, where relevant, the principles of the MCA must always be

followed. This includes taking all practicable steps to help the person make decisions for themselves.

16.3 Where possible, the LPS assessments, determinations, reviews and renewals) should be embedded in the assessments and reviews processes carried out under these other legislative frameworks. For example, it will be particularly important to carry out the necessary and proportionate assessment and determination under the LPS, as part of a relevant health or social care assessment or review. This is because both processes look at the needs of the person and the necessary arrangements for their care or treatment, and should be aligned as far as possible. Embedding the processes will reduce the total number of formal processes that the person goes through. It will also integrate the LPS into mainstream care and treatment processes, leading to more comprehensive care and treatment plans.

16.4 It may be that the person already has an equivalent assessment that meets the same evidence requirements for the medical or capacity assessment and determination under the LPS, for example as a result of the care or treatment planning process starting before the LPS process was triggered, or because the person already has a care and support plan. Where this is the case, and it is reasonable to rely on that assessment and determination, that assessment and determination may be used for the purposes of the LPS. The relevant sections of this chapter provide further information on when it would be reasonable to use these assessments.

16.5 An equivalent assessment cannot be used for a necessary and proportionate assessment and determination.

16.6 Further information on the arrangements for 16- and 17-years olds can be found in chapter 21. Further information on the overall process can be found in chapter 13.

Assessments and determinations required for the LPS

16.7 In order for a responsible body to give an authorisation, the authorisation conditions must be met. There are three formal assessments and determinations which establish whether or not the authorisation conditions are met. These are:

- a mental capacity assessment and determination that the person lacks capacity to consent to the arrangements,
- a medical assessment and determination that the person has a mental disorder, and;
- a necessary and proportionate assessment and determination that the arrangements are necessary to prevent harm to the person and proportionate in relation to the likelihood and seriousness of harm to the person.

16.8 To ensure that decisions taken regarding deprivations of liberty are not arbitrary, there should be no fewer than two professionals involved in carrying out the three assessments and determinations required under the LPS. For example:

- a social worker involved in the person's care could undertake the capacity and necessary and proportionate assessments and determinations, and a doctor could provide the medical assessment and determination, or
- in a hospital, a doctor could carry out the medical and capacity assessments and determinations, and an occupational therapist could provide the necessary and proportionate assessment and determination, or
- all three assessments and determinations could be carried out by three different professionals.

16.9 The professionals carrying out the assessments and determinations should have a degree of independence from each other. It will be a matter for Responsible Bodies to decide the precise arrangements to ensure independence based on the individual circumstances of the case, but the following principles should be considered:

- an individual carrying out an assessment and determination should not be involved in the same business venture as another carrying out an assessment and determination, including being a partner, director, other office holder or major shareholder; and
- an individual carrying out an assessment and determination should not direct the work or employ another carrying out an assessment and determination; and
- those carrying out an assessment and determination should not be members of the same team who work together for clinical purposes on a routine basis. For example, they could work in the same hospital, but should not routinely work on the same ward.

16.10 The Assessment and Determination Regulations set out the relevant requirements for professionals carrying out each assessment and determination. For all three assessments and determinations Responsible Bodies need to be satisfied that the professional carrying them out:

- is insured in respect of any liabilities that might arise in connection with carrying out the assessment;
- has the skills and experience appropriate to carry out the assessment, including an applied knowledge of the MCA and the related Code of Practice, and the ability to keep appropriate records and to provide clear and reasoned reports in accordance with legal requirements and good practice;
- has an enhanced criminal record certificate or other prescribed criminal record certificate;
- is not a relative of the person in respect of whom the assessment is being carried out;

- is not financially interested in the care of the person; and
- is not a relative of a person who is financially interested in the care of the person.

16.11 In Wales, Responsible Bodies will also need to be satisfied that the professional carrying them out:

- has the ability to communicate effectively with a view to identifying characteristics and attributes of the person that are relevant to that person's needs; and
- has the ability to act independently of any person who appoints them to carry out an assessment and of any person who is providing care or treatment to the person.

16.12 Further requirements on who may undertake each assessment and determination are set out in the relevant sections of this chapter, as well as in the Assessment and Determination Regulations themselves.

16.13 The assessment and determination must be carried out by a professional who meets the relevant eligibility requirements for the specific assessment. However, that professional may ask another professional or practitioner to carry out some or all of the elements of that assessment and determination on their behalf. Ultimately, that professional will remain legally accountable for the assessment and determination, including those elements carried out by others. For example, the assessor may ask a non-qualified social worker to carry out some elements of the necessary and proportionate assessment and determination on their behalf.

16.14 There are some instances where it may be appropriate to rely on a previous medical or capacity assessment and determination. Further information is provided on using previous assessments in the relevant sections of this chapter.

16.15 It may also be that a previous assessment has been carried out by someone who is not eligible under the LPS, for example a medical assessment carried out by a nurse. Whilst this does not qualify as an LPS previous assessment, it can be taken into account by the assessor providing the assessment and determination.

16.16 Following completion of each assessment, a determination must be made on whether the person meets the relevant condition for an authorisation under the LPS. Where a new assessment has been carried out, the assessor should normally make a determination on the assessment they have carried out. In the case of necessary and proportionate assessments, the assessor must always carry out the determination.

16.17 In line with legal framework in the Care Act 2014, the Social Services and Wellbeing (Wales) Act 2014 and the Children Act 1989 and 2004, and associated statutory guidance, professionals working with adults and children should be alert to any potential safeguarding issues. If any potential safeguarding concerns arise when a professional is carrying out the LPS assessments and determinations, these should be escalated under the local safeguarding adults or children procedures. In Wales, the national Wales Safeguarding Procedures must be followed.

16.18 There are a number of other requirements that must be confirmed before a Responsible Body can authorise the person's arrangements under LPS. Please see chapter 13 on the Overall Process for more information about these additional factors.

What happens to assessments at renewal or when there is a change in the person's circumstances?

16.19 When the authorisation period is coming to an end and if the Responsible Body is satisfied that the authorisation conditions continue to be met, the authorisation may be renewed. In some cases, it may not be necessary to carry out new assessments and determinations for this purpose. For example, a person may have severe dementia, their capacity has not changed, and the arrangements and their situation are the same or have been varied slightly. If the Responsible Body is confident that the authorisation conditions continue to be met, then it is possible for the authorisation to be renewed without needing to carry out new assessments and determinations.

16.20 At renewal stage, there is no requirement to carry out further assessments and determinations if the Responsible Body is satisfied that the authorisation conditions are still met and it is unlikely that there will be any significant change in the person's condition during the renewal period which would affect whether the authorisation conditions are met. However, if, depending on the circumstances of the case, the Responsible Body is not satisfied that the authorisation conditions are still met, further assessments and determinations may be needed. At the renewal stage, consultation must be carried out, and it may become evident that the person's condition or circumstances may have changed, and so further assessments may be needed. Further information on the process is provided in chapter 17 on consultation. Alternatively, a review may be carried out to decide if the authorisation conditions continue to be met or whether further assessments and determinations are needed. Further information on the process of renewal can be found within chapter 13 on the Overall Process.

16.21 If the Responsible Body becomes aware that a person's condition or circumstances have significantly changed, for example their health has deteriorated or improved or greater or lesser restrictions are needed to prevent harm to the person, a review must be carried out. The Responsible Body should also consider whether one or

more assessments and determinations need to be arranged. If the review or assessment(s) and determination(s) finds that the authorisation conditions are no longer met, then the authorisation must end.

16.22 If the review indicates, or the Responsible Body otherwise has reason to believe, that the arrangements need to be changed, (for example if the person needs to be moved to a new placement), then a new authorisation may be needed. If so, new assessments and determinations should be commissioned, unless previous or equivalent assessments may be used. Further information on using on previous and equivalent assessments is provided in the relevant sections of this chapter.

The Mental Capacity Assessment and Determination

16.23 An assessment and determination that the person lacks capacity to consent to the proposed arrangements must be completed before an authorisation can be given. Please see chapter 12 on the Definition of a Deprivation of Liberty for information on the principles to consider when assessing capacity to consent.

16.24 Mental capacity assessments and determinations for the LPS fall under the framework established by sections 1 to 3 of the MCA. They should be carried out with reference to sections 2 and 3 of the MCA, and the principles of the MCA must be followed. One of the main differences for a capacity assessment and determination carried out under the LPS – unlike other capacity assessments carried out under the MCA - is that they must be undertaken by a professional who meets the requirements set out in the Assessment and Determination Regulations. For information on capacity assessments under the MCA see chapter 4.

16.25 Assessments for mental capacity are both decision and time specific. Therefore, a mental capacity assessment and determination undertaken as part of the LPS process must be specific to the arrangements proposed or in place for the person's care or treatment that give rise to a deprivation of liberty. In some cases, the proposed arrangements will cover multiple settings and arrangements, in which case the Responsible Body should consider whether more than one capacity assessment and determination is necessary. In making this decision, the Responsible Body should consider factors such as whether the arrangements in place across multiple settings are materially different, and whether the interdependence between the different arrangements mean that a single assessment is appropriate. Each case will have its own unique circumstances. This decision must never be based on resource considerations or administrative convenience.

16.26 If it is decided that separate capacity assessments and determinations are needed, these can be carried out at the same time and by the same professional if this is considered to be appropriate. Decision makers should ensure that individual

capacity assessments and determinations are consistent and coherent and do not contradict each other.

Who can undertake the mental capacity assessment and determination under the LPS?

16.27 It is the Responsible Body's role to decide who is best placed to undertake the capacity assessment and determination. The Assessment and Determination Regulations set out the eligibility requirements for carrying out the mental capacity assessment and determination. To carry out the capacity assessment and determination an individual must meet the requirements set out in paragraph 16.10, and must be one of the following:

- a medical practitioner
- a nurse
- an occupational therapist
- a social worker
- a psychologist
- a speech and language therapist

16.28 The assessor must be registered with their professional regulator as specified in the Assessment and Determination Regulations and may be a registered professional in any part of the UK. The Responsible Body must be satisfied that the person is not suspended from the register relevant to the person's profession.

Fluctuating capacity

16.29 Chapter 4 provides advice on what to do when a repeat decision is being made for a person who has fluctuating capacity. When assessing and determining whether the person has the relevant mental capacity to consent to a deprivation of liberty, and their capacity may be fluctuating, the principles for repeat decisions should be applied.

16.30 If the professional carrying out the assessment and determination has reasonable belief that the person's capacity is fluctuating on the first occasion they meet, the professional should arrange to meet with the person on several occasions. This belief may be established during the assessment itself or, through further evidence provided by those who are close to or work with the person. The professional should, as far as possible, arrange for further visits according to the person's routine, for example if the person tends to have greater capacity to make decisions in the morning than in an evening and it would therefore be appropriate to assess their capacity at both times.

16.31 Where a person is not likely to regain capacity often, or if they do regain capacity it is only likely to be for a short time, it may be appropriate to proceed on the basis

that they lack the relevant capacity. However, if the person is likely to regain capacity more often than they lack capacity, and/or will have capacity for longer periods, it may be more appropriate to proceed on the basis that the person has the relevant capacity for the purposes of the LPS.

16.32 It may be that if the person is likely to regain capacity often, a shorter authorisation period would be appropriate or at least regular reviews should be considered. This may mean that a new capacity assessment and determination is needed regularly in order to cease the current authorisation and, where necessary, put a new authorisation in place. Further information on authorisations for people who have fluctuating capacity is in chapter 14.

16.33 It may be appropriate to rely on a previous assessment and determination that the person has fluctuating capacity. However, this would only ever be appropriate if the person's fluctuating capacity is likely to be consistent and predictable.

What should be included in the final record of the capacity assessment and determination?

16.34 When recording the capacity assessment and determination for the Responsible Body, the assessor should explain all the practicable steps taken to support the person with their decision-making. The assessor should also detail the relevant information that the person needs to understand, retain or use and weigh information for the decision, or that the person was unable to communicate their decision. The record should also include evidence of the person's impairment or disturbance of the mind or brain and how this directly causes the person's lack of relevant mental capacity, and any other evidence that the assessor feels is necessary.

16.35 If the assessor considers the authorisation condition is met but the person is likely to experience fluctuating capacity, they should consider and record a view on whether the person's capacity will fluctuate often, how long the periods of incapacity are likely to last and whether the periods of capacity are likely to outweigh the periods of incapacity, or vice versa. This will assist the Responsible Body in setting the length of the authorisation and the frequency of reviews.

16.36 As outlined in paragraph 16.33, a record should be made of the assessment of the person's capacity to make the decision. This should cover whether the person can understand, retain, and use or weigh the information to make the relevant decision, and communicate their decision. The person can be assessed as lacking the relevant capacity if the assessment demonstrates that they are unable to do any of these things and this is the direct result of an impairment or disturbance in the functioning of the mind or the brain.

16.37 One of the main principles of the LPS is keeping the person at the centre of the process, so, where the person has ascertainable wishes and feelings, these should be clearly documented.

16.38 As well as providing a report to the Responsible Body, those undertaking the assessment and determination may record details of the outcome in the person's health or social care records if appropriate.

When is it appropriate to rely on a previous capacity assessment or a capacity assessment carried out for a different purpose?

16.39 As capacity is decision and time specific, in the majority of cases a new capacity assessment and determination will need to be completed.

16.40 However, in some circumstances, it will be possible for the Responsible Body to rely on an earlier assessment and determination or an assessment carried out for another purpose. It is not possible to give a prescriptive list of such cases, as there will be many case-specific factors to consider. In considering whether it is reasonable to rely on a previous or equivalent assessment, as a minimum, the Responsible Body should:

- Have regard to the degree of the incapacity; the nearer to the borderline, the less reasonable in principle it will be to rely on that assessment.
- Check who undertook the assessment, and that it was completed by a person who meets the eligibility requirements set out in the Assessment and Determination Regulations (see paragraph 16.10 and 16.26).
- Consider how long ago the assessment was undertaken. Although no specific time limit is given, it is more likely that the longer ago the assessment was done, the less likely it is to be valid.
- Ensure that the relevant information (i.e. the factors that need to be understood, used and weighed in order to reach a decision) is the same or of sufficient similarity to the relevant information in the previous assessment. Given this is an assessment determining capacity to consent to the proposed arrangements, unless the assessment was in relation to those arrangements or arrangements of a sufficiently similar nature and degree, it cannot be relied upon.
- Consider whether there has been a change since the assessment was undertaken in the person's condition or behaviour, or a deterioration or improvement in physical or mental health. If there has been a change which indicates the possibility of an improvement in capacity, the previous assessment is unlikely to be acceptable.
- Check whether, since the last assessment, the person has received or has been receiving any medication, treatment, rehabilitation, education or support that may reasonably improve their condition or capacity.

- Check whether the previous assessor expressed an opinion on the likelihood of the person regaining capacity, particularly in the relevant domain of capacity.

16.41 A previous or equivalent capacity assessment cannot be relied on for the purpose of the Liberty Protection Safeguards if it has been completed by an individual who does not meet the requirements set out in the Assessment and Determination Regulations.

16.42 If the pre-authorisation reviewer is not satisfied that it was appropriate to rely on a previous or equivalent assessment, they will not be able to conclude that the authorisation conditions are met or that it is reasonable for the Responsible Body to reach this conclusion. If this occurs an authorisation cannot be given, and the Responsible Body may need to consider whether to arrange a new assessment. Further guidance is provided in chapter 13 on the Overall Process.

The Medical Assessment and Determination of a Mental Disorder

16.43 The Mental Health Act (1983) ("the MHA") defines a mental disorder as any disorder or disability of the mind. Mental disorder under the LPS is given the same meaning as mental disorder under the MHA. Under the LPS, a medical assessment and determination is required to establish whether the person has a mental disorder before an authorisation can be given.

16.44 The determination made on a medical assessment is whether the person has a mental disorder as defined under the MHA. However, the learning disability exclusion that applies to certain sections of the MHA does not apply to the medical assessments under the LPS. This means that the deprivation of liberty of a person with a learning disability, even if that learning disability is not associated with 'abnormally aggressive' or 'seriously irresponsible conduct', can be authorised under the LPS, providing the other authorisation conditions apply. See chapter 22 for more information on the interface between Liberty Protection Safeguards and the MHA.

Who can undertake the medical assessment and determination?

16.45 It is the Responsible Body's role to decide who is best placed to undertake the medical assessment and determination. The Assessment and Determination Regulations specify the eligibility requirements for an assessor to undertake a medical assessment. Medical assessments and determinations may only be carried out by a registered medical practitioner (including GPs and psychiatrists) or a registered psychologist who meets the conditions of these regulations. The same professional should normally carry out both the assessment and determination.

16.46 The professional undertaking the medical assessment and determination should consider consulting with other professionals when establishing whether or not the person has a mental disorder, in cases where it may be harder to identify.

16.47 The Responsible Body can rely on a previous medical assessment and determination if it is reasonable to do so. For example, if a previous assessment has determined that that the person's mental disorder is likely to be permanent or progressive. Please see further information about using previous assessments below.

Medical assessment and determinations of a medical assessment

16.48 The meaning of mental disorder is extremely broad and will cover conditions such as schizophrenia, bi-polar disorder, dementia, learning disability, autism, and most forms of brain injuries. In order to authorise arrangements under the LPS, the Responsible Body must be satisfied that the person has a mental disorder.

16.49 In most cases this will be simply established by obtaining a diagnosis of a specific condition. A diagnosis letter, signed by a registered medical practitioner (including GPs and psychiatrists) or a registered psychologist who meets the conditions of the regulations, will normally meet the required evidence for the assessment and determination. Where the person has a diagnosis, or it is possible to obtain a diagnosis in the relevant timeframes for LPS, then the Responsible Body should request a letter confirming the diagnosis. If the Responsible Body is not aware that a previous diagnosis has been made, the Responsible Body should contact a clinician with oversight of the person's care in the first instance to seek this information (this may be for example a GP, registered psychologist or psychiatrist). If the person does not already have a diagnosis, the Responsible Body should seek a diagnosis of the person's condition through the clinician overseeing the person's care.

16.50 In some cases, where a diagnosis has not already been made, diagnosing a precise condition may not be straightforward and may take a significant amount of time. If it is not possible to reach a final diagnosis before an authorisation needs to be given, either within the 21 day timeframe for completing LPS authorisations, or within a shorter timeframe for urgent cases, an authorisation may need to be given before a final diagnosis has been made. In such cases an authorisation can still be given as long as the medical assessment and determination has concluded that the person has a mental disorder, but that the precise diagnosis cannot currently be confirmed. In such cases a preliminary diagnosis may be appropriate. The Responsible Body should, where appropriate, seek a precise diagnosis of the person's condition as soon as possible and update its records accordingly. In some cases, the Responsible Body should consider whether a shorter authorisation or regular reviews would be appropriate if the precise diagnosis is not yet confirmed.

What should be included in the final record of the medical assessments and determinations?

16.51 The medical assessment and determination should clearly set out whether the person has a mental disorder.

16.52 The recording of a medical assessment and determination should be supported with supplementary evidence as appropriate, such as a record of when and where the patient was interviewed or the views of other professionals.

16.53 If no precise diagnosis is possible, the medical professional carrying out the assessment and determination should clearly record that the person has a mental disorder within the assessment and determination. They should also indicate why it was not possible to obtain a more precise diagnosis.

16.54 Additionally, the assessor should consider whether it is possible to also provide information on whether the person's diagnosis is likely to change in the future (for example someone with a short-term brain injury), or whether the person's diagnosis is unlikely to change, such as someone born with a learning disability. If it is possible to provide this information, it should also be recorded on the medical assessment and determination.

When is it appropriate to rely on a previous or equivalent medical assessment or a medical assessment carried out for a different purpose?

16.55 It may be that an assessment has already been undertaken. For example, an equivalent assessment under another framework or when a person has already been under an LPS authorisation, but their circumstances have changed significantly which led to that authorisation being ceased and a new authorisation is needed.

16.56 When considering relying on a previous or equivalent assessment and, determination, the Responsible Body as a minimum, should:

- Check who undertook the assessment and determination – was it completed by a person who meets the eligibility requirements set out in the Assessment and Determination Regulations (see paragraphs 16.10 and 16.44)
- Check how long ago the assessment and determination was undertaken. Although there is no specific time limit for the use of previous assessments and determinations, depending on the person's condition, it may be that the longer ago the assessment was completed, the less likely it is to be still relevant.
- Check whether there has been a change in the person's condition since the assessment was undertaken. If the person has improved since, it may be that they no longer have a mental disorder. For example, a person who has depression may recover over time.

16.57 If the previous assessment has determined that the person's mental disorder will not change, then it may be reasonable for the Responsible Body to rely on this. Unless the evidence is clear, or there is reason to believe the person may no longer have a mental disorder, a new assessment and determination will be necessary.

16.58 If the pre-authorisation reviewer is not satisfied that it was appropriate to rely on a previous assessment and determination, they will not be able to conclude that the authorisation conditions are met or that it is reasonable for the Responsible Body to reach this conclusion. If this occurs, an authorisation cannot be given, and the Responsible Body may need to consider whether to arrange a new assessment and determination. Further guidance on the pre-authorisation review is provided in chapter 13 on the Overall Process.

The Necessary and Proportionate Assessment and Determination

16.59 Arrangements amounting to a deprivation of liberty can only be authorised under the LPS if the arrangements are both necessary to prevent harm to the person and proportionate in relation to the likelihood and seriousness of this harm. An assessment must be completed, and a determination made on that assessment that this authorisation condition is met.

16.60 For the first authorisation of arrangements, a new necessary and proportionate assessment and determination must be completed. An equivalent assessment cannot be used for the necessary and proportionate assessment and determination. At the point of renewal, if the responsible body is satisfied that this condition continues to be satisfied, it may be appropriate to use a previous necessary and proportionate assessment and determination.

Who can undertake the necessary and proportionate assessment role?

16.61 Unlike the capacity and medical assessments where the assessor can be different from the person making the determination, the assessor for the necessary and proportionate assessment must also make the determination.

16.62 The necessary and proportionate assessment and determination must be completed by a professional who meets the eligibility requirements in the Assessment and Determination Regulations, as set out in paragraph 16.10, and must be one of the following:

- a medical practitioner
- a nurse
- an occupational therapist
- a social worker

- a psychologist
- a speech and language therapist.

16.63 The person must be registered in their profession, in any nation of the UK. The Responsible Body must be satisfied that the person is not suspended from the register relevant to the person's profession.

16.64 The assessment should, whenever possible and appropriate, be carried out as part of any other care and treatment assessments or reviews under other legislation that is happening at the same time, as outlined in paragraph 16.3. The professional undertaking a social care or health assessment or review where the proposed arrangements may amount to a deprivation of liberty, should when possible and appropriate, also complete the necessary and proportionate assessment for the LPS, provided they meet the requirements set out in the Assessment and Determination Regulations. Responsible Bodies should consider this when arranging a social care assessment, or health assessment or review.

16.65 If the individual carrying out the care or health assessment or review does not meet the requirements, then someone who is able to carry out the necessary and proportionate assessment should, where possible and appropriate, carry out both assessments. Further information on the interface between LPS and health and social care planning is provided in chapter 16.3 and in chapter 13 on the Overall Process.

What does the assessor need to consider?

16.66 In order to determine whether the arrangements are necessary and proportionate, the assessor should:

- have regard to the person's wishes and feelings;
- consider whether there are less restrictive options; and
- have regard to whether the arrangements will improve the person's health and wellbeing.

16.67 The professional undertaking the assessment and determination should ascertain and have regard to the person's past and present wishes and feelings, and how strongly they feel about the proposed arrangements. Considering both criteria is especially important in cases where the proposed arrangements are contrary to the person's own wishes and feelings, as this is likely to make the arrangements even more restrictive. For example, in some cases it will be clear that the person is adamantly opposed to the arrangements, in which case there must be a strong justification for determining that the arrangements remain necessary and proportionate. The assessor will have to consider what weight should be given to the person's wishes and feelings: the greater the gap between the person's wishes

and feelings and the proposed arrangements, the greater the need for a clear and robust justification for those arrangements.

16.68 In order to ascertain the person's wishes and feelings, the Responsible Body must consult with the person and those involved in their care or close to the person. As the professional carrying out the necessary and proportionate assessment and determination would also need to talk to people involved in the person's care in order to get a good understanding of the person's circumstances, the Responsible Body should ask the professional to carry out the required consultation on its behalf. Chapter 17 provides further guidance on consultation for the purposes of LPS.

16.69 The professional undertaking the assessment and determination must consider if the arrangements are both necessary to prevent harm to the person and proportionate in relation to the likelihood and seriousness of harm to the person. For example, proposed arrangements that are necessary to prevent harm to the person may not be proportionate in relation to the actual likelihood of harm occurring, especially if the person is strongly opposed to the arrangements.

16.70 The professional undertaking the assessment and determination should consider the following points and ensure they are properly recorded within the assessment and determination:

- Do the proposed arrangements amount to a deprivation of liberty and if so how?
- What harm might arise if the deprivation of liberty is not put in place?
- Is there evidence of previous harm and, if so, what is the likelihood of this happening again?
- What is the nature of that harm; how likely it is to happen, and what is the seriousness of harm if it were to occur?
- Can the proposed arrangements prevent this harm?

16.71 When considering the risk of harm to the person, the professional undertaking the assessment and determination should consider how that risk would be reduced by the arrangements. For the arrangements to be necessary and proportionate, they should be intended to minimise the risk of harm to the person. If they are unlikely to do this, then they are unlikely to be necessary and proportionate.

16.72 If the person presents a risk of harm to others, it may still be possible to determine that the arrangements are necessary and proportionate to authorise the arrangements to prevent harm to the cared-for person. Such a determination would only ever be appropriate if, as a result of being a risk to others, the person is also themselves at risk of harm. For example, if a person in a care home is likely to harm another resident, who then may retaliate and harm the person, it may be necessary and proportionate to deprive the person of their liberty. However, the greater the risk to another person – as opposed to the person themselves – the greater the need to

consider other alternative legal frameworks such as the MHA. Chapter 22 provides more information on the interface with the MHA.

16.73 The professional carrying out the necessary and proportionate assessment and determination should always consider if a best interest decision has been made in respect of the care and treatment that the deprivation of liberty is intended to enable. The arrangements would only ever be necessary and proportionate where a lawful best interest decision has been made in respect of the care or treatment. Guidance is provided in paragraphs 16.80 – 16.85

16.74 The professional carrying out the assessment and determination should consider whether a deprivation of liberty is the only practical way to enable care or treatment to be provided. For example, if the only way to keep someone on an IV drip is to restrict them to the bed by the use of steps, prevent them from leaving and place them under constant supervision and control to prevent them from pulling it out, this could be necessary and proportionate.

16.75 The assessor should consider whether there are less restrictive arrangements which are available in order to provide the person's care or treatment (see paragraphs 5.24 – 5.26 on considering available options). For example, is the NHS and/or the local authority offering alternative care packages or, if the person is a self-funder, what other services might be purchased on their behalf for example by their family or an attorney. If there are alternative options – and these are available options - then these should be recorded within the necessary and proportionate assessment, and they should be weighed against each other when making the determination. In doing so, the professional carrying out the assessment and determination should also be prepared to question robustly the commissioning bodies and find out whether they are prepared to fund any additional or alternative services that may be more proportionate. If the additional or alternative services remain unavailable following the professional's enquiries, the reasons given for this by the commissioning body should be clearly recorded.

16.76 The professional should also consider the person's care or health pathway to the current proposed arrangements. This includes looking at any other care or health arrangements that have previously been in place for the person, which may or may not have amounted to a deprivation of liberty. This will help the professional to understand the person's care and health history. It will also help them to consider whether there may be more proportionate or less restrictive alternative arrangements or identify an option that is more in line with the person's wishes and feelings.

16.77 The professional carrying out the assessment and determination should also consider if a deprivation of liberty results in more benefits to the person's health or well-being than if a less restrictive arrangement was put in place which did not

amount to a deprivation of liberty. The professional should also consider if there are less restrictive arrangements that may be put in place even if they still amount to a deprivation of liberty. It is important to identify what the benefits of the proposed arrangements are for the person when carrying out the necessary and proportionate assessment and determination (e.g. in safety, health and welfare).

16.78 The professional carrying out the assessment and determination should also be aware that there are some cases where arrangements in place under the MHA mean that an LPS authorisation cannot be issued. Further guidance on the interface between LPS and the MHA is provided in chapter 22.

16.79 The assessor needs to consider all the proposed arrangements and whether they are necessary and proportionate. This may involve liaising with different settings and ensuring that professionals and other practitioners are aware of the proposed arrangements and willing to implement them in accordance with the authorisation record.

16.80 During the necessary and proportionate assessment and determination, the assessor may become aware of new arrangements that need to be considered. Once identified, the assessor should liaise with the Responsible Body to ensure they are happy to consider these new arrangements and inform the settings.

The necessary and proportionate assessment and best interests

16.81 A determination that the arrangements are necessary and proportionate should not be made unless the professional is satisfied that a lawful best interests decision has been made in respect of the person's care or treatment. This must have been made in line with section 4 of the MCA, please see chapter 5 for further details on best interests decisions.

16.82 Therefore, if an attorney under an LPA or deputy with appropriate authority has been appointed and has not agreed to the care or treatment on the person's behalf, then the necessary and proportionate condition will not be met. Similarly, if an advance decision has been made and the proposed arrangements would conflict with this, then the necessary and proportionate condition will not be met. See chapter 5 for further information on best interests decisions and chapter 11 for further information on advance decisions.

16.83 Where the LPS process is being carried out at the same time as another health or care planning process, the same professional carrying out the best interests assessment can also carry out the necessary and proportionate assessment, providing they meet the eligibility requirements for the relevant regulations. The professional must support the person to be involved in the decision as far as reasonably practicable. Where this is the case, the professional should clearly record the steps taken to make the best interest decision, and then subsequently

why the arrangements are necessary and proportionate to enable the care or treatment.

16.84 The person may already have a best interests decision for their care or treatment before the LPS process has been triggered. For example, a person with dementia may have been receiving their care under arrangements that do not amount to a deprivation of liberty, following a best interests decision. If the person's behaviour changed a period of time after that decision was made, decision makers may decide arrangements amounting to a deprivation of liberty were necessary to enable the care to continue.

16.85 In this scenario, the professional carrying out the necessary and proportionate assessment should check that the best interests decision is in place, why it was made, and whether it is still relevant, before determining whether the arrangements are necessary and proportionate. If the necessary and proportionate assessor determines that a lawful best interests decision has not been completed they should contact the relevant body or the Responsible Body to advise them that a best interests decision is needed.

16.86 If the person has privately funded and/or arranged care, it may be that a family member or someone else involved in their care has made the best interests decision for their care or treatment. If this is the case, and the professional carrying out the assessment is satisfied that the best interests decision is lawful and appropriate in the circumstances a further best interests decision does not need to be made. If a best interests decision has not been taken, the assessor should contact the relevant body or the Responsible Body to advise them that a best interests decision is needed.

17. What is the consultation duty in the Liberty Protection Safeguards process?

The LPS are designed to keep the person at the centre of the process. The main purpose of the consultation duty is therefore to find out about the person's wishes and feelings about the proposed arrangements.

The Responsible Body also has a duty to publish information about the consultation process. The Liberty Protection Safeguards are designed to keep the person at the centre of the process.

Quick summary

- The person and any people interested in the person's welfare, as well as others, must be consulted by the Responsible Body during the assessment process of an initial authorisation, when a variation for an authorisation is being considered, and when an authorisation is being considered ahead of renewal.
- Additionally, where an AMCP is carrying out the pre-authorisation review they must also consult the person and any people interested in the person's welfare, as well as others.
- The person may be supported by an IMCA or an Appropriate Person during the consultation. They, or a family member or friend, may be able to advise how best to communicate with the person during the consultation process.
- The evidence that is gained from the consultation should be recorded and must be considered when the Responsible Body decides whether to authorise the arrangements.

Who must be consulted on the proposed arrangements and the wishes and feelings of the cared-for person?

17.1 As part of the LPS process, the Responsible Body has a duty to carry out consultation prior to an initial authorisation, when a variation is recommended or ahead of any renewal. Approved Mental Capacity Professionals (AMCP), where one is carrying out a pre-authorisation review, have a duty to carry out additional consultation at that stage.

17.2 The following people must be consulted, if it is reasonable and practicable:

- the person
- anyone named by person as someone to be consulted about arrangements of the kind in question
- anyone engaged in caring for the person or interested in the person's welfare
- any donee of a lasting power of attorney or an enduring power of attorney of any kind, granted by the person
- any deputy appointed for the person by the court
- any Appropriate Person
- any Independent Mental Capacity Advocate concerned

17.3 The individual carrying out the consultation should ensure that the person is aware that they can ask for anyone to be consulted any time that the consultation duty applies, and that they are given opportunities to make a request. The individual should ensure that appropriate support is put in place to help the person communicate their wishes and feelings. The individual should also in appropriate cases, explore with friends and those involved in the person's care whether there is anyone else that the person would want to be consulted.

17.4 The person may have named certain individuals (either during consultation or before) that they wish to be consulted, when they had capacity. Where this is the case, the Responsible Body must ensure that anyone that the person has named is consulted, as far as is practical and appropriate.

17.5 Individuals "interested in the person's welfare" could include anyone who has a relationship with the person. For example, individuals from their community, including those from their faith community, friends, volunteers from local charities, or teachers. The person may be a member of a peer advocate group, and group members may know them well.

17.6 There may be times when it is not appropriate to consult a particular person, and/or it may not be practicable. For example, if the individual to be consulted is in an abusive relationship with the person, and consultation might put the person at risk of further harm by making the individual aware of where they are residing. In such cases, the duty to consult them may not apply.

17.7 Additionally, the person may request that a specific individual is not consulted. If that individual is someone who would have otherwise been included, the individual carrying out the consultation must consider whether appropriate to consult the person. In doing so, the individual should have regard to the person's wishes and feelings, their reasoning for not wanting the individual to be consulted, their Article 8 rights, and any other relevant factors.

17.8 In either scenario mentioned in para 17.6 or 17.7, the individual carrying out the consultation should record why that individual has not been consulted and the reasons for this. This information should be shared with the person, their Appropriate Person or IMCA.

17.9 The duty to consult does not apply if it is not practicable to do so. This may be the case, for example if a relative has gone on a long holiday and cannot be contacted directly, and the arrangements need to be authorised urgently. In such cases, efforts made to do so should be documented, and the Responsible Body should be informed. Ultimately, the Responsible Body or AMCP will need to be satisfied that the consultation is sufficient in the circumstances of the case.

17.10 If an individual not consulted feels that they should have been consulted, they may make a complaint to the Responsible Body. The Responsible Body should therefore ensure that it has an accessible complaints procedure to enable an individual to raise such concerns.

Who should undertake the consultation and when should it take place?

17.11 The Responsible Body should arrange for someone to carry out the consultation on its behalf. It should always obtain this individuals agreement to this arrangement. Where a necessary and proportionate assessment and determination is being carried out, the Responsible Body should ask the professional carrying out the assessment and determination to also carry out the consultation.

17.12 If a necessary and proportionate assessment is not being carried out, for example, when it is not required for a renewal, the Responsible Body may arrange, for example, for the consultation to be carried out by someone from within the organisation or someone involved in the person's care.

17.13 The Responsible Body should always inform the person and their IMCA or Appropriate Person who will do the consultation.

17.14 Where an AMCP is carrying out the pre-authorisation review, they must meet with the person and others listed in para 17.2. In some cases, if an AMCP becomes involved in a review of an authorisation they may also decide it is necessary to carry out further consultation.

What is the consultation in the Liberty Protection Safeguards process?

17.15 The Responsible Body must consult with everyone named in para 17.2, unless it is not practicable or appropriate. This must take place during the assessment process of an initial authorisation, when a variation for an authorisation is being considered, and when an authorisation is being considered ahead of renewal. In some circumstances, an Approved Mental Capacity Professional (AMCP) will undertake the pre-authorisation review. Where this is the case, that AMCP must also consult those named in para 17.2 if it is appropriate and practicable to do so. See chapter 18 for more information on the role of an AMCP, and chapter 13 for more information on variations and the overall process.

17.16 The Liberty Protection Safeguards are designed to ensure that the person is at the centre of the process. One of the most important aspects of the process, therefore, is the consultation. The main purpose of consultation is to ascertain the person's wishes and feelings in relation to the proposed arrangements that amount to a deprivation of liberty. If the authorisation is being considered for a renewal, the consultation should also determine if the person's wishes and feelings have changed. The individual carrying out the consultation should ensure those being consulted understand that this is the main purpose of the consultation.

17.17 Each Responsible Body has a duty to publish information about the consultation process and how it works in that area. This information should be available in accessible formats and in addition to publishing this information. See chapter 14 for more information on the information the Responsible Body must publish.

17.18 The individual carrying out the consultation should inform the person and their Appropriate Person or IMCA who is being consulted or anyone that the Responsible Body was not able to contact. This will also enable the person or their Appropriate Person, where relevant, to name anyone else that should be consulted or raise concerns about those that are already named.

17.19 Some people may need to be consulted more than once under the LPS process, sometimes by different individuals. The individual carrying out the consultation should be aware of this and the impact that it may have on the individual. They may

experience consultation fatigue if they are consulted too frequently, which could impact on the quality of the consultation. The individual should therefore try to gather the information they need in as few consultations as is necessary.

How is the person consulted?

17.20 The person may want to be supported by their Appropriate Person or IMCA, if they have one, during their consultation. The individual carrying out the consultation should seek to clarify what the person's wishes and feelings are about being supported during their consultation. If the person is unable to express their wishes and feelings, the individual should make a best interest decision on behalf of the person.

17.21 If the person asks to be consulted on their own, then the individual carrying out the consultation should consider this request and, where required, discuss this with the Responsible Body. In most cases, this should be respected. However, there may be instances where it is appropriate for the Appropriate person or IMCA to join the consultation.

17.22 If the person is unhappy with the Appropriate Person supporting them, it may be that there is a wider issue that may mean that individual is not suitable to represent and support the person. This may also apply if the person is unhappy with their IMCA supporting them. The person may display this through verbal or behavioural signals. The Responsible Body should be alive to such issues, and where this is the case consider if they need to take any action in relation to the Appropriate Person or IMCA appointment.

17.23 The individual carrying out the consultation should always consider how the person wishes to be consulted, this may be face to face or over the phone, for example. Ahead of the consultation, the individual should explore whether the person has a preference on how they would like to be consulted or any specific communication needs. The person's Appropriate Person or IMCA, or a family member or friend, may be able to advise on how best to communicate with the person. Alternatively, the person may have a "communication passport" or a summary of their communication techniques, which will outline the best ways to communicate with them.

17.24 If the person has a specific communication need (including verbal, non-verbal, and behavioural methods), the individual carrying out the consultation should ensure that, where reasonable, they have put the appropriate measures in place to be able to communicate with the person during consultation.

17.25 The individual carrying out the consultation should explain the proposed arrangements for the person in an appropriate level of detail. The individual should ask the person what their wishes and feelings are with respect to the arrangements.

Where an AMCP is carrying out the consultation, the AMCP should check that the person was given all the relevant information about the arrangements at the initial consultation.

17.26 If the person lacks the relevant mental capacity to understand the proposed arrangements, or is unable to express their wishes and feelings, the individual carrying out the consultation may need to frame the consultation differently. It is possible to determine the person's wishes and feelings by asking questions such as, "what is important to you?", "what does a good/bad day look like?", or "how did you live your life in the past?". The individual should consider the specific arrangements being proposed and the needs of the person in order to determine the best questions. The person's Appropriate Person or IMCA, or a family friend or friend, may be able to provide insight on how best to help the person express their wishes and feelings.

17.27 The person's condition may mean that they communicate or behave in a certain way. The individual carrying out the consultation should not assume to have a full understanding of the person's condition and how it may affect them. It may therefore be helpful to have the support of someone who is an expert in the person's condition.

How are others consulted?

17.28 It is important that those who know the person are encouraged, where appropriate, to take part in consultation as they are the people who are most likely to be able to understand and describe the person's wishes and feelings to the Responsible Body.

17.29 The individual carrying out the consultation should explain the purpose of the consultation within the Liberty Protection Safeguards to those they are consulting. The individual should also stress the importance of identifying the person's wishes and feelings even if the consultee does not share these wishes and feelings.

17.30 The consultation needs to be meaningful. Therefore, those being consulted should have an understanding of the arrangements being proposed, in order to determine what the person's wishes and feelings about them are or would be. However, providing information in order for the consultation to be meaningful should be limited to the salient details in order to meet the main purpose of the duty to consult.

17.31 The person may have talked about their wishes and feelings regarding their care or treatment in the past. Whilst these are important to consider, and may be relevant to the LPS process, it is also important to remember that the person's wishes and feelings may have changed. The Responsible Body or AMCP should try to focus on the person's current wishes and feelings as far as possible.

17.32 The Liberty Protection Safeguards relates to the arrangements for the person's care or treatment, not the care or treatment itself. The consultation should, as far as possible, focus on the arrangements. However, in many cases, there may not be a clear separation between the care or treatment and the arrangements. Where this the case, it may be appropriate to talk about the whole care or treatment package in order to determine the person's wishes and feelings.

17.33 The individual carrying out the consultation should consider how the individual would most like to be consulted. It does not matter what format the consultation takes place in, as long as the individual can get a good understanding of the person's wishes and feelings. It may be that, for example, it may suit the individual to be consulted to use technology to carry out the consultation, including video or telephone calls. Alternatively, an individual may wish to participate in the consultation either via email or written correspondence. However, this may limit the individual carrying out the consultation's opportunity to ask further questions and probe any particular issues, and therefore the practicalities of this should be considered on a case by case basis.

17.34 Additionally, others being consulted may have specific communication needs, such as brail or sign language. Those carrying out the consultation should ensure they understand how best to communicate with the individual being consulted and ensure that where reasonable there is sufficient support for them during the consultation.

17.35 Some consultees may have helpful knowledge about what the person enjoys or dislikes or ideas on how a slight alteration to the arrangements might be better for the person and more aligned with their wishes and feelings. For example, if it is known that the person is claustrophobic, and likes to be outside, this would help inform a better understanding of the person and therefore their likely wishes and feelings about the arrangements. This may influence the proposed arrangements and, where practical and appropriate, the Responsible Body should seek to make reasonable adjustments to align the arrangements with the person's wishes and feelings as far as possible.

What happens to the information after consultation?

17.36 The record of conclusions from the consultation should include:

- Who was consulted,
- What was asked in each consultation and the individual's responses,
- If anybody was not available or appropriate to be consulted, reasons for this,
- The overall conclusion of the person's wishes and feelings and any other relevant information.

17.37 The evidence regarding the person's wishes and feelings from the consultation (depending on when it is carried out and by who) may inform the necessary and proportionate assessment and determination. This assessment determines whether the proposed arrangements are both necessary to prevent harm to the person and proportionate to the risk of harm. As part of this assessment and determination, the person's wishes and feelings about the arrangements will be considered. See further information on the necessary and proportionate assessment and determination, and how the consultation influences this, at chapter 16.

17.38 If, during the consultation, it becomes clear that the person's wishes and feelings are that they do not wish to reside or receive care or treatment in a specified place, then this would trigger the duty to make a referral to an Approved Mental Capacity Professional (AMCP). The person may themselves not express that they do not wish to reside or receive care and treatment at the proposed place, this may come from others who are being consulted. This may still trigger the duty to refer to an AMCP, if it is reasonable for the Responsible Body to believe that the person does not wish to reside or receive care or treatment in the place. See more information on the role of an AMCP at chapter 18.

17.39 At pre-authorisation review stage, if an AMCP carries this out, the purpose of the consultation the AMCP will carry out is to ensure the arrangements are necessary and proportionate. The AMCP may use the evidence from their consultation, and the consultation undertaken by the Responsible Body, to identify where there are alternative arrangements that may be more appropriate.

17.40 If the pre-authorisation review is not carried out by an AMCP, that individual may still wish to consult those that have been consulted again, if they feel that more evidence on the person's wishes and feelings is needed. See more information on pre-authorisation reviews at chapter 13.

17.41 If the consultation is taking place ahead of a renewal, the main purpose of this is to determine if the person's wishes and feelings have changed. If they have not, and the arrangements also have not changed, and the Responsible Body believes that the authorisation conditions continue to be met, the Responsible Body can renew authorisation without taking any further steps. If they have, then the Responsible Body may need to take further steps. See chapter 13 for further information on renewals.

17.42 The individual being consulted may request that certain information is not shared with the person, or the Appropriate Person or IMCA. If so, the Responsible Body should consider this request in accordance with its statutory and common law duties and obligations with respect to sharing information (including the Data Protection Act 2018, the UK GDPR and the common law of duty confidence).

18. What is the role of an Approved Mental Capacity Professional?

The Approved Mental Capacity Professional (AMCP) is a specialist role that provides enhanced oversight for those people that need it most.

A case must be referred to an AMCP there is reasonable belief a person does not wish to reside or receive care or treatment in a certain place, and the arrangements provide for this.

Quick summary

When should a referral be made to an AMCP?

- A case must be referred to an AMCP if:
    - there is reasonable belief a person does not wish to reside or receive care or treatment in a place, and the arrangements provide for this
    - the arrangements are being carried out mainly in an independent hospital
    - a case is referred to the AMCP and the AMCP accepts.

The role of an AMCP and what they do

- Where the referral criteria are met, the case must be referred to an AMCP. If the AMCP accepts the case, they will look at the assessments and consultation to determine whether the authorisation conditions are met. They will also meet with the person and anyone who was consulted and take any further action they deem necessary, including proposing less restrictive arrangements.

- Once the AMCP has assessed their case, they will then advise the Responsible Body whether or not the authorisation conditions are met.
- AMCPs will also carry out reviews where it becomes clear, after an authorisation is given, that the person does not wish to reside or receive care or treatment in the place.

The duty of the local authority to approve AMCPs and to ensure there are enough AMCPs for its area

- **Local authorities have a duty to ensure that there are enough AMCPs for the cases in their area. Local areas should work together to determine how many AMCPs are likely to be required by each Responsible Body, in order for LAs to plan.**

Who is eligible to become an AMCP, and training requirements?

- Professionals who can become AMCPs are:
  - Nurses
  - Social Workers
  - Psychologists
  - Speech and Language Therapists
  - Occupational Therapists.
- AMCPs are required to complete initial training and must seek approval from a local authority before they can begin to practice. Once approved, AMCPs must compete 18 hours of further training per year to continue approval.

The duty of the local authority to approve AMCPs

18.1 Local authorities have a statutory duty to make arrangements for approving individuals to practice as AMCPs. In order to approve or reapprove an individual as an AMCP, the local authority must be satisfied the AMCP meets the eligibility and training requirements set out in the Mental Capacity (Deprivation of Liberty: Training and Criteria for Approval as an Approved Mental Capacity Professional) (England) Regulations and the Approved Mental Capacity Professional (Wales) Regulations in Wales. In this chapter these regulations are referred to as “the AMCP Regulations”.

Please see paragraphs 18.15 – 18.17 for more information on who can be an AMCP.

18.2 AMCPs will normally be employed by a Responsible Body (local authority, NHS hospital trust, local health board or CCG). Regardless of their employer, all AMCPs must be approved by a local authority.

18.3 The local authority that has approved the AMCP should manage their approval and the continuation of their approval. In England, AMCPs should only be approved by one local authority at a time, although they can act for other local authorities, and other Responsible Bodies within those local authorities. with the agreement of their approving local authority. In Wales, AMCPs may be approved by more than one local authority or may, subject to agreement between the local authorities, be approved by one local authority acting on behalf of a number of local authorities, to allow them to work across multiple local authority areas. Workforce planning locally should determine the appropriate approach to managing AMCP capacity. An approving local authority should check whether an applicant is approved elsewhere in order to determine capacity to deliver AMCP services within that local authority.

18.4 The local authority and AMCP should agree expectations for the proportion of cases the AMCP is acting in cases for other local authorities, however most cases an AMCP acts in will likely be within the area of the local authority who manages their approval.

18.5 In England, if an AMCP wishes to be approved by another local authority, for example because they have relocated to a new area, they should first notify the new local authority to request that their approval is transferred from their previous local authority. The AMCP should also notify the previous local authority that this request has been made. Both local authorities must agree to the transfer of approval. The AMCP should supply the new local authority with certain information to support their request, such as their practice portfolio and performance reviews. Further information on continuation of approval is provided in paragraph 18.20.

The duty of the local authority to ensure there are enough AMCPs for its area

18.6 The local authority is responsible for ensuring that there are enough AMCPs available for its area, including for cases where it is not the Responsible Body, e.g. where an NHS hospital, CCG or Local Health Board is the Responsible Body. Local authorities should ensure there are enough AMCPs to cover all cases for their area, including cases where the person is placed or otherwise residing out of area but responsibility remains with a local Responsible Body. The local authority should work with all Responsible Bodies in their area to determine how many AMCPs are required.

18.7 In Wales, Local Authorities may cooperate with each other and NHS bodies as they consider appropriate in order to make arrangements for the approval of AMCPs and to ensure they have sufficient AMCPs to meet demand within their area.

18.8 NHS bodies should fully co-operate with local authorities in determining the numbers of AMCPs that will be needed. NHS bodies should always ensure that they are putting forward a sufficient number of professionals to become AMCPs.

18.9 In cases where a person is living out of area, but responsibility remains with the placing Responsible Body, an AMCP in the new local authority area can carry out the pre-authorisation review or a review of the case. Before an AMCP acts in an 'outside area case', the AMCP must obtain agreement from the local authority which manages their approval.

How could AMCPs be organised locally?

18.10 The role of the AMCP is to provide an additional layer of scrutiny to the LPS process. In order to ensure the independence of AMCPs, local areas should set up clear management and referral structures for AMCPs in their area to maintain and reinforce their role in acting as an independent professional, not on behalf of any organisation.

18.11 A suggested model would be, in England, for all Responsible Bodies in a local area to provide AMCPs to the central "AMCP team". The AMCP team could be run by the local authority for the area – acting in its role as the approving body for AMCPs. Alternatively, Responsible Bodies could establish an AMCP team either for their own purposes (e.g. in an individual hospital) or jointly with other Responsible Bodies, including the local authority. Local authority agreement should always be sought for such arrangements. Whichever approach is adopted, a senior manager or practitioner should be appointed with overall responsibility for matters such as the conduct, performance and allocation of AMCPs to cases. There should also be established a central duty system for AMCP referrals, including out of hours referrals.

18.12 In cases where an AMCP team has been set up to cover multiple Responsible Bodies, the senior manager or practitioner will need to decide, based on the individual circumstances of the case, whether is appropriate to allocate an AMCP to a case referred by the Responsible Body they are employed by.

18.13 Local authorities and other Responsible Bodies can also consider working together to establish a joint AMCP team that covers different local authority and Responsible Body areas.

18.14 The suggested AMCP team model is referenced throughout the Code, however whatever structure is established, it should be most suitable for the needs of the area. It is important that a structure is put in place which underlines the independent role of AMCPs. The Responsible Body should not decide which individual AMCP carries out the pre-authorisation review. In Wales, these arrangements will be determined locally, in compliance with the national workforce plan.

Who can be an AMCP?

18.15 The AMCP Regulations set out that the following professionals can be AMCPs, providing that they are registered in the UK and have at least two years post registration experience of practice in their profession:

- Nurses
- Social Workers
- Psychologists
- Speech and Language Therapists
- Occupational Therapists

18.16 The AMCP Regulations also set out other requirements which must be met before a local authority can approve an AMCP. These are that the individual:

- has the skills necessary to obtain, evaluate and analyse complex evidence and differing views and to weigh them appropriately in decision making, and has knowledge of best practice in relation to arrangements in England or Wales,
- has completed appropriate training, in line with the AMCP Regulations (see paragraphs 18.18 – 18.20),
- is not suspended from the register for their profession,
- has an adequate and appropriate indemnity arrangement, and
- has the required criminal record certificate(s).

18.17 Where an AMCP is employed by an organisation such as a Responsible Body, the organisation should organise an appropriate indemnity arrangement.

Training for Approved Mental Capacity Professionals

18.18 In order to become an AMCP, an individual must carry out an initial training course, which has been approved by Social Work England or Social Care Wales. In addition, in each year of approval AMCPs must undertake at least 18 hours of further training. This further training is part of an AMCP's continued professional development. All training must be approved.

18.19 If a professional from another part of the UK seeks approval to act as an AMCP in England or in Wales, they must have completed the necessary training required to

become an AMCP and must also meet the requirements to be an AMCP, as set out in paragraphs 18.15 – 18.17. The local authority should also consider whether that professional has appropriate knowledge regarding best practice and the relevant health and social care legal frameworks in England or in Wales. The relevant legal frameworks will include the Care Act 2004, Children Act 1989 and NHS Continuing Healthcare (in England) and the Social Services and Wellbeing (Wales) Act 2014 and Continuing NHS Healthcare (in Wales). The local authority should consider suggesting training courses the professional should go on, prior to giving approval.

Continuing approval

18.20 In order for an AMCP to continue to be approved, in each year of approval certain requirements must be satisfied. These are that:

- The AMCP has been carrying out their functions to an appropriate standard. The local authorities must satisfy itself of this, e.g. through annual performance reviews. If the AMCP has acted in outside area cases, the local authority may consider if evidence of performance in these cases would assist in ascertaining that the AMCP is meeting the appropriate standard.
- The AMCP has not, without the agreement of the approving local authority, carried out AMCP functions in respect of another local authority. This only applies in England.
- The AMCP has completed at least 18 hours of further training in that year of approval, approved in England by Social Work England or in Wales by either the approving local authority or Social Care Wales.

Suspending or ending a person's approval as an AMCP when an AMCP no longer meets the criteria for approval

18.21 AMCPs must notify the approving local authority if they no longer satisfy the criteria for approval set out in paragraphs 18.15 – 18.17 and should cease to act as an AMCP.

18.22 If an AMCP is suspended from the register relevant to their profession, the approving local authority must suspend their AMCP approval. They must not carry out the functions of an AMCP while the suspension is in place.

18.23 The local authority who manages their approval must end a person's approval as an AMCP if they no longer satisfy the criteria for approval set out in paragraphs 18.15 – 18.17. The local authority must also end the AMCP's approval if the AMCP requests this.

Temporary exemption from the requirements to continue approval

18.24 An AMCP may request that the relevant local authority temporarily exempts them from the requirements for continuation of approval. This may be, for example, to enable a maternity break, or for ill health or other personal reasons.

18.25 If the local authority believes there is good reason, it should grant the exemption. The period of exemption should be agreed between the AMCP and the local authority. During this period, the individual must not carry out any AMCP functions.

18.26 When the AMCP wants to return to practicing, they must have carried out 18 hours of further training in the previous 12 months (or, in Wales, in such a period as specified by the local authority) before they can resume carrying out functions as an AMCP.

18.27 The AMCP's new year of approval begins on the date on which they resume their functions as an AMCP.

What is the AMCP's role in the pre-authorisation review?

18.28 Before a Responsible Body can decide whether to authorise arrangements amounting to a deprivation of liberty, a pre-authorisation review of the person's case must be carried out and the appropriate determination made. In certain circumstances the pre-authorisation review must be carried by an AMCP. In such cases the case should be referred to the AMCP team, and the team will then consider whether the threshold for an AMCP is met.

Referral criteria for an AMCP and when an AMCP may decline a case

18.29 The role of an AMCP is to carry out the pre-authorisation review of the person's case if:

- it is reasonable to believe that the person does not wish to reside in the place proposed in the arrangements,
- it is reasonable to believe that the person does not wish to receive care or treatment at the place proposed in the arrangements,
- the proposed arrangements are for the person to receive care or treatment mainly in an independent hospital, or
- the Responsible Body refers the case to an AMCP and the AMCP accepts the referral.

18.30 It would be reasonable to believe that a person does not wish to reside in or receive care or treatment at a place, if there is valid evidence to support this belief. Where possible, this should be presented in writing to the AMCP by the Responsible Body. It does not require absolute certainty, but good evidence will be

needed to show why there is a belief that the criterion in question is met. Examples of the types of evidence which should be considered are provided in paragraphs 18.35 and 18.36.

18.31 It would only be reasonable to believe that a person does not wish to reside in or receive care or treatment at a place if the belief is based on the individual circumstances of the case and decisions are rooted in evidence. For example, it would not be reasonable to conclude that an AMCP must consider the case of a person in a care home based on the assumption that no-one would want to reside in a care home.

18.32 It is irrelevant whether the person's wishes and feeling are reasonable or not. The focus should be on the fact that the person does not wish, or is perceived not to wish, to reside in or receive care or treatment at the place proposed in the arrangements.

18.33 The focus should be on the person's current wishes and feelings. The duty to refer the case to an AMCP would apply if the person was actively trying to leave the place they live even if in the past (when they had the relevant capacity) they had indicated that they would be content to live there.

18.34 Past wishes and circumstances should only be considered insofar as they are relevant to the perception of the person's current wishes. The duty to refer the case to an AMCP could arise if the person (since losing capacity) was not expressing that they did not wish to reside or receive care or treatment in a place, but had previously expressed that they did not want those specific arrangements.

18.35 In considering whether the relevant referral criteria are met, regard should always be had to:

- Any statements made by the person about their wishes and feelings in relation to the arrangements.
- Any expressions of his/her emotional state.
- The frequency with which the person expresses wishes and feelings that they don't wish to reside or receive care or treatment in a place.
- The consistency of his/her expressed wishes or emotional state.
- The potential alternative reasons for his/her expressed wishes or emotional state.

18.36 In considering whether it is reasonable to believe that the person does not agree with the arrangements, regard should be had to:

- Verbal and non-verbal behaviour.
- The possible reasons for the person's behaviour.

- Whether the person is being medicated for depression or sedated.
- Whether the person actively resists (e.g. trying to leave the place).
- Whether the person takes preparatory steps to leave (e.g. packing bags).
- The person's demeanour and relationship with those responsible for implementing the arrangements.
- Any records of challenging behaviour and triggers for such behaviour.
- Whether the person's behaviour is a response to particular aspects of the care arrangements or the entirety of those arrangements.

18.37 Concerns that the person does not wish to reside or receive care or treatment in a place can be raised by anyone, including the person themselves or by another on their behalf. Prior to the formal AMCP pre-authorisation review, Responsible Bodies should try to resolve any disagreements relating to the proposed arrangements throughout the process. This might involve considering alternative arrangements that the person would wish to be put in place, or does not express disagreement with. However, where it is not possible for the Responsible Body to resolve these issues, the AMCP pre-authorisation review provides an additional opportunity for disagreements to be considered and addressed before an authorisation decision is made. The AMCP role does not amount to a formal mediation role, but it is a way to resolve a difference of view between the person and those proposing the arrangements.

18.38 As introduced in paragraph 18.29, where the duty for an AMCP to undertake the pre-authorisation review does not apply, but the Responsible Body nevertheless believes a case would benefit from specialist advice and expertise, it may refer the case to an AMCP. The AMCP team must then decide whether to accept the case. The following principles should be considered by the Responsible Body when deciding which cases to refer to the AMCP team:

1. The impact of the restriction on the person.

    - For example, when a high level of restraint (including physical and/or chemical) is proposed (irrespective of whether or not the person expresses that they do not wish to be subject to the restraint).

2. If the case is a borderline case.

- For example, when a case is on the boundary between the MCA and Mental Health Act 1983 (MHA). In other words, where it is not clear whether the person is objecting to the admission to hospital for mental disorder or for medical treatment for that disorder. See chapter 22 for further advice on the MCA-MHA interface.
- For example, if, at the time of the pre-authorisation review, the individual making the decision on behalf of the Responsible Body reviews the

assessments/determinations and decides the case would benefit from the expertise of an AMCP e.g. because of its complexity.

These scenarios are provided as examples of when an AMCP referral may be needed, and do not constitute an exhaustive list of cases which should be referred to an AMCP team.

18.39 It will be a matter for the AMCP team to decide whether to accept the referral. The AMCP team should consider whether they think the threshold for an AMCP is met before accepting the case. The AMCP team may choose to decline a case for a number of reasons, these may include:

18.40 If the AMCP team does not believe the threshold for requiring an AMCP is met. That is, that they do not think it is reasonable to believe that the person does not wish to reside or receive care or treatment in the place proposed in the arrangements.

18.41 If the AMCP team believes a Responsible Body is regularly referring cases to AMCPs that fall outside the criteria set out in the Act or the Code. In these circumstances, they should explain the criteria, and that those cases should be dealt with by mainstream services.

18.42 If the Responsible Body and AMCP team disagree on whether the case requires the expertise of an AMCP, they should discuss the circumstances of the case, taking into account the legal criteria for a referral and the principles set out in this chapter. The Responsible Body and AMCP team should seek to come to an agreement on who will take the case forward. If the AMCP team rejects a case as they believe that the threshold is not met, the Responsible Body should continue processing the case unless they are able to provide further evidence that an AMCP is required. The Responsible Body should weigh the potential benefits of seeking this additional evidence with the risks of delaying the LPS process to do so. If evidence is found, they should then refer to case to an AMCP team. If the Responsible Body and the AMCP team are still in disagreement, other actions should be considered, and in some circumstances, it may be appropriate to seek a view from the Court of Protection. Please see Chapter 7 for further information on applying to the Court.

18.43 If it is agreed that the threshold for referring a case to an AMCP is met, the AMCP team accepts a referral, or the duty to appoint an AMCP applies, the appointed AMCP must not have a conflict of interest in the case. This means they cannot be involved in the day to day care of the person, be providing any treatment to the person, nor can they have a prescribed connection to a care home as set out in the relevant Mental Capacity (Deprivation of Liberty: Eligibility to Carry out Assessments and Make Determinations) Regulations for England and Wales (“the Assessment and Determination regulations”). AMCPs are able to complete capacity and necessary and proportionate assessments and determinations, providing they

meet requirements set out in regulations, but should carry this out under their main professional role rather than as an AMCP. If an AMCP has undertaken any of the assessments and determinations they should not undertake the pre-authorisation review. The AMCP team should consider these factors when appointing AMCPs to cases.

What happens when an AMCP undertakes a pre-authorisation review?

18.44 Guidance on pre-authorisation reviews which are not carried out by AMCPs, and how all pre-authorisation reviews interact with giving an authorisation, can be found at Chapter 13 on the Overall Process.

18.45 The AMCP's primary role is to determine if the authorisation conditions are met. In doing so, the AMCP is providing an independent review of the justification for a deprivation of liberty.

18.46 The AMCP also performs an essential safeguarding role. When reviewing a case, the AMCP should be looking for any potential issues of concern or indicators of issues of concern, such as overly restrictive arrangements, abuse and neglect, and unlawful deprivation of liberty. The AMCP should deal with such issues with the seriousness they deserve, including making formal referrals to relevant safeguarding teams. This provides further protection for the person in cases where the application falls short or has not been as thorough as it ought to have been.

18.47 When the AMCP carries out the pre-authorisation review, they are in effect certifying that the conditions for an authorisation are met. This means that the AMCP must scrutinise the assessments/determinations. The AMCP should also review the other information on which the Responsible Body is relying, such as evidence that:

- The proposed arrangements amount to a deprivation of liberty.
- Proper consultation has been carried out with the person and those concerned for their welfare (e.g. family and friends).
- Any duty to appoint an IMCA has been complied with, or there is an Appropriate Person in place.
- The relevant information has been provided to the person and their Appropriate Person.
- The underlying care or treatment decision that the deprivation of liberty relates to is in the person's best interests.

18.48 The role of the AMCP is to review the evidence, including the assessments and determinations contained within the referral and to decide whether the authorisation conditions are met. The AMCP is not acting as an assessor, nor do they have authority to instruct professionals from the Responsible Body or elsewhere, to carry out assessments. The assessments should be included in the referral, and if they

are missing or inadequate, the AMCP should request them, and refuse to accept the referral if they are not received.

18.49 The AMCP is expected to consider matters using their own professional judgment and should consider the evidence in the assessments and check if new evidence has come to light. If the AMCP does not approve the arrangements, they should give reasons in writing to the Responsible Body and describe any steps the Responsible Body could take in order to obtain approval. To avoid delays, the AMCP could indicate informally that they intend not to approve the arrangements and make recommendations for how the issues may be resolved without having to resubmit to the AMCP.

18.50 It will be particularly important for the AMCP to scrutinise carefully whether or not the arrangements are both necessary and proportionate from the information contained within the assessment and determination. For example, it may be that a local authority is proposing to place a person in a specific residential setting and their family support an alternative placement, or that the local authority has identified a range of options and is maintaining that their proposed placement has been identified as being based on the person's best interests being met. In both cases, the AMCP would be required to review the assessment which has determined that the arrangements are necessary and proportionate, as well as whether the original placement decision has been informed appropriately by the person's wishes and feelings. For example, the AMCP may need to consider if the duty to meet a person's preference for specific accommodation under either the Social Services and Well-being (Wales) Act 2014 for Wales or the Care Act 2014 for England has been considered.

18.51 In addition to reviewing the assessments, determinations and other evidence, when an AMCP undertakes the pre-authorisation review, they must meet with the person, if it is appropriate and practical. Such a meeting will, amongst other matters, enable the AMCP to get an understanding of the person's wishes and feelings.

18.52 It would be rare for the AMCP not to meet with the person. Examples of where it would not be appropriate or practicable to meet with the person could include occasions when it might be detrimental to the person's well-being, such as at the end of life and the person is adamant they do not want to see an AMCP, or where there is a risk to the AMCP's personal safety and this cannot be addressed by a different AMCP visiting. In all such cases, the AMCP should clearly record the reasons for not meeting with the person.

18.53 An AMCP is also required to consult the following if it appears to be appropriate and practical to do so:

- Anybody the person names as someone to be consulted.

- Anyone engaged in caring for the person or interested in their welfare (including family/friends and care staff).
- Any donee of a lasting power of attorney or enduring power of attorney.
- Any court-appointed deputy.
- Any Appropriate Person (if there is one).
- Any IMCA (if there is one).

18.54 The AMCP can also take any other action if it appears to be appropriate and practicable to do so. This could include consulting any other person not covered by the list above or accessing previous assessments or alerting other services of cases, including safeguarding teams and relevant monitoring bodies.

18.55 The AMCP may make recommendations to the Responsible Body. The Responsible Body should have regard to the AMCPs recommendations. Examples include:

- Suggesting a programme of support to enable the person to make their own decision.
- Exploring the suitability of a trial period with relevant, enhanced support at home.
- Suggesting new or different communication methods to enhance the person's participation.
- Challenging one or more of the assessments and advising the Responsible Body that new assessments and determinations are commissioned.
- Suggesting a second opinion for one or more of the assessments.
- Reviewing other information, including historic records about the person's care and treatment or safeguarding concerns.
- Visiting the location and seeing how the arrangements might work, and exploring whether they could be made less restrictive, and/or more acceptable to the person.
- If the AMCP isn't drafting the authorisation record, recommending conditions to be placed on the authorisation record
- Suggesting less restrictive options.

18.56 In some cases, the AMCP may feel that the person may benefit from certain changes in their care plan, or they may determine that the authorisation conditions would only be met if certain changes were made. For example, that the arrangements would not be necessary and proportionate unless certain changes were made. If this is the case, the AMCP should inform the Responsible Body and the commissioning organisation, where they are different, to reach a solution before continuing with the pre-authorisation review. It may be that there are some alternative arrangements that can be proposed, which the AMCP can consider instead, once new assessments and determinations have been carried out.

18.57 When it makes a referral, the Responsible Body may submit a request to the AMCP team asking that the draft authorisation record be completed by the AMCP completing the pre-authorisation review. If this is agreed by the AMCP team, the AMCP should complete the draft authorisation record and submit it to the Responsible Body if they determine that the conditions are met. Information on what should be contained in the authorisation record is provided in chapter 13 on the Overall Process.

18.58 If the AMCP decides that placing conditions on the authorisation (such as those relating to contact issues, cultural issues, or ensuring the person can leave the premises regularly), these should be included in the draft authorisation record. If the AMCP isn't drafting the authorisation record, they may recommend such conditions to the Responsible Body. When deciding to authorise the arrangements, the Responsible Body should have regard to the information in the draft authorisation record and the AMCP's recommendations and be aware that the rejection or variation of these conditions or recommendations will affect the determination that the authorisation conditions are met.

18.59 If the authorisation is given, the authorisation record must be shared with the person and their Appropriate Person or IMCA. If there has been any disagreement or discussion on the recommendations or conditions suggested by the AMCP, these should be clearly stated on the final record that is shared.

Can the AMCP carry out the authorisation?

18.60 In some circumstances, it may be appropriate for the AMCP carrying out the pre-authorisation review to also give the final authorisation. The AMCP team and Responsible Body should consider the impartiality of the AMCP, and the Article 5 human rights of the person when deciding whether the AMCP will also give the authorisation. This is particularly important considering the complexities of the cases AMCPs consider. Additional scrutiny from an individual may be more appropriate ahead of authorisation.

18.61 If the AMCP does carry out the authorisation, they should act independently from their role as an AMCP. The role of the authoriser is to decide whether the Responsible Body should authorise the proposed arrangements. The authoriser is therefore acting as the Responsible Body in this role, making it a fundamentally different role to that of the pre-authorisation reviewer. Whilst the same individual can carry out both roles, they must be able to differentiate their decisions at each stage in order for the two processes to remain impartial of each other. For example, if at pre-authorisation review stage, the individual determined it was reasonable for the Responsible Body to conclude that the authorisation conditions are met, then they must consider additionally from the Responsible Body's perspective whether there is sufficient justification to give the authorisation.

18.62 The AMCP role does not replace the role of the Responsible Body. Whilst the AMCP completes the pre-authorisation review, and determines that the authorisation conditions are met, the Responsible Body holds responsibility for the decision to authorise the arrangements.

What is the AMCP Role in Reviews?

18.63 If it becomes clear that it is reasonable to believe that the person does not wish to reside or receive care or treatment in a place, a review must take place. If the case had not previously been considered by an AMCP, in most cases, the Responsible Body should refer the case to an AMCP to carry out the review and also to determine whether the authorisation conditions are met. In determining if the person wishes to reside in, or receive treatment in, a particular place, the Responsible Body should consider all the circumstances so far as they are reasonably ascertainable including the person's behaviour, wishes, feelings, views, beliefs and values. Circumstances from the past are to be considered only so far as it is still appropriate to consider them. It may be necessary for the Responsible Body to consider the person's past wishes and feelings, views, beliefs and values insofar as they are relevant, to determine whether a referral to an AMCP is necessary.

18.64 Additionally, the Responsible Body should consider the circumstances around the arrangements, including any changes, to get a full understanding of how the person is feeling. For example, it may be that the person is residing in a mental health ward in a hospital and was happy when the arrangements were first authorised, however, since the authorisation more people have moved into the ward and have made the person feel uncomfortable.

18.65 If someone who is engaged in caring for, or is interested in the welfare of, the person believes the person's wishes and feelings have changed, and they no longer wish to reside or receive care or treatment in a place, they can request a review. In this situation, the Responsible Body must review the request and if it is a reasonable request, they may refer it to an AMCP for consideration. If the AMCP accepts the referral, they should complete the review and determine whether the authorisation conditions are met.

18.66 The AMCP should carry out the review, by reviewing the authorisation, meeting with the person as far as appropriate and practicable and, consult as far as appropriate and practicable all who were consulted in the initial authorisation process. The AMCP may also decide it is necessary to consult with some other people who were not consulted before the authorisation was given.

18.67 If the AMCP decides further assessment and determinations are required, they should advise Responsible Body which may decide to commission further assessments and determinations.

18.68 Once the review is complete, the AMCP must determine whether the authorisation conditions continue to be met. More information on reviews is provided in chapter 13.

Other times when an AMCP may contribute

18.69 As the AMCP is a specialist role, they may be consulted for expert advice by health and social care services. AMCPs can provide valuable information and advice, about the meaning of deprivation of liberty and the LPS process more generally.

18.70 AMCPs are able to complete capacity and necessary and proportionate assessments, providing they meet requirements set out in regulations, but should carry this out under their main professional role rather than as an AMCP.

18.71 If an AMCP has been closely involved in advising those who are involved in the case, or in undertaking any of the assessments, they should not undertake the pre-authorisation review. A different AMCP, who is not in the same line management chain, should be asked to do this to ensure an independent view and avoid a conflict of interest.

19.What is Section 4B?

Except in exceptional circumstances, it is unlawful to place restrictions which amount to a deprivation of liberty on a person before a decision to authorise such arrangements has been made by the Responsible Body or a relevant decision is made by the court. Exceptional circumstances are circumstances where it is necessary to take steps to carry out life-sustaining treatment or prevent a serious deterioration in the person's condition.

If certain conditions are met, section 4B of the MCA provides the legal basis for decision makers to take steps to place restrictions on a person. This chapter sets out the conditions which must apply before section 4B can be relied upon.

Quick summary

- Four conditions must be met for the legal authority of section 4B to be relied upon. These are that:
    - the steps consist of, or are for purpose of, giving a life-sustaining treatment or carrying out a vital act,
    - the steps are necessary in order to give the life-sustaining treatment or carry out the vital act,
    - the decision maker believes that the person lacks capacity to consent to the steps taken, and
    - a relevant decision is being sought from the court, a Responsible Body is determining whether to authorise arrangements under the LPS, or there is an emergency.
- Section 4B of the MCA provides the legal basis for decision makers to take steps to place restrictions on a person in these scenarios.
- The legal authority provided by section 4B can only be relied upon in very limited circumstances and should not be used on a routine basis.
- Section 4B only enables steps to be taken for giving life-sustaining treatment or a vital act. For the purposes of section 4B, it is unlawful if steps are carried out which deprive the person of liberty which are not for the purposes of giving life-sustaining treatment or a vital act.

When can section 4B be relied upon?

19.1 Section 4B provides a legal basis for decision makers to take steps which deprive a person of liberty, only if the following four conditions are met.

Condition 1: the steps must wholly or partly:

- be for the *purpose* of giving the life-sustaining treatment or any vital act

For example, restraining a person to enable a medical treatment to be administered which would help sustain the person's life, such as dialysis.

or

- *consist* of giving the life-sustaining treatment or the vital act

For example, using anti-psychotic medication with a sedative effect to prevent a serious deterioration in the patient's dementia and stop them from leaving the hospital and disengaging with the treatment.

Condition 2: the steps must be necessary in order to give the life-sustaining treatment or carry out the vital act.

Condition 3: the decision maker must reasonably believe that the person lacks capacity to consent to the steps.

Condition 4: one of the following applies:

- a relevant decision is being sought from the court (e.g. a decision relevant to whether a decision maker is authorised to deprive the person of liberty),
- a Responsible Body is determining whether to authorise arrangements under the LPS, or
- there is an emergency.

If these four conditions apply, then a decision maker can take steps which deprive the person of their liberty.

19.2 Condition 4 means that section 4B cannot be relied upon once an LPS authorisation is in place. Once an authorisation is in place, if additional restrictions which amount to a deprivation of liberty are needed, and these do not fall within the terms of the authorisation, the decision maker or someone else should make the Responsible Body aware. This will trigger an urgent review of the authorisation, if required. Further guidance on authorisation records is given in chapter 13 on the Overall Process.

19.3 The legal authority provided by section 4B only applies to the steps needed for the life-sustaining treatment or vital act in question. It is not a ‘continuous’ or ‘ongoing’ power. For example, if a person is trying to leave a hospital and needs to be restrained, and this amounts to a deprivation of liberty, the legal basis provided by the power applies to that act of restraint only (as long as the other conditions are met). If a further vital act is required and the person needs to be restrained, the decision maker must make a new decision about whether the steps are authorised under the terms of section 4B, and this should be documented separately from earlier applications of the power (see paragraphs 19.39 – 19.44 on record keeping). See also paragraphs 19.8 – 19.15 for more information on what constitutes a vital act and life-sustaining treatment.

19.4 If it is not an emergency (see paragraphs 19.16 – 19.19), and no relevant decision is being considered by a court, section 4B cannot be relied on until the LPS process has been triggered. Information on the different routes through which the LPS process can be triggered is provided in chapter 13. Once the process has started, decision makers are authorised to take steps which deprive a person of liberty under section 4B if the other conditions apply.

19.5 For example, a person with dementia could move into a care home and the LPS process is triggered so arrangements for the person’s care can be authorised. As the move is urgent, the LPS process has not been completed before the move takes place. While the Responsible Body is considering whether to authorise the arrangements, the person tries to leave the care home to return to their previous home. Leaving the care home alone and unsupervised puts the person at risk of harm and severe distress, and this will lead to a serious deterioration in their condition. Section 4B provides the decision maker in the care home with the legal authority to carry out the steps to deprive the person of their liberty, in this case through the use of restraints, in order to prevent the person from leaving the care home.

Decisions being sought from the courts

19.6 In the majority of cases, the Responsible Body will make the decision to authorise arrangements under LPS. While it is possible for the Court of Protection, to grant authorisations, it is likely that this will only be needed in limited circumstances. Further information about the role of the Court of Protection is provided in chapter 7.

19.7 The legal authority provided by section 4B applies if a relevant decision is being sought from the court. A ‘relevant decision’ means a decision relevant to the question of whether the decision maker is authorised to deprive the person of liberty.

What is life-sustaining treatment?

19.8 Life-sustaining treatment means any medical treatment that in the view of a person providing health care for the person concerned is necessary to sustain life. This might include, for example:

- artificial ventilation to enable breathing,
- cardiopulmonary resuscitation,
- medication to stimulate heart function,
- artificial nutrition and hydration for those who cannot swallow, and
- blood transfusion.

What is a vital act?

19.9 A vital act means any act which the individual doing it reasonably believes to be necessary to prevent a serious deterioration in the person's condition.

19.10 The vital act should be proportionate in relation to the likelihood and seriousness of harm to the person and should not put unnecessarily restrictive arrangements on the person.

19.11 Depending on the circumstances of the case, examples of vital acts include:

- providing medical treatment,
- suicide prevention measures,
- restraint,
- delivering care and support,
- therapeutic intervention.

19.12 Vital acts are not restricted to certain settings and may need to be carried out in places such as care homes, education establishments, shared lives settings and rehabilitation centres. For example, in a rehabilitation centre, a person may require treatment at a particular stage of their recovery and a delay would reduce the effectiveness of this treatment and negatively impact their health. Some arrangements which constitute a deprivation of liberty may be necessary in order to immediately deliver this treatment to the person to prevent a serious deterioration in their condition.

19.13 It is important to remember that it is not the nature of the act itself that determines whether section 4B would apply, but rather the purpose of the act. The decision maker must be able to justify the act on the basis that they reasonably believe it is necessary to prevent a serious deterioration in the person's condition.

19.14 In all cases, the purpose of the act must be to prevent a serious deterioration in the person's condition. In other words, the level of the likely deterioration must be

severe and acute, and not minor. The vital act may be to take steps to prevent harm coming to the person, or harm coming to others, if such harm would cause a serious deterioration in the person's condition.

19.15 For example, in some circumstances it might be possible to rely on the authority of section 4B to carry out steps to prevent a person from returning to their family home from respite care if this poses a risk to the person's family. The decision maker must have a reasonable belief that the person lacks the relevant capacity and the steps are necessary to prevent a serious deterioration in the person's condition. In this case the person's family are at risk of being hurt by the person, and as a consequence would restrain the person which may then cause the person harm. If the family are not professionally trained in restraint practices, the consequences of this could cause a serious deterioration in the person's condition. In this example, the purpose of the vital act is to prevent harm to the person and harm to others.

Emergency situations

19.16 For the purposes of section 4B, the situations which constitute an emergency are when:

- the decision maker reasonably believes that there is an urgent need to take the steps to deprive the person of their liberty in order to give the life-sustaining treatment or carry out a vital act, and
- it is not reasonably practicable, before taking those steps to make an application to the court, to trigger the LPS authorisation process or to make an application under the Mental Health Act 1983 (MHA).

19.17 Decision makers must remember that in order to rely on this power in emergency situations, the person providing the care must reasonably believe that the person lacks mental capacity to consent to the steps.

19.18 In order to take steps in an emergency, the decision maker should have a reasonable belief that an application to the court, an authorisation under the LPS, or a referral for an assessment under the MHA will be required. It is likely that such emergencies will only last for a very short period of time. The LPS process should be triggered, application made to the court, or referral made for an assessment under the MHA, as soon as practically possible once the emergency has ended. In rare cases, such a step may prove not to be necessary after the emergency. If this is the case, the decision maker should provide timely notification to the body with the statutory responsibility for the person's care or treatment (if there is such a body) that section 4B has been relied upon. If, in the future, an application for an LPS authorisation is made, the Responsible Body should be made aware that the section 4B emergency provision has been relied on.

19.19 If the decision maker decides that a referral for an assessment under the MHA is needed and a referral is made, they cannot rely on section 4B for any further deprivations of liberty in order to carry out a life-sustaining treatment or carry out a vital act. The MHA provides various powers which can be used during emergencies in certain cases. These include holding powers and the ability to convey the person to a place of safety for assessment. Further information is provided in the MHA and the MHA Code of Practice. Information on the interface between the MCA and MHA is provided in chapter 22.

Are the steps necessary and proportionate?

19.20 The decision maker must reasonably believe that the act is necessary to give life sustaining treatment or carry out any vital act at the time when the act is carried out, on the basis of the information available to them. What might be a reasonable belief in the context of an emergency may no longer be a reasonable belief when there has been more time to investigate or consider the position.

19.21 As well as being necessary, the steps must also be proportionate in relation to the likelihood and seriousness of harm to the person.

19.22 For example, a person with dementia who usually resides at home could be taken to hospital for unplanned treatment of a physical condition. The person's dementia causes memory loss and confusion. The decision maker believes that proposed arrangements to enable the care and treatment of the person are necessary, however before the LPS process can be triggered, the person tries to remove their intravenous cannula and leave the hospital. At that moment, the decision maker has a reasonable belief that it is necessary to take steps which amount to a deprivation of liberty to deliver the vital act. In this case, the vital act is restraining the person so that there is not a serious deterioration in their condition due to harm caused by leaving the hospital unescorted, and as a consequence of not receiving medical treatment. As it is an emergency, and the decision maker has reasonable belief that an LPS authorisation will be needed and the other conditions are met, the legal authority of section 4B enables them to take these steps.

Advance decisions to refuse treatment

19.23 If a person has made an advance decision to refuse treatment, this treatment cannot be carried out under the authority of section 4B. Please see chapter 11 for further details on advance decision to refuse treatment.

What is the interaction between Responsible Bodies and the use of section 4B?

19.24 As set out in chapter 14, Responsible Bodies should always ensure that the authorisation decision is taken within 21 calendar days from receiving the referral. If the Responsible Body becomes aware that section 4B is being relied on by decision makers frequently, it should prioritise that case to ensure that the authorisation decision is made as a matter of urgency.

19.25 Responsible Bodies should never rely on the use of section 4B in order to deprioritise cases or justify delays in the assessment process. Section 4B is only intended to be relied upon on a short term or emergency, and in particular does not offer the same safeguards as the LPS process does. It is therefore not appropriate to rely on this in the medium or long-term.

19.26 If for example, care providers, IMCAs or an Appropriate Person becomes concerned about the inappropriate reliance on section 4B, they should raise this with the Responsible Body as soon as possible. If there are concerns about the person's welfare, there may also be a need to raise a safeguarding concern with the relevant authority. If a resolution cannot be achieved through these routes, a decision may need to be sought from the court.

Who should be informed when section 4B is relied upon?

19.27 Section 4B is a restricting power, so the decision maker should make certain organisations and individuals aware if steps under the authority of section 4B have been taken.

19.28 For example, Responsible Bodies will need to have this information so they can consider it during the LPS process, and the person's Appropriate Person or IMCA should be made aware so they are up to date with the person's case.

Decision makers acting in a professional capacity

19.29 This section applies to decision makers working in a professional capacity. Professional capacity means any person who is paid to carry out the person's care or treatment, either privately or publicly funded. Paragraph 19.38 provides information for decision makers not acting in a professional capacity, for example family members.

19.30 All professionals, those with a duty of care and public bodies have legal or professional duties and/or requirements to share relevant information with appropriate bodies or people, as appropriate. These legal or professional duties and/or requirements are applicable under LPS.

19.31 There is no additional duty or expectation, over and above the decision maker's other legal or professional duties and/or requirements to share relevant information, which requires the decision maker to inform the Responsible Body each time the authority of section 4B is used. However, the decision maker should inform the Responsible Body when section 4B is relied upon for the first time.

19.32 Beyond the initial application of 4B, decision makers do not need to inform the Responsible Body every time the power is relied upon. However, in some circumstances, the decision maker may consider it important to inform the Responsible Body that 4B has been used. For example, if steps under the authority of section 4B were being used a significant number of times within a short time period or the act of restraint was significant. The decision maker may also consider other reasons to inform the Responsible Body, such as when it would be in the best interests of the person. The decision maker may wish to seek legal advice on such matters as appropriate, such as when involved in legal proceedings.

19.33 Sharing information about the use of section 4B should be done as soon as possible within 72 hours. If the steps taken under the authority of section 4B were used multiple times in a short period, the decision maker can inform the Responsible Body of these in one communication. This should be done within 72 hours of the first instance section 4B was relied upon in this period.

19.34 If a Responsible Body is determining whether to authorise a person's arrangements under the LPS the Responsible Body should be informed as soon as possible if steps to deprive that person of liberty have been taken under the authority of section 4B. This is because this may be relevant to the arrangements and circumstances it is considering, and the priority given to the referral. The decision maker should also share information about the circumstances that led to the steps being implemented.

19.35 The decision being sought from a Responsible Body may be in relation to arrangements not connected to the life-sustaining treatment or vital act. Condition 4 can still be met if this is the case. Decision makers should inform the Responsible Body that steps have been taken under the authority of section 4B and provide details about the steps which have been carried out. Decision makers and the Responsible Body should consider whether the original proposed arrangements should be altered to include these additional arrangements.

19.36 If an Independent Mental Capacity Advocate (IMCA) or an Appropriate Person has been appointed, the decision maker should inform the IMCA or Appropriate Person that section 4B has been relied upon at the same time as they inform the Responsible Body.

19.37 Information about the use of section 4B and the context within which it arose would likely be put before the court in any proceedings in which it would be relevant

information for the purpose of those proceedings, such as any application pursuant to section 4B(7)(a) of the MCA.

Non-professional decision makers

19.38 When the decision maker is not acting in a professional or paid capacity, for example they are a family member, the requirements for informing the Responsible Body outlined in paragraphs 19.29 – 19.37 do not apply. As part of the LPS process, a necessary and proportionate assessment and determination must be carried out. The assessor should use this assessment and determination process to find out if section 4B has been relied upon by a decision maker not acting in a professional or paid capacity.

Record keeping and sharing

19.39 When considering whether the person has capacity to consent to the steps required to enable the life-sustaining treatment or carry out the vital act, decision makers should ensure that the relevant information is recorded and shared appropriately in accordance with their usual professional duties and/or requirements to take such steps, including with the wider care team, the IMCA and any deputy or attorney.

19.40 Consideration should also be given to sharing relevant information with the person's family members, Appropriate Person and others interested in their welfare where lawful and proportionate to do so.

19.41 Decision makers should keep records of decisions about the four conditions (see paragraph 19.1) for appropriate sharing of relevant information in accordance with the provider or professional's duties and powers to do so. Such information should include:

- the reasons for deciding that each of the four conditions is met,
- the reason for steps being taken to deprive the person of their liberty, that is, the vital act or life-sustaining treatment required, and
- the precise steps that have been taken.

19.42 In emergency cases, decision makers should still keep an accurate record of the matters listed above, as well as other relevant matters. This should be completed as soon as possible after the emergency intervention.

19.43 The requirement to keep records only applies to decision makers acting in a professional capacity.

19.44 Further guidance on information sharing for family carers and other carers, deputies and attorneys, who care for or represent someone who lacks capacity to make

specific decisions and in particular, lacks capacity to allow information about them to be disclosed, is provided in chapter 3.

20. Monitoring and Reporting on the Liberty Protection Safeguards scheme

The deprivation of a person's liberty is a significant issue. The LPS are designed to ensure that people are only deprived of their liberty if this is necessary and proportionate. In order to provide reassurance that the LPS are being operated correctly, it is important that there is effective monitoring of and reporting on the operation of the scheme.

Quick summary

Who the bodies are that are responsible for monitoring and reporting on the Liberty Protection Safeguards (LPS) in England and Wales.

- The bodies responsible for monitoring and reporting on the LPS in England are the Care Quality Commission, CQC (for adults) and the Office for Standards in Education, Children's Services and Skills, Ofsted (for 16-17 year olds).
- In Wales, the bodies are the Health Inspectorate Wales (HIW) and Care Inspectorate Wales (CIW). In respect of education settings, the function is also performed by Estyn.
- These bodies are referred to collectively for the purposes of the LPS as the 'monitoring bodies'.

Who must provide data to the monitoring bodies and what this should consist of in order to carry out their monitoring and reporting responsibilities.

- The monitoring bodies have a duty to monitor and report on the operation of the LPS. To assist them to carry out this duty, Responsible Bodies are required to regularly notify the monitoring bodies when the LPS process has been triggered.
- Responsible Bodies should also regularly notify the monitoring bodies when they have decided to authorise or not authorise the arrangements, and when an authorisation is renewed or comes to an end.

The powers that the monitoring bodies have that they may exercise to carry out their monitoring and reporting responsibilities.

- The monitoring bodies have the following powers they may exercise to carry out their monitoring responsibilities:
    - Visit settings where an authorised deprivation of liberty is being carried out. The monitoring bodies may require relevant consent in order to visit the place.
    - Meet with the person that the LPS authorisation applies to. The monitoring bodies will need the consent of the person in order to meet them, or if they lack the relevant capacity to consent then a best interests decision may be needed in accordance with section 4 of the Mental Capacity Act (2005).
    - Require access to and inspect records relating to the care and treatment of that person before, during or after they visit the setting.
    - Meet any person engaged in caring for a person the LPS authorisation applies to, or a person interested in their welfare.
- The monitoring bodies will report annually, summarising their activity and findings about the operation of the LPS.

What are the aims of monitoring and reporting on the Liberty Protection Safeguards?

20.1 The aims of the LPS monitoring and reporting scheme are to:

- Monitor the manner in which the LPS is being operated.
- Report on and identify trends in the operation of the LPS (See para 20.19 for more detail).
- Help prevent abuse and neglect and/or unauthorised deprivations of liberty, as far as possible by ensuring oversight of the scheme. (It is important to note that the role of the monitoring bodies differs to that of the Responsible Body. For example, it is the role of the Responsible Body to consider whether to authorise arrangements that give rise to a deprivation of liberty and keep authorised arrangements under review. See chapter 14 on Responsible Bodies for more detail).

Who will monitor the Liberty Protection Safeguards?

20.2 Regulations confer responsibility for the monitoring and reporting on the operation of the LPS in England on the Care Quality Commission (CQC) and Office for Standards in Education, Children's Services and Skills (Ofsted).

20.3 Under the regulations for England, CQC are responsible for monitoring and reporting the scheme in relation to adults aged 18+ and Ofsted are responsible for monitoring and reporting the scheme in relation to 16-17 year olds. There will be cases where a 16-17 year old is in a setting that CQC already inspects and/or regulates (e.g. a 16 year old deprived of liberty in a hospital), and likewise where an adult is in a setting that Ofsted inspects and/or regulates (e.g. an 18 year old in a special school). The regulations provide that Ofsted and CQC may request assistance from each other in carrying out their monitoring and reporting duties in scenarios of this nature, though this will not affect their underlying legal responsibilities.

20.4 In Wales, the functions of monitoring the operation of the LPS falls to Welsh Ministers. These functions are performed on their behalf by Health Inspectorate Wales (HIW) and Care Inspectorate Wales (CIW). In respect of education settings, the function is also performed by Estyn. In Wales – the regulations provide that CIW, HIW and Estyn may work together and sets out a clear requirement that assistance should be provided if a body asks for it, unless there are legitimate grounds not to provide it.

20.5 For the purposes of this chapter, the English and Welsh bodies with the statutory duty to monitor and report on LPS are referred to collectively as the 'monitoring bodies'. There may be cases where a deprivation of liberty is authorised by an English Responsible Body for the care and treatment of a person who is living in Wales, and vice versa. In these cases, the Welsh and English monitoring bodies should implement joint working arrangements.

What powers do the monitoring bodies have and what do they do?

20.6 The monitoring bodies have a duty to monitor and report on the operation of the LPS. To assist monitoring bodies to carry out this duty, Responsible Bodies are required to regularly notify the monitoring bodies of certain matters (the LPS notification duty is explained further at para 20.17).

20.7 Under the regulations the monitoring bodies have the following powers they may exercise in respect of LPS authorisations:

- Visit settings where an authorised deprivation of liberty is being carried out (such visits may require the monitoring bodies to have relevant consent, explained further below at the section – Conducting visits).
- Meet with the person that the LPS authorisation applies to (either in the settings where the authorised arrangements are taking place, or elsewhere). Monitoring bodies will require the consent of the person in order to meet them or if the person lacks the relevant capacity, a best interests decision may be needed, explained further below at the section – Meeting with the person subject to an LPS authorisation.
- Require access to and inspect records relating to the care and treatment of that person. The monitoring bodies can require records from the Responsible Body that authorised the deprivation of liberty, as well as a setting where an authorisation is in place before, during or after they visit the setting.
- Meet any individual engaged in caring for, or is interested in the welfare of, the person that the LPS authorisation applies to. This might include for example the person's care worker or nurse or a family carer. The monitoring bodies will require consent of the individual in order to meet them and should also consider the wishes and feelings of the person that the LPS authorisation applies to, and any other relevant circumstances

20.8 In order to carry out their duty to monitor the LPS, the monitoring bodies may exercise some of their powers, if appropriate, on a case sampling basis.

20.9 The monitoring bodies should each report annually, summarising their activity and their findings about the operation of the LPS. In England these reports will be made to the Secretary of State for Health and Social Care and the Secretary of State for Education, and in Wales the report will be made to the Welsh Ministers.

Meeting with the person subject to an LPS authorisation

20.10 In order for the monitoring bodies to meet the person that the LPS authorisation applies to, that person must have capacity to consent to the meeting and give consent, or it must be determined that such a meeting is in the person's best interests in accordance with section 4 of the Mental Capacity Act 2005 (MCA).

20.11 The best interests decision-maker will be an attorney under a Lasting Power of Attorney or deputy appointed by the Court of Protection, who has the relevant authority to make a valid best interests decision about the meeting. If there is no such person, then the "decision maker" should make the best interests decision. This might be someone involved in caring or interested in the person's welfare, including the monitoring bodies. For further information on who can be a decision-maker and making a best interests decision, see Chapter 5. The best interests

decision-maker is required to consult, if it is practicable and appropriate, the relevant IMCA and/or Appropriate Person, as to what would be in the person's best interests and in particular the person's past and present wishes and feelings.

20.12 Such meetings may be held at the place where the authorisation is being carried out or at any other place agreed with the person. If the person subject to the LPS authorisation has capacity to consent to the meeting and asks for the meeting in private, the monitoring bodies should have regard to that request. In most cases this is likely to be appropriate. A meeting may be in person but can also, for example, be conducted using audio or video conferencing facilities, where appropriate. When considering whether to hold an in-person or audio or video conference meeting, the monitoring bodies should consider the person's communication needs. Views should also be sought from those who are caring for the person or interested in the person's welfare, where practicable and appropriate.

Conducting visits

20.13 Monitoring of LPS may take place as part of monitoring bodies' routine inspections. For example, the CQC could monitor the LPS as part of their periodic inspections of care homes. Similarly, for example, Ofsted could do likewise as part of their inspection of children's homes and education settings. Monitoring bodies are also expected to respond appropriately to concerns arising in settings where an LPS authorisation is in place which may be raised before, during or after a visit. If at any point the concern meets the criteria for a safeguarding enquiry under the Care Act 2014, the Children Act 1989 or the Social Services and Wales Act 2014, the monitoring body should refer it as a safeguarding concern to the relevant local authority in line with existing safeguarding statutory frameworks.

20.14 Monitoring bodies have existing regulatory frameworks and policies that apply to their routine inspections. When conducting inspections monitoring bodies are required to respect the person's Article 8 rights to private and family life, under the European Convention on Human Rights. In undertaking their duty to monitor and report on the LPS, monitoring bodies should consider applying or adapting the same standards not only to regulated settings but to all settings where authorisations occur.

20.15 In order to visit settings where arrangements are being carried out, consent will normally be required for example from the owner of person occupying the premises. There may be some cases where consent is not possible or not required, for example when the person lacks the relevant capacity and a best interests decision will be required instead.

20.16 Such consent may be from someone other than the person that the LPS authorisation applies to depending on the living arrangements, such as the owners,

occupiers or managers of the place. Some examples of the types of scenarios where consent is required and from whom are set out below at para 20.17. Monitoring bodies will need to consider and assess the individual circumstances of the case, including whether there are people other than the person who the LPS authorisation applies to who usually live at that property or own the property.

- Refusal of a visit should not automatically raise a safeguarding concern. For example, there may be legitimate reasons for the individual from whom consent is required to refuse a visit (such as to minimise distress to the person that the LPS authorisation applies to).
- Where refusal triggers the duty to make safeguarding enquiries under the Care Act, Children Act of Social Services and Well-being (Wales) Act, the monitoring body should refer to the relevant local authority, and inform the Responsible Body (if they are not the same).

20.17 If the monitoring body comes across a case during the course of their inspections where they believe deprivation of liberty may be occurring without an authorisation, they should inform the relevant Responsible Body as soon as possible. It is ultimately the role of the Responsible Body to determine if a deprivation of liberty is occurring. As part of their duty to report on the operation of the LPS, the monitoring bodies should consider reporting on the numbers of these cases that they come across in their annual reports.

Notification system

20.18 Under the LPS, Responsible Bodies are under a duty to regularly notify the monitoring bodies of when the LPS process has been triggered and they are considering whether to authorise arrangements or not. They should also notify the Responsible Body when they have decided to authorise or not authorise the arrangements and when an authorisation is renewed or comes to an end.

20.19 Notifications should be sent on a regular basis to the relevant monitoring body as identified on the basis of the person's age in accordance with para 20.3. To ensure consistency of frequency and reporting across all Responsible Bodies, the administration of the notification scheme for Responsible Bodies is subject to national agreement in England. In Wales, this is set out in Wales' national Monitoring and Reporting Strategy.

20.20 Where monitoring bodies identify concerning trends in the data regarding the way individual Responsible Bodies are discharging their functions under the LPS they should refer these concerns to the Responsible Body in the first instance. For example, the monitoring bodies may identify a very low number of LPS authorisations by one Responsible Body, or a high proportion of authorisations still pending decision after 21 days from the LPS process being triggered (see Overall

Process chapter 14 for more detail on the assessments process timeframe). Responsible bodies have a duty to co-operate with the monitoring bodies in respect of their powers to visit, meet the person, access and inspect records and meet others.

20.21 Where the Responsible Body does not respond to these concerns or does not respond adequately, the monitoring bodies may require access to records which the Responsible body holds, and/or use the data to inform inspection activity. If the monitoring body continues to have concerns, they may refer their concerns to the Secretary of State for Health and Social Care (if concerns belong to CQC), the Secretary of State for Education (if concerns belong to Ofsted) or to the relevant Welsh Minister (if concerns belong to the Welsh monitoring bodies). The Secretary of State will consider whether any existing powers should be initiated in response.

21. How does the Act apply to children and young people?

This chapter explains the position of young people aged 16 and 17 years old under the Mental Capacity Act, including detail on how the Liberty Protection Safeguards (LPS) scheme applies to 16 and 17 year olds. This chapter also looks at the few parts of the Mental Capacity Act that may affect children under 16 years of age.

Within this Code of Practice, 'children' refers to people aged below 16. 'Young people' refers to people aged 16 and 17. This differs from the Children Act 1989, the Social Services and Well-being (Wales) Act 2014 and the law more generally, where the term 'child' is used to refer to people aged under 18.

In some places this chapter also refers to the Special Educational Needs and Disability (SEND) system for people up to the age of 25. It will discuss the use of Education, Health and Care Plans (EHC plan) in England[138], and Individual Development Plans (IDP) in Wales[139].

This chapter does not deal with research, which is covered in chapter 26.

> In this chapter, as throughout the Code, a person's capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

Quick summary

Young people aged 16–17 years

[138] Section 37 of the Children and Families Act 2014 sets out that an Education, Health and Care (EHC) needs assessment ensures that a child or young person's needs are assessed in a joined-up way. EHC plans must be produced by the local authority in partnership with parents, children and young people and based on a co-ordinated approach to the delivery of services across education, health and care, supported by a duty to plan and commission services jointly. EHC plans can remain in place from birth to the age of 25 and have a clear focus on outcomes, including the support a child or young person will need to achieve them, further information is available at: https://www.legislation.gov.uk/ukpga/2014/6/section/37/enacted.

[139] The Additional Learning Needs and Education Tribunal (Wales) Act 2018 establishes a statutory system in Wales for meeting the additional learning needs of children and young people. Section 10 provides for individual development plans (IDPs). An IDP is a document that contains a description of the person's additional learning needs, a description of the additional learning provision which the person's learning difficulty of disability calls for and anything else required or authorised under the 2018 Act. Further information is available at: https://www.legislation.gov.uk/anaw/2018/2/section/10.

- Most of the Act applies to young people aged 16–17 years, who may lack the relevant capacity to make a particular decision.

- There are three exceptions:

    - Only people aged 18 and over can make a Lasting Power of Attorney (LPA).

    - Only people aged 18 and over can make an advance decision to refuse medical treatment.

    - The Court of Protection may only make a statutory will for a person aged 18 and over.

Care or treatment for young people aged 16 and 17

- The same principles and approach that apply to adults apply to determine the best interests regarding care or treatment of a young person who lacks capacity to make a decision. This means considering the factors set out in the best interests checklist (see chapter 5) to ascertain what is right for the young person when the decision needs to be made.

- Professionals may consider it more appropriate, due to the circumstances of the case, to rely upon the consent of a person with parental responsibility regarding the young person's care and treatment. Professionals should be clear and explicit as to which framework is appropriate and why.

Children under 16

- The Mental Capacity Act does not generally apply to people under the age of 16.

- There are two exceptions:

    - The Court of Protection can make decisions about a child's property or finances (or appoint a deputy to make these decisions) if the child lacks capacity to make such decisions and is likely to still lack capacity to make financial decisions when they reach the age of 18.

    - Offences of ill treatment or wilful neglect of a person who lacks capacity within section 2(1) can also apply to victims younger than 16 (section 44).

LPS and 16 and 17 year olds

- The LPS, together with the other provisions of the MCA, apply to any person aged 16 or over.
- This chapter focuses on the LPS processes as they affect young people and those aged between 18 and 25. It also considers the relationship of LPS with other legal frameworks which affect these age groups such as the Children Act 1989 and Social Services and Well-being (Wales) Act 2014. It sets out the role of those with parental responsibility in supporting a young person, the role of health and social care professionals working with young people, and the process for the use of LPS for young people.

The Mental Capacity Act and 16 and 17 year olds

21.1 Most of the Mental Capacity Act applies to 16 and 17 year olds who lack capacity to make a particular decision, in line with the Act's definition of lack of capacity described in chapter 4.

21.2 There may be situations when either the Mental Capacity Act or the Children Act 1989 may apply, depending upon the particular circumstances (see paragraphs 21.10 and 21.21-21.25). However, there may also be situations where neither of these Acts provides an appropriate solution. In such cases, it may be necessary to look to the powers available under the Mental Health Act 1983 or the High Court's inherent powers to deal with cases involving young people.

Additional legislation for 16 and 17 year olds

21.3 Adults supporting vulnerable young people should be familiar with their rights, which are set out in domestic and international legislation, including the Children Act 1989, the Social Services and Well-being (Wales) Act 2014, the Children and Families Act 2014, the Additional Learning Needs and Education Tribunal (Wales) Act 2018[140], the Education Act 1996, the Learning and Skills Act 2000, the Chronically Sick and Disabled Person's Act 1970, as well as the Human Rights Act 1998. Regard should also be had to the United Nations Convention on the Rights of the Child, which is a statutory requirement in Wales.

[140] Until the Additional Learning Needs and Education Tribunal (Wales) Act 2018 comes into force [phased implementation expected to start from late 2021], part IV of the Education Act 1996 (and the Special Educational Needs Code of Practice for Wales) provides for the provision of statements of special educational needs in Wales.

21.4 In England, the statutory 'SEND code of practice: 0 to 25 years' sets out the duties of local authorities, health bodies, schools and colleges to provide for those with special educational needs under part 3 of the Children and Families Act 2014[141].

Do any parts of the Act not apply to young people aged 16 or 17?

Lasting Power of Attorneys

21.5 Only people aged 18 or over can make a Lasting Power of Attorney (LPA) (section 9(2)(c)).

Advance decision-making for 16 and 17 year olds

21.6 Young people aged 16 and17 cannot make an advance decision to refuse medical treatment (see chapter 11).

21.7 16 and 17 year olds can make a written advance statement, which can cover any aspect of their future health or social care. This is something that decision makers must have regard to when making a best interests determination (see chapter 5).

Making a will

21.8 The law generally does not allow anyone below the age of 18 to make a will. Section 18(2) confirms that the Court of Protection can only make a statutory will on behalf of those aged 18 and over.

What does the law say about care or treatment of young people aged 16 or 17?

21.9 The law applies to 16 and 17 year olds differently to the way it applies in relation to adults in two important ways in the context of decisions about care and treatment.

21.10 Decision-making in relation to 16 and 17 year olds who lack the relevant capacity can in many cases be undertaken either by reference to the Mental Capacity Act or by reference to the Children Act 1989 and the operation of parental responsibility142. Professionals can therefore choose which regime to apply, but should be clear as to which one they are using.

[141] SEND code of practice: 0 to 25, available at: https://www.gov.uk/government/publications/send-code-of-practice-0-to-25

[142] The concept of parental responsibility in the Children Act 1989 in the context of consent being given on behalf of someone applies in Wales as well as England, available at: https://www.legislation.gov.uk/ukpga/1989/41/section/3

21.11 As set out above, 16 and 17 year olds do not have an absolute right to refuse medical treatment. A court can override their refusal, even if there are no doubts about their decision-making capacity[143].

Applying the Act

21.12 The principles and approach that apply to adults may be used when considering the decision-making capacity of a young person. A professional can generally act upon the consent of a young person to any surgical, medical or dental treatment if they reasonably believe that the young person has the capacity to give that consent144.

21.13 The principles and approach that apply to adults can be applied to determine what is in the best interests of a young person who lacks the capacity to make a decision, under section 2(1) of the Act. This means considering the factors in the best interests checklist (see chapter 5) to ascertain what is right for the young person when the decision needs to be made.

21.14 Where it is practical and appropriate to do so, professionals must establish, as best as they can, the wishes and feelings of the young person, together with the views of anyone with an interest in their care and welfare, and carefully consider these views in reaching a decision. In the majority of cases, this should include the young person's parents or others with parental responsibility. Care should be taken not to unlawfully breach the young person's right to confidentiality (see chapter 25).

21.15 If a young person has said they do not want their parents to be consulted it may not be appropriate to involve them (for example, where there have been allegations of abuse).If there is a disagreement between those involved in the care of the young person as to what is in their best interests, then the steps set out in chapter 24 should be followed.

[143] NHS Trust v X (No 2) [2021] EWHC 65 (Fam) (18 January 2021), available at: https://www.bailii.org/ew/cases/EWHC/Fam/2021/65.html.

[144] Section 8 Family Law Reform Act 1969, available at: https://www.legislation.gov.uk/ukpga/1969/46/section/8

Scenario: Working out a young person's best interests

Ms M is 16 and has Down's syndrome. Her mother accompanies her to a dental check-up and tells the dentist that she thinks Ms M should have a dental treatment which is not medically necessary but will improve the appearance of Ms M's teeth.

The dentist must decide whether to go ahead with the cosmetic treatment. To be protected under section 5 of the Act (protection from liability), she must consider whether Ms M has capacity to agree to the treatment and, if not, what would be in her best interests. The dentist talks with Ms M and assesses her as lacking the capacity to understand what is involved in the treatment or the possible consequences, and therefore lacking capacity to make the decision.

However, observing and talking to Ms M shows that she is very self-conscious about her teeth and has been upset by comments people have made about them. She says she wants her teeth to look better.

The dentist takes Ms M's wishes into account when deciding whether the treatment is in Ms M's best interests. She also consults both of Ms M's parents as well as her teacher and GP to see if there are other relevant factors to take into account. The teacher confirms Ms M's self-consciousness about her appearance, and the GP advises there would be no medical issues arising from the treatment.

The dentist decides that the treatment is likely to improve Ms M's confidence and self-esteem and is in her best interests.

The common law: parental responsibility

21.16 Where a young person lacks the relevant capacity under section 2(1) of the Act, professionals may, where circumstances indicate that it is appropriate to do so, choose to seek consent from those with parental responsibility rather than relying on the best interest provisions within the MCA set out in chapter 5. Where a person with parental responsibility gives or refuses consent they must make a decision based upon what is in the young person's best interests.

21.17 If professionals consider that the person with parental responsibility is not acting in the young person's best interests, and if they cannot reach agreement with this person as to what should be done, then they will need to make an application to court. This will be particularly important if the professionals consider that the person with parental responsibility is refusing to give consent to a particular treatment on behalf of the young person and that this is not in the best interests of the young person.

21.18 Where nobody has been identified as having parental responsibility for a young person who lacks capacity, the MCA framework must be applied to make decisions.

The common law: young people outside the scope of the Mental Capacity Act

21.19 Though the courts have not yet had to consider such a case, some young people may appear to be unable to make a specific decision, but it may not be clear whether this is due to an impairment or disturbance in the functioning of their mind or brain. For example, they may appear to be overwhelmed by the implications of the decision, having never had to make such a decision previously. In such a situation the apparent or initial inability to make a decision may be resolved where the young person is supported with as much time, space and explanation as practicable to enable them to make the decision. If appropriate, expert assistance should be sought to identify whether or not the young person's inability to make the decision stems from an identifiable impairment or disturbance in the functioning of the mind or brain.

21.20 If, exceptionally, the young person remains unable to make the decision even with support, and those involved do not reasonably consider that the young person lacks capacity applying within the meaning of section 2(1) of the Act, the common law will apply. In these circumstances consent could be obtained from a person with parental responsibility, or, alternatively and exceptionally, the doctrine of necessity may apply. This would provide a defence for any action immediately required to secure the young person's interests145. If the decision relates to an ongoing situation (for example admission to and remaining in hospital), the young person should continue to be given support, and their decision-making ability be kept under review.

Which courts consider cases involving young people?

21.21 Different courts/tribunals may be involved in determining issues concerning a young person who lacks the relevant capacity. For example, the Family Court may be involved to review a local authority's use of a provision within the Children Act 1989 or the Social Services and Wellbeing (Wales) Act 2014. The First-tier Tribunal (Special Educational Needs and Disability (England) or Education Tribunal (Wales) may be involved in a decision concerning educational provision. The nature of the challenge or objection will determine which court is able to determine the issue.

[145] It may also be necessary to make an application to the High Court under its inherent jurisdiction to determine what should happen.

Interrelationship between the Family Court and the Court of Protection

21.22 A case involving a young person who lacks mental capacity to make a specific decision may be heard in the Family Court or in the Court of Protection. This will depend upon whether the young person's interests can be more effectively safeguarded within the Court of Protection or under the Children's Act146. If a case is likely to require ongoing decisions (because it is anticipated that the young person will continue to lack capacity when they are 18), it may be more appropriate for the Court of Protection to hear the case. For one-off cases not involving property or finances, the Family Division may be more appropriate.

21.23 The Family Court and the Family Division of the High Court deal with matters concerning public (and private) family law – these are cases where a local authority is involved in relation to the care of a child up to the age of 18 due to safeguarding or welfare concerns in respect of that child.

21.24 In some cases, even if issues under the MCA are being considered, the Family Court may be the more appropriate court to consider the case. This will ultimately be for the courts to decide.

21.25 So that the appropriate court hears a case, the Court of Protection can transfer cases to the family court, and vice versa. The Mental Capacity Act 2005 (Transfer of Proceedings) Order sets out when proceedings in the Court of Protection may be

Scenario: Applying the Act to children

Mr T was nine when a drunk driver knocked him off his bicycle which caused severe head injuries including an acquired brain injury. His parents make a claim for compensation and two years later receive a settlement which is significant because of Mr T's lifelong care and accommodation needs as a result of the accident.

Mr T is assessed as highly unlikely to recover enough to be able to make major or complex financial or health and welfare decisions when he is 18 or over. His parents therefore apply to the Court of Protection to be his property and finance and health and welfare deputies. The court makes the orders appointing them, so they can make the complex decisions to arrange and pay for the care Mr T will need in the future.

Despite being deputies Mr T's parents continue to support Mr T to make the decisions which he has capacity to make, and to involve him in, and ascertain his wishes and feelings regarding, the decisions he lacks capacity to make.

146 *B (A Local Authority) v RM & Ors* [2010] EWHC 3802 (Fam), available at: https://www.bailii.org/ew/cases/EWHC/Fam/2010/3802.html.

transferred to a court with jurisdiction under the Children Act, and vice versa, and how proceedings are to be dealt with.

Scenario: Hearing cases in the appropriate court

Ms S is 17. She has learning disabilities and has lived with her mother since her parents' divorce several years ago.

Ms S's father is worried that her mother is not enabling Ms S to develop life skills and independence to her full potential, and says it would be best for Ms S to move into residential accommodation where she will be supported to learn to live more independently in adulthood. Ms S's mother disagrees and says she wants to continue to care for Ms S at home. Ms S lacks the capacity to decide where she should live, but articulates her wishes to remain living with her mother.

Ms S's father speaks to the local authority expressing his views about where Ms S should live. Given that the disagreement with Ms S's mother cannot be resolved, Ms S's father makes an application to the Court of Protection for an order to decide where Ms S should live. (An order could be made by the family court under the Children Act 1989 but this would end on Ms S's eighteenth birthday and therefore would not be appropriate for Ms S's case.) The Court of Protection order can continue into Ms S's adulthood.

The Mental Capacity Act and children under 16

21.26 Section 2(5) of the Act states that, with the exception of section 2(6), no powers under the Act may be exercised in relation to a child under 16.

21.27 Section 2(6) makes an exception for some decisions about a child's property and financial affairs. The Court of Protection can make decisions about property and affairs of those under 16 in cases where the person is likely to still lack capacity to make financial decisions after reaching the age of 18. The court's ruling will still apply when the person reaches the age of 18, which means there will not be a need for further court proceedings once the person reaches the age of 18.

21.28 The Court of Protection can:

- make an order (for example, concerning the investment of an award of compensation for the child), and/or
- appoint a deputy to manage the child's property and affairs and to make ongoing financial decisions on the child's behalf.

21.29 In making a decision, the court must follow the Act's principles and decide in the child's best interests as set out in chapter 5.

21.30 The criminal offence of ill treatment or wilful neglect of a person lacking capacity under Section 44 of the Act also applies to a person of any age, including a child (see further chapter 23).

How do the Liberty Protection Safeguards apply to young people?

21.31 The Liberty Protection Safeguards (LPS) provide a legal framework by which to consider and, if appropriate, authorise arrangements that give rise to a deprivation of liberty in order to provide care or treatment for a person who does not have the relevant mental capacity to consent to those arrangements. If arrangements might amount to a deprivation of liberty, and the young person for which the arrangements are proposed is unable, even with support, to consent to the proposed arrangements, then it may be necessary to trigger the LPS assessments process. Please see chapter 13 for the overall process of the LPS.

21.32 A deprivation of liberty should be for the shortest appropriate period of time and must be necessary and proportionate. Less restrictive options should always be considered before putting in place arrangements amounting to a deprivation of liberty. Please see chapter 12 for the definition of a deprivation of liberty.

21.33 The principles of the Act apply once a young person turns 16. Therefore, an LPS authorisation cannot come into force prior to a young person's 16th birthday. However, an LPS authorisation can be given up to 21 days prior to its coming into effect. In some cases, it may be appropriate to authorise the arrangements under LPS ahead of the young person's 16th birthday, for the authorisation to then come into effect on that day. Where this is the case, this should be clearly recorded within the young person's records.

21.34 It may be that the young person has been under arrangements that amount to a deprivation of liberty prior to the age of 16. If arrangements amounting to a deprivation of liberty are required before the young person turns 16, these arrangements should always have the appropriate authorisation in order to be lawful. For example, an order of the High Court or under an appropriate statutory scheme, such as section 25 Children Act 1989 or the Mental Health Act 1989. If there is a reasonable expectation that these arrangements will still be necessary once the young person turns 16, this should be planned for well in advance. Decision makers should not wait for the young person to turn 16 to formalise such arrangements.

21.35 The young person should be supported as far as possible to express their wishes and feelings about the LPS process and the proposed arrangements. When doing

so, practitioners should discuss and agree the most appropriate communication methods with those people involved in the person's care. If the young person expresses that they do not wish to reside or receive care or treatment in a place during the assessments process, the Responsible Body must refer the case to an Approved Mental Capacity Professional. Please see chapter 18 for further information on AMCPs.

What is the interaction between the LPS and Education, Health and Care and Support Plans in England, or Individual Development Plans in Wales?

21.36 Many young people who are subject to an LPS authorisation will have complex special educational needs (in England) or complex additional learning needs (in Wales) and will therefore also have an EHC plan or IDP respectively. For children and young people with EHC plans, planning for adulthood should start from school year 9, in line with the expectations set out in the SEND Code of Practice147. Likewise, this approach should also apply for children and young people with IDPs in Wales in line with expectations set out in the ALN Code.

21.37 Unless the arrangements for the young person are mainly occurring in an NHS hospital, then the Responsible Body will be the local authority maintaining the young person's EHC or IDP. If the young person's arrangements are taking place in an NHS hospital, the Responsible Body would be the relevant Trust. See chapter 14 for more information.

21.38 Where the young person is under arrangements amounting to a deprivation of liberty, reviews from the age of 14 onwards should consider whether they are still necessary and proportionate, including consideration of less restrictive options. Likewise, if the young person is moving into a new setting or their plan is changing in such a way that may mean that new arrangements for the person's care or treatment are required that may amount to a deprivation of liberty, then this should be considered in reviews. It is particularly important that the relevant local authority attend year 9 (age 14) reviews to explore the possible need for an LPS authorisation at 16. This should usually be someone from the local authority that is involved in the young person's case.

21.39 If arrangements amounting to a deprivation of liberty are required once the young person turns 16 then, in most cases, the LPS process should be triggered at an appropriate time before their 16th birthday.

21.40 Practitioners and decision makers involved in the LPS process should remain aware of how it interacts with the special educational provision set out in the young person's EHC plan, or additional learning provision set out in the young person's

[147] See further *SEND Code of Practice: 0 to 25 years* (2015), paragraphs 8.9-8.12, available at: https://www.gov.uk/government/publications/send-code-of-practice-0-to-25

IDP. Further information can be found in the SEND Code of Practice or the ALN Code.

21.41 Once the LPS process is triggered, the process set out in chapter 13 should be followed. Where relevant, and as far as possible, any assessments or consultation for the LPS process should be carried out alongside consultation or assessments for any changes to the young person's respective plan. Please see information on the LPS consultation duty in chapter 17 and the LPS assessments in chapter 16.

21.42 Education, health and social care professionals who support the young person and their family as part of the EHC or IDP planning process will know the person and their wishes and feelings best, and therefore should be consulted as part of the LPS assessments process.

21.43 Where the Responsible Body gives an LPS authorisation for a young person's care and treatment arrangements, an authorisation record will be issued to the young person and their Appropriate Person or Independent Mental Capacity Advocate (IMCA). The LPS authorisation record is standalone to EHC plans (in England) or IDPs (in Wales). However, any information in an LPS authorisation record that is relevant to meeting a young person's special educational needs should be included in their EHC plan or IDP.

21.44 The LPS authorisation records relate specifically to the arrangements that give rise to a deprivation of liberty, a schedule for reviews, the length of an authorisation, and the support and representation for the person. Whereas, an EHC plan or IDP sets out the young person's special educational needs/additional learning needs and the provision needed to meet those needs to achieve an improved outcome. Given the close links between the authorisation record and an EHC plan or IDP, local authorities (where they are the Responsible Body) should consider linking reviews of LPS authorisations and EHC plans or IDPs. Such steps will ensure a joined-up discussion takes place about how best to meet the young person's needs, and to support them to prepare for adulthood.

21.45 In some cases, the young person or others, such as their parents, may appeal to the First Tier SEND Tribunal against the EHCP. This may include an appeal against the school or other institution specified in the EHCP. If an LPS authorisation is in place for the original setting, and the Tribunal directs that the young person is placed in a different setting, the authorisation may need to be reviewed and/or ceased. If arrangements are required that may amount to a deprivation of liberty in the new setting, then the LPS process should be triggered again.

What is the interrelationship between care plans and support plans (for looked after children) and LPS authorisations?

21.46 An LPS authorisation is not a power to place a young person in a particular setting: it authorises the arrangements within that placement for the care and treatment of the young person which amount to a deprivation of liberty.

21.47 Unless the young person is being deprived of liberty mainly in an NHS hospital, the Responsible Body for a looked after child subject to an LPS will normally be the local authority with responsibility for that young person.

21.48 Local authorities have a duty to develop a care plan (in England) or a care and support plan (in Wales) for a looked after child. This plan will outline that child's developmental needs and sets out how they will be met. Where the local authority begins looking after a child at age 16 or 17, and it is likely that an LPS authorisation will be required, the LPS process should be carried out alongside the initial care planning.

21.49 Likewise, if the child is looked after by the local authority before their 16th birthday, and it seems likely that the child will require an LPS authorisation, the local authority should plan for this as early as possible. This may include reviewing the young person's care arrangements to determine whether they remain necessary and proportionate or whether new arrangements would be more appropriate. Decision makers should always consider less restrictive options as far as possible. Where arrangements are reviewed, the LPS process should be carried out alongside this where appropriate.

21.50 The young person's wishes and feelings should be considered both within the LPS process and the care planning process. As far as practically possible, the local authority should carry out the consultation for LPS at the same time it is ascertaining the person's wishes and feelings in respect of their care services. If the young person has an advocate representing and supporting them, and that advocate is trained as an LPS IMCA, they can also represent and support them in the LPS process. This would ensure consistency during the care plan process and the LPS authorisation process. Decision makers should consider the guidance in chapter 10 to consider whether the duty to appoint an IMCA applies, or whether an Appropriate Person should be appointed instead.

21.51 Likewise, when setting arrangements under the care and support plan, the necessary and proportionate assessment and determination should be carried out at the same time. Please see chapter 17 for consultation and chapter 16 for assessments and determinations.

21.52 The young person may also have an EHC or an IDP. See the SEND Code of Practice, England, and the ALN Code of Practice, Wales, for more information on

the interaction of these plans. See paragraphs 21.36 to 21.45 above for more information on the interaction between these plans and the LPS.

21.53 Reviews of LPS authorisations should be carried out alongside reviews of the young person's LAC care and support plan (England) or care and support plan (Wales), as far as practically possible. An Independent Reviewing Officer, who has the relevant training on the LPS, should be appointed to manage the young person's care plan. This will ensure those processes are aligned.

21.54 The LPS authorisation record should be included in the young person's social services records.

Secure Children's Homes and disapplication of Section 25 under the Children Act 1989 and Section 119 of the Social Services and Well-being (Wales) Act 2014

21.55 In a very limited number of circumstances, a young person may be placed in a secure children's home and require and LPS authorisation for their arrangements during their stay. However, in most cases, the LPS will not be the most appropriate systems for authorising arrangements for young people in secure children's homes. Decision makers should therefore carefully consider which system would be most appropriate for the young person.

21.56 Where a local authority has authorised arrangements under LPS for a young person within accommodation such as a secure children's home, section 25 (England) or section 119 (Wales) will not apply. For further information on section 25 under the Children Act 1989, please see the supporting guidance for this legislation[148].

21.57 Where a young person is placed in secure accommodation under LPS, Responsible Bodies should review these arrangements in the same way that arrangements under s25 or s119 would be reviewed. This means that arrangements should be reviewed one month after they begin, and then regularly going forward with no longer than three months between each review.

Who is suitable to be an Appropriate Person for a young person?

21.58 A parent of a young person may undertake this role, if they are suitable (see paragraphs 21.82 to 21.83 on the parent's role, and more information on appointing an Appropriate Person at chapter 15). If the young person is cared for by a foster carer, it's likely that they will know the young person and their wishes and feelings well. It may therefore be appropriate for the foster carer to undertake the role of the Appropriate Person, if they are suitable.

[148] Statutory guidance – Children Act 1989 :court orders, available at: https://www.gov.uk/government/publications/children-act-1989-court-orders--2

21.59 However, someone who is involved in the looked after person's care or treatment in a professional capacity or for remuneration cannot be the Appropriate Person (e.g. doctor, nurse, social worker etc). If there is no suitable person to undertake the role of an Appropriate Person, an IMCA must be appointed. For further information about appointing an IMCA, see chapter 10.

21.60 The young person may also have an advocate under other legislation, such as the Children Act 1989 or the Social Services and Wellbeing (Wales) Act 2014. If that advocate is also trained as an LPS IMCA, they may also be appointed to act as the young person's IMCA. Alternatively, if they are not trained as an LPS IMCA, they may be suitable to be the Appropriate Person, providing they are willing to take on the role.

Who is the correct Responsible Body?

21.61 The Responsible Body is the organisation that is responsible for the LPS process. This includes commissioning the assessments and determinations, carrying out consultation, deciding whether to authorise arrangements, and reviewing authorisations.

21.62 In England, Responsible Bodies include local authorities, Hospital Managers of NHS Trusts, and Clinical Commissioning Groups. In Wales, Responsible Bodies include local authorities and local health boards. For young people, in most cases, the local authority will be the correct Responsible Body. Chapter 14 provides further information on the role of the Responsible Body and the identification of the appropriate Responsible Body in different situations.

What settings may LPS authorisations apply to for 16- and 17- year olds?

21.63 An LPS authorisation can be granted wherever arrangements for care or treatment amount to a deprivation of liberty. For young people, this may mean that an authorisation can cover one or all of the following settings:

- their domestic home,
- a day or residential school or college, including any pre or post school activities organised by the school,
- a children's home,
- a fostering placement,
- a short break or other respite provision,
- and a planned hospital stay.

21.64 Chapter 12 provides guidance on what constitutes a deprivation of liberty. The principles in that chapter can be applied to any setting. Decision makers should therefore consider the guidance in chapter 12, before triggering the LPS process.

21.65 In some cases, the young person may be deprived of their liberty when being transported between settings. An LPS authorisation can also cover such arrangements.

21.66 For the LPS authorisation to cover different settings, it must be known that the young person will be deprived of their liberty in those settings at the time of the assessments process. If the young person has an authorisation in place, and new arrangements are proposed, a new authorisation may be required. Please see chapter 13 for more information on variations to an authorisation.

21.67 The Responsible Body should work with all settings involved, or anyone who may potentially be involved in the young person's care to agree the best arrangements for the person. This includes ensuring that the provider is able and willing to implement the arrangements proposed in the LPS authorisation.

Deprivation of Liberty at home

21.68 An LPS authorisation can cover multiple settings, but that does not necessarily mean that the young person will be being deprived of their liberty in every setting they spend time in. In some cases, for example, the person may not be deprived of liberty at school, even if they are under such arrangements at home. Decision makers should consider the most appropriate arrangements for each setting, based on the young person's needs.

Young people in mental health inpatient hospitals

21.69 If a young person needs to be admitted for psychiatric care and treatment, a decision may need to be made as to whether the Mental Health Act 1983 or the LPS is more appropriate regime. For full details of the interface, and when to apply each legislative framework, please see chapter 22.

Implications for education settings

21.70 If a young person has an EHC plan or IDP, which sets out their educational needs, then their education is considered part of that person's care. Therefore, if a young person who lacks the relevant mental capacity is under arrangements amounting to a deprivation of liberty within an educational setting, then an LPS authorisation will be required.

21.71 Chapter 12 sets out the definition of a deprivation of liberty. The key principle to remember for considering whether a young person is deprived of their liberty, is how their arrangements compare with other young people of the same age who do

not have a mental disorder. In the case of education settings, where children and young people are not generally “free to leave” of their own accord and “constantly supervised”, this is particularly important. For example, when it comes to freedom to leave decision makers should consider whether young people of the same age and relative maturity and who do not have a mental disorder, could request to move to a different school. Or, when it comes to supervision and control, whether they would be allowed to leave the school for their lunch break. If the arrangements are more restrictive at school than they would be for the young person’s peers of the same age and maturity and who are free from disability, it may be that the arrangements amount to a deprivation of liberty and an LPS authorisation would be required.

21.72 If an education setting (for example, a special school or college) has cause to suspect that the young person is being deprived of their liberty the setting should inform the Responsible Body immediately. They should also consider whether there are less restrictive arrangements that could be put in place instead.

21.73 For further information about reducing restraint and restrictive intervention in health and social care services and special education settings, see non-statutory guidance[149] published by the Department for Education and the Department for Health and Social Care (Guidance on reducing the need for restraint and restrictive intervention in special schools and health and social care settings). Ofsted’s guidance for inspectors (Positive Environments Where Children Can Flourish[150]) about how to approach the use of physical intervention, restraint and restrictions of liberty in social care settings and schools may also be of interest to settings.

What is the role and rights of parents or those with parental responsibility in the LPS system?

21.74 Those with parental responsibility (parents) play a critical role in bringing up, and caring for, their children, and this role becomes even more vital when their child lacks the mental capacity to make decisions about their care and support. In many cases, those with parental responsibility will be the parents of the young person. However, in some cases, it may be others, for example the local authority.

21.75 Those with parental responsibility of a young person cannot consent to arrangements that amount to a deprivation of liberty on the young person’s behalf. An LPS authorisation may therefore be required if the young person’s arrangements

[149] Guidance ‘Reducing the need for restraint and restrictive intervention‘, available at: https://www.gov.uk/government/publications/reducing-the-need-for-restraint-and-restrictive-intervention (2019)

[150] Guidance ‘Positive environments where children can flourish’, available at: https://www.gov.uk/government/publications/positive-environments-where-children-can-flourish

for their care or treatment amount to a deprivation of liberty, and the young person cannot consent to the arrangements.

21.76 However, those with parental responsibility still play a vital role in the LPS process. Unless it is not practical or appropriate, those with parental responsibility should be consulted by the Responsible Body during the Liberty Protection Safeguards process for authorisation. Additionally, in many cases, those with parental responsibility will often undertake the Appropriate Person role, which is a role to represent and support the person through the LPS process both prior to and during an authorisation. Please see chapter 15 for more information on the role of the Appropriate Person.

21.77 If the local authority has parental responsibility for the young person, it should be mindful of potential conflicts of interest between this and its role as the Responsible Body. It may need to take steps, such as ensuring that separate individuals from different functions within the local authority undertake the different roles, to minimise any actual or perceived conflicts of interest. This should be considered on a case by cases basis.

21.78 Usually, the Responsible Body should involve the parents closely in making decisions about the arrangements for the young person, where it is appropriate to do so. For more information on the role of the Responsible Body see chapter 14.

How are those with parental responsibility involved in the consultation?

21.79 Consultation plays a vital role in the LPS authorisation process. The main purpose of the consultation is to determine the person's wishes and feelings about the proposed arrangements. Unless it is not practicable or appropriate to do so, the Responsible Body must consult anyone engaged in caring for or with an interest in the young person's welfare. This will often include those with parental responsibility for the young person. For more information on consultation please see chapter 17.

21.80 In some cases, it may not be appropriate to consult those with parental responsibility. For example, where a young person is subject to a care order, there may be a conflict of interest regarding the welfare of the child to consult with the parents. Where this is the case, the Responsible Body should record this appropriately. The Responsible Body should consider whether there are other family members or friends who should be consulted. For example, an advocate appointed to support the young person under one of the statutory advocacy duties (such as the SSWBA or the Children Act 1989), older siblings, grandparents, or other family members or friends.

21.81 Please note that local authorities may have a duty to consult parents with regard to other legislative requirements, such as the EHC plan or for looked after children.

Where the local authority is the Responsible Body, they may combine the two consultation processes.

The role of the Appropriate Person

21.82 One of the key roles those with parental responsibility may fulfil within the LPS authorisation process is to act as an Appropriate Person. Those with parental responsibility may be able to take on this role if they are suitable to do so. For full information on the Appropriate Person, see chapter 15.

21.83 It should be noted that where someone with parental responsibility is not the Appropriate Person, they should still be consulted during the LPS authorisation process, unless this is not practicable or appropriate. The Appropriate Person or IMCA should work closely with those with parental responsibility at every stage. Even when the person has turned 18, it is highly likely that the majority of parents will continue to be closely involved in the care and treatment of their adult child.

What happens if those with parental responsibility or young person is concerned about the arrangements?

21.84 The Responsible Body must, as far as practically possible, ensure that the young person and their Appropriate Person (where relevant) understand the proposed arrangements and other relevant information relating to the LPS process. Please see chapter 14 for all the information the Responsible Body must publish.

21.85 If the Appropriate Person is someone who has parental responsibility for the young person and they disagree with the Responsible Body, they should try to resolve this as far as possible via conversation prior to the authorisation being given. If this is not possible, the Appropriate Person can also make an application to the Court of Protection. Please see chapter 24 for further information on how to raise concerns and challenge any arrangements on behalf of the person.

21.86 Even if those with parental responsibility have not taken on the role of the Appropriate Person, they still have the right to raise concerns about the LPS process or the arrangements. If someone with parental responsibility has any concerns about how the process has been handled, they can, in the first instance, raise this with the Responsible Body. The Responsible Body should have appropriate complaints procedures and all issues should be handled appropriately.

21.87 If, once an authorisation is in place, the young person is unhappy in the arrangements, or those with parental responsibility feel that the young person's liberty is being unfairly restricted, they have the right to make an application to the Court of Protection.

What happens if a parent of a young person accommodated under the Children Act 1989 or the Social Services and Wellbeing (Wales) Act 2014 objects to the arrangements?

21.88 Where a young person is accommodated by their local authority under s20 of the 1989 Act or s75 of the 2014 Act, the local authority will have worked closely with those with parental responsibility to determine what is in the best interests of that young person. Arrangements for the young person can only be implemented if those parental responsibility agree. In most cases, the local authority and those with parental responsiblity will be able to reach an agreement over these arrangements.

21.89 However, those with parental responsibility may agree in principle to the placement, but object to the local authority's proposed arrangements where they amount to a deprivation of liberty. In such cases, the local authority should work with those with parental responsibility to try to address their concerns, as far as possible. Where agreement cannot be reached, the local authority will need to determine whether or not the duty to refer the case to an AMCP is triggered. For example, it may be reasonable to believe that the young person may not wish to reside at the place, on the basis of the concerns of those with parental responsibility. This consideration would apply equally at the time of a review where an AMCP had not been involved in the initial authorisation.

21.90 Where a young person is already accommodated by a local authority under one of the two Acts, those with parental responsibility could withdraw their consent to the accommodation arranged by the LA. Where this is the case, they may choose to remove the young person from the accommodation[151]. This may mean the LA cannot continue with the placement.

21.91 Where those with parental responsibility remove their child from accommodation arranged by a local authority, this may mean that it is unable to implement the LPS authorisation. Where there are serious concerns about the young person's welfare in the new accommodation the local authority may consider the use of child protection powers (such as under the Children Act 1989) to remedy safeguarding concerns. Further guidance is available in the Children Act 1989: Court Orders statutory guidance[152].

[151] Under section 20(11) of the Children Act 1989, parental objections to the placement of their 16 or 17 year old child will not apply where the young person agrees to being accommodated. However, parental objection will be relevant to those young people who do not have capacity.

[152] Statutory guidance- Children Act 1989: court orders, available at: https://www.gov.uk/government/publications/children-act-1989-court-orders--2

Duration of LPS authorisations, frequency of reviews and renewals for young people

21.92 For full information on the duration of an authorisation under LPS, how often reviews should be held and the process for renewing an authorisation, please refer to chapter 13.

21.93 Responsible Bodies should consider the appropriate length of an authorisation, and the frequency of reviews within that period. For young people, it may be appropriate to authorise arrangements for a shorter period or schedule more frequent reviews. Factors Responsible Bodies may need to consider include:

- any plans to change school or college, or a move to different residential accommodation, where these are known in advance they can be incorporated into the authorised arrangements;
- 16-17-year olds are still potentially developing their decision-making abilities alongside other physical and emotional attributes, and therefore their ability to consent to the arrangements may change over time;
- if the young person's transition to adult services is being planned, this may require a review, a variation or possibly a new LPS authorisation to cover this transition;
- the requirements of other reviews under frameworks and statutory plans for the young person, such as an EHCP, IDP, care plan for a looked after child, or other care and support or care and treatment plans.

The transition of young people to adult services

21.94 The transition to adulthood is a critical time for all young people, especially for those lacking mental capacity. It can mean moving to a different education setting or leaving education altogether. It may involve moving residence, either to a different education setting or into supported living accommodation. Transition planning in England should ideally start in year 9 (age 14).

21.95 All transitions for young people lacking the relevant mental should be carefully planned and managed, in line with the relevant statutory frameworks and principles. The relevant teams within the local authority should work together in order to ensure a smooth transition, including considering whether the young person's arrangements amount to a deprivation of liberty.

22. What is the relationship between the Mental Capacity Act and the Mental Health Act 1983?

This chapter explains the relationship between the Mental Capacity Act 2005 (MCA) and the Mental Health Act 1983 (MHA). It describes how the MCA may apply to people lacking the relevant capacity who are also subject to the MHA; explains when doctors cannot give certain treatments to someone who lacks capacity to consent to them; and sets out the position in relation to the MHA.

This chapter does not provide a full description of the MHA. The MHA has its own Codes of Practice, for both England and Wales, to guide people about how to use it[153].

Where the LPS and the MHA meet, there is an interface. Decision makers may need to decide which is the most appropriate regime to deprive a person of their liberty under, or if the person is subject certain sections of the MHA whether an LPS authorisation is also required. The interface between these two regimes only occurs in a very small number of specific cases[154].

In this chapter, as throughout the Code, a person's capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

Quick summary

- People who lack relevant mental capacity suffer mental health problems like everyone else and may need to be treated under the MHA. The MCA applies to people subject to the MHA in the same way as it applies to anyone else, with four exceptions:

[153] The MHA Code of Practice:

- For England, see https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983
- For Wales, see https://gov.wales/mental-health-act-1983-code-practice

[154] The content of this Code supersedes the equivalent content in the current MHA Codes until the MHA Codes are re-written to be consistent with the Mental Capacity (Amendment) Act 2019.

- if someone is detained under the MHA, decision-makers cannot normally rely on the MCA to give treatment for mental disorder or make decisions about that treatment on that person's behalf
- if somebody can be treated for their mental disorder without their consent because they are detained under the MHA, healthcare staff can, with some exceptions relating to more invasive treatments, administer treatment to them even if it goes against an advance decision to refuse that treatment
- if a person is subject to guardianship under the MHA, the guardian has the exclusive right to take certain decisions, including where the person is to live
- IMCAs do not have to be involved in decisions about serious medical treatment or long-term accommodation, if those decisions are made under the MHA.

The interface between LPS and the MHA in hospitals

- In certain situations, either the LPS or the MHA could be relied upon to deprive a person of their liberty when they are admitted to hospital.
- Where the relevant conditions, are met, a decision must be made between the MHA and the LPS. This decision should be based on the circumstances of the case.

Community MHA patients and the LPS

- Some people may be under community arrangements under the MHA, where the LPS may still be applicable.
- If the person is under section 17 leave and are not under the custody of someone for that leave, then the LPS could be used to authorise arrangements around their care or treatment in the community, if they amount to a deprivation of liberty.
- Likewise, if the person is under a community treatment order and needs arrangements put in place that amount to a deprivation of liberty, the LPS could be used to authorise those arrangements.

The MHA learning disabilities exclusion and the LPS

- In some cases, a person with learning disabilities is excluded from certain sections of the MHA. However, this exclusion does not apply to the LPS.

Who does the MHA apply to?

22.1 The MHA provides the legal framework for the assessment, detention and treatment of people when they have a serious mental disorder that puts them or other people at risk. The MHA includes provisions for civil patients and those who go to hospital through decisions made in the criminal justice system.

22.2 Its provisions include powers for when people with mental disorders can be detained in hospital for assessment or treatment; and when people who are detained can be given treatment for their mental disorder without their consent.

22.3 It also provides for the safeguards people have, including rights to appeal to an independent tribunal and for a second clinical opinion about treatment, and how people can be given leave; made subject to guardianship; given a conditional discharge; or placed on a Community Treatment Order (CTO).

22.4 Generally, the MHA does not distinguish between people who have the capacity to make decisions and people who do not. Many people subject to the MHA have the capacity to make specific decisions for themselves. Most people who lack capacity to make decisions about their treatment will never be subject to the MHA, even if they need treatment for a mental disorder.

22.5 But there are cases where decision makers will need to decide whether to use the MHA or MCA, or both, to meet the needs of people with a mental health condition who lack capacity to make decisions about their own treatment.

What are the MCA's limits?

22.6 Section 5 of the MCA provides legal protection for people who care for or treat someone who lacks capacity (see chapter 6). But they must follow the Act's principles and may only take action that is in a person's best interests (see chapter 5). This applies to care or treatment for physical and mental conditions. So it can apply to treatment for people with mental disorders, however serious those disorders are.

22.7 Section 5 has limits. For example, section 6 makes clear that somebody using restraint only has protection if the restraint is:

- necessary to protect the person who lacks the relevant capacity from harm, and
- in proportion to the likelihood and seriousness of that harm.

22.8 There is no protection under section 5 for actions that deprive a person of their liberty (see chapter 6 for guidance). The MCA does not allow giving treatment that goes against a valid and applicable advance decision to refuse treatment (see chapter 11). The MHA on the whole allows for this but makes an exemption for electro convulsive therapy.

22.9 The MHA may therefore be appropriate to consider if the person has made a valid and applicable advance decision to refuse psychiatric treatment in hospital.

Scenario: Using the MHA

Mr O has a learning disability and lives in supported living accommodation. For the last four years, he has had depression from time to time, and has twice had treatment for it at a psychiatric hospital. He now has severe depression and his care workers are worried about the deterioration in his condition.

On assessing Mr O's condition, the consultant would like to increase his medication, however, Mr O lacks the capacity to consent to medical treatment. The consultant is concerned about the previous treatment Mr O has received. The consultant shares his concerns with an approved mental health professional and advises that the increase in the medication would be in Mr O's best interests and that a care and support plan should also be drawn up, to include Mr O being detained in hospital.

This will allow close observation and is necessary for Mr O's own health and safety. The consultant thinks an application should be made under section 2 of the MHA, rather than LPS, in the first instance and can be reviewed before the end of 28 days to see if Mr O would need to be sectioned under section 3 of the MHA.

The approved mental health professional explains the consultant's concerns and his observations to Mr O's nearest relative, his mother, as is ascertained under the MHA. and She raises concerns regarding the treatment, and the need for Mr O to be detained, when he has not needed this in the past. But after she raises her concerns with the consultant, and listens to his answers, she does not object to the application.

As Mr O lacks capacity to consent to treatment, the consultant is able to provide it without consent if he follows the MHA's principles. However, the consultant recommends that it would be appropriate to record Mr O's capacity to consent to the decision on his care, on the care and support plan.

Mr O's mother, with the consultant and approved mental health professional, sit with Mr O and provide him with the relevant information about the decision to be made and explain what will happen and why. Mr O appears to listen but shows no visible response to what is being communicated to him and they also attempt to explain by using an 'easy read' leaflet.

The approved mental health professional makes the application, on the basis of two medical recommendations. Mr O is then detained in the hospital so that his new treatment for depression can begin.

22.10 There will be some cases where a person who lacks the relevant capacity cannot be treated either under the MHA or the MCA – even if the treatment is for mental disorder.

Scenario: Deciding whether to use the MHA or MCA

Ms C is in her 80s and has dementia. Somebody finds her wandering in the street, confused and angry. A neighbour takes Ms C home and calls her doctor. At home, it looks like she has been deliberately smashing things. There are cuts on her hands and arms, but she won't let the doctor touch them, and she hasn't been taking her medication.

Ms C's doctor wants to admit her to hospital for assessment, as he is concerned about her welfare. Ms C gets angry and says that they'll never keep her in hospital. So the doctor thinks that it might be necessary to use the MHA. He arranges for an approved mental health professional to visit, who discovers that Ms C was expecting her son this morning, but he has not turned up.

They find out that he has been delayed but could not call because Ms C's telephone has become unplugged.

When she is told that her son is on his way, Ms C brightens up. She lets the doctor treat her cuts – which the doctor thinks is in her best interests to do as soon as possible. When Ms C's son arrives, the approved mental health professional explains the doctor is very worried, especially that Ms C is not taking her medication. The son explains that he will help his mother take it in future. It is agreed that the MCA will allow him to do that

The approved mental health professional sits with Ms C and provides her with the relevant information about the decision to be made and whether **she** understands the reason for the medication, the risks of not taking the medication and that her son will ensure she takes her medication daily. Ms C is able to understand, retain and use the relevant information being explained to her and is able to communicate her decision and agrees to listen her son and take her medication.

The approved mental health professional arranges to return a week later to review Ms C's capacity and calls the doctor to say that she thinks Ms C can get the care she needs without being detained under the MHA. The doctor agrees.

How does the MCA apply to a patient subject to guardianship under the MHA?

22.11 Guardianship gives someone (usually a local authority social services department) the exclusive right to decide where a person should live – but in doing this they cannot deprive the person of their liberty. The guardian can also require the person to attend for treatment, work, training or education at specific times and places, and they can demand that a doctor, approved mental health professional or another relevant person has access to the person wherever they live. Guardianship can apply whether or not the person has the capacity to make decisions about care and treatment. It does not give anyone the right to treat the person without their permission or to consent to treatment on their behalf.

22.12 An application can be made for a person who has a mental disorder to be received into guardianship under section 7 of the MHA when:

- the situation meets the conditions summarised in paragraph 22.13
- the relevant people agree an application for guardianship should be made (normally two doctors and an approved mental health professional), and
- the person's nearest relative does not object.

22.13 An application can be made in relation to any person who is 16 years or over if:

- the patient is suffering from mental disorder of a nature or degree which warrants their reception into guardianship, and
- it is necessary, in the interests of the welfare of the patient or for the protection of other people, that the patient should be so received.

22.14 Applicants (usually approved mental health professionals) and doctors supporting the application will need to determine whether they could achieve their aims without

guardianship. For patients who lack the relevant capacity, the obvious alternative will be taking steps under the MCA.

22.15 But the fact that the person lacks capacity to make a relevant decision is not the only factor that applicants need to consider. They need to consider all the circumstances of the case. They may conclude that guardianship is the best option for a person with a mental disorder who lacks capacity to make those decisions if, for example:

- they think it is important that one person or authority should be in charge of making decisions about where the person should live (for example, where there have been long-running or difficult disagreements about where the person should live)
- they think the person will probably respond well to the authority and attention of a guardian, and so be more prepared to accept treatment for the mental disorder (whether they are able to consent to it or it is being provided for them under the MCA), or
- they need express authority to return the person to the place they are to live (for example, a care home) if they were to go absent (although this could also be provided under the LPS).

22.16 Decision makers must never consider guardianship as a way to avoid applying the MCA.

22.17 A guardian has the exclusive right to decide where a person lives, which means that it is not lawful for another person to use the MCA to arrange for the person to live elsewhere. Somebody who knowingly helps a person leave the place where a guardian requires them to stay may be committing an offence under the MHA. A guardian also has the exclusive power to require the person to attend set times and places for treatment, occupation, education or training. This does not stop other people using the MCA to make similar arrangements or to treat the person in their best interests. But people cannot use the MCA in any way that conflicts with decisions which a guardian has lawfully made under the MHA. See paragraph 22.11 above for general information about a guardian's powers.

Scenario: Interface between the MHA and the MCA when someone is under guardianship

Mr B is required to reside in his sheltered accommodation, and to give access to his mental health community team, as a condition of a guardianship made under the Mental Health Act 1983.

Every month he presents himself at the clinic for a depot antipsychotic injection and each time the community team explains the reasons for taking the injection and why it is his in best interests to do so. Despite many attempts, by the community team, Mr B does not have capacity to understand what the antipsychotic injection is or what it is for.

Given their ongoing assessments that Mr B lacks capacity to consent to the injections, but that they are in his best interests, the community team use the authority of the MCA to give them.

How does the MCA apply to a patient subject to a Community Treatment Order (CTO) under the MHA?

22.18 When people are discharged from detention for medical treatment under the MHA, their responsible clinician may decide to place them on a CTO. The responsible clinician is the person approved for the role under the MHA who is directly responsible for a patient's care. Another doctor and an approved mental health professional must support their application.

22.19 A CTO provides a framework for the management of care in the community, it requires that the patient make themselves available for examination, provides for other conditions as may be required, and gives the responsible clinician the power to recall the patient to hospital for treatment if necessary.

22.20 Only patients who are detained in hospital for treatment under section 3 of the MHA, or are unrestricted part 3 patients, can be considered for a CTO. Patients detained in hospital for assessment under section 2 of the MHA are not eligible.

22.21 A CTO is an option only for patients who meet the criteria set out in the MHA, which are that:

- The patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment
- It is necessary for the patient's health or safety or for the protection of others that the patient should receive such treatment
- Subject to the patient being liable to be recalled as mentioned below, such treatment can be provided without the patient continuing to be detained in a hospital
- It is necessary that the responsible clinician should be able to exercise the power under section 17E(1) of the MHA to recall the patient to hospital, and Appropriate medical treatment is available for the patient.

22.22 CTOs can be used whether or not the person lacks capacity to make relevant decisions. But if a person lacks capacity, decision-makers will need to decide whether action under the MCA could achieve their aims before making an application. The kinds of cases in which CTOs might be considered for patients who lack capacity to take decisions about their own care and treatment are similar to those for guardianship. CTOs do not in themselves allow for deprivations of liberty, although they do allow conditions to be set to which people should adhere.

Scenario: Interface between the MHA and the MCA when someone is under a Community Treatment Order

Ms F is required to stay at a care home under a Mental Health Act Community Treatment Order. Like Mr B (previous scenario), she has in the past willingly received a monthly depot antipsychotic injection but lacks capacity to provide consent for it.

Ms F has recently shown resistance to the injection, and the community team have assessed Ms F's best interests and have decided that she is likely to require restraint beyond that provided for under the MCA. .Therefore she is recalled to hospital and eventually receives the injection under the authority of the MHA.

After a time, Ms F's care team agree that Ms F needs more supervision to keep her safe when outside, as she shows little awareness of traffic and other hazards and is vulnerable to exploitation. The team agree that this can be provided in the least restrictive manner if Ms F remains at the care home.

As the closer supervision may amount to a constant supervision, it may be that Ms F is deprived of her liberty if she meets the other criteria for this. If so, a Liberty Protection Safeguards (LPS) assessment would need to be arranged to consider providing an authority through the LPS provisions, which would run in parallel to the MHA CTO. CTO and LPS provisions would be required, with LPS providing for the constant supervision and CTO for the depot injections.

the MHA. The doctor agrees.

How does the Mental Capacity Act affect people covered by the Mental Health Act?

22.23 There is no reason to assume a person lacks capacity to make their own decisions just because they are subject (under the MHA) to detention, guardianship, or a CTO.

22.24 People who lack capacity to make specific decisions are still protected by the MCA even if they are subject to the MHA (this includes people who are subject to the MHA as a result of court proceedings). But there are four important exceptions:

- if someone is liable to be detained under the MHA, decision-makers cannot normally rely on the MCA to give mental health treatment or make decisions about that treatment on someone's behalf
- if somebody can be given mental health treatment without their consent because they are liable to be detained under the MHA, they can also be given mental health treatment that goes against an advance decision to refuse treatment, excluding electroconvulsive therapy unless an emergency.
- if a person is subject to guardianship, the guardian has the exclusive right to take certain decisions, including where the person is to live, and
- Independent Mental Capacity Advocates do not have to be involved in decisions about serious medical treatment or accommodation, if those decisions are made under the MHA

What are the implications for people who need treatment for a mental disorder?

22.25 Subject to certain conditions, Part 4 of the MHA contains provisions which allow doctors to give patients who are subject to the MHA treatment for mental disorders without their consent. As stated above at 22.4, the MHA generally does not

distinguish between whether or not a person has the capacity to give that consent. Paragraph 22.26 below lists a few important exceptions.

22.26 Where Part 4 of the MHA applies, the MCA cannot be used to give medical treatment for a mental disorder to patients who lack capacity to consent. Nor can anyone else, like an attorney or a deputy, give consent for that treatment under the MCA. Part 4 of the MHA already allows clinicians, if they comply with the relevant rules, to give patients medical treatment for mental disorder, in most cases, even though they lack the capacity to consent. In this context, medical treatment includes nursing, psychological intervention and specialist mental health rehabilitation, rehabilitation and care.

22.27 Clinicians treating people for mental disorder under the MHA cannot however simply ignore a person's capacity to consent to treatment. As a matter of good practice, and as set out within the MHA Code of Practice, they will always need to assess and record:

- whether a patient has capacity to consent to treatment, and
- if so, whether they have consented to or refused that treatment.

22.28 Part 4 of the MHA deals mainly with the treatment of people who are liable to be detained in hospital, including patients who have been recalled to hospital from CTOs and conditional discharge. Patients subject to emergency and short-term detention are generally not subject to part 4 of the MHA.

22.29 Since the MHA does not allow treatment of these patients after a period of three months without their consent, or a second medical opinion, the MCA applies in the normal way, even if the treatment is for mental disorder.

22.30 Even when the MHA allows patients to be treated for mental disorders, the MCA applies in the normal way to treatment for physical disorders. But sometimes healthcare staff may decide to focus first on treating a detained patient's mental disorder in the hope that they will regain the capacity to make a decision about treatment for the physical disorder.

22.31 Where people are subject to guardianship or a CTO under the MHA, the MCA applies as normal to all treatment. Guardianship and CTOs do not give people the right to treat patients without consent. A patient on a CTO may however be recalled to hospital if they require medical treatment.

Scenario: Using the MCA to treat a patient who is detained under the MHA

Mr P has paranoid schizophrenia, resulting, when he is acutely unwell, in delusions, hallucinations and thought disorder. He is detained in hospital under section 3 of the MHA and is receiving treatment under Part 4 of the MHA and his condition means that he rejects medical treatment which he regards as invasive or perceives as threatening.

Mr P develops blood in his urine and, after discussion with the hospital staff, agrees to have an ultrasound scan. The scan reveals suspected renal carcinoma.

Mr P's consultant advises him that he needs a diagnostic CT scan and then treatment for the carcinoma which will be done under general anaesthetic. Mr P refuses to consent to the anaesthetic and subsequent medical procedures.

The consultant assesses Mr P as lacking capacity to consent to treatment under the MCA. The MHA is not relevant to the renal carcinoma because the CT scan is not a symptom, manifestation or treatment of Mr P's mental disorder.

Under section 5(1) of the MCA, as Mr P lacks capacity to consent to treatment, the consultant is able to provide it without consent if he follows the Act's principles. As well as considering Mr P's medical needs as regards to the carcinoma treatment, the consultant consults with Mr P's family and hospital carers. This leads him to decide that going ahead with the scan and treatment is in Mr P's best interests and raises Mr P's treatment with the multi-disciplinary team. The multi-disciplinary team draws up a care plan and include an assessment of Mr P's best interests and capacity to consent to the actions covered by the care plan. The consultant and Mr P's psychiatric team and family work together to explain to him what will happen and why, in an appropriate way and at an appropriate time. They also answer Mr P's questions and concerns, so that he does not feel threatened by the upcoming medical procedures.

How does the Mental Health Act affect advance decisions to refuse treatment?

22.32 The MHA does not generally affect a person's advance decision to refuse treatment, although Part 4 of the MHA means the person can be treated for mental disorder without their consent. In this situation healthcare staff can treat patients for their mental disorder, even if they have made an advance decision to refuse such treatment, with the exception of electroconvulsive therapy, where it is unlawful to give this treatment if it would be in conflict with an advance statement, except in an emergency.

22.33 Generally, an advance decision to refuse treatment for mental disorder can be overruled if the person is detained in hospital under the MHA and treatment is given compulsorily under Part 4, However healthcare staff should try to consider the person's wishes as set out in a valid advance decision as far as possible. For example, they should consider whether they could use a different type of treatment which the patient has not refused in advance. If healthcare staff do not follow an advance decision, they should record in the patient's notes why they have chosen not to follow it.

22.34 Even if a patient is being treated without their consent for a mental disorder under Part 4 of the MHA, a valid advance decision to refuse forms of treatment for physical health or for another aspect of treatment for mental disorder is still binding. Being subject to guardianship or a CTO or conditional discharge does not affect an advance decision in any way. See chapter 11 for further guidance on advance decisions to refuse treatment.

Scenario: Deciding on whether to follow an advance decision to refuse treatment

Ms K gets depression from time to time and has old physical injuries that cause her pain. She does not like the side effects of medication, and manages her health through diet and exercise. She knows that healthcare staff might doubt her decision-making capacity when she is depressed. So she makes an advance decision to refuse all medication for her physical pain and depression. Ms K is unaware that under the MHA the wishes of an advance decision can be disregarded at the discretion of mental health professionals.

A year later, she gets severe depression and is detained under the MHA. Her GP notifies her consultant at the hospital of her advance decision.

Ms K's condition deteriorates such that she refuses to discuss treatment. The consultant decides to prescribe medication for her depression, despite her advance decision. This is possible because Ms K is detained under the MHA, although the consultant must consider carefully whether to go against the advance statement, as her Article 8 rights to privacy and a family life apply.

The consultant also assesses Ms K as lacking the capacity to consent to medication for her physical pain. He considers the validity of the advance decision to refuse medication for the physical pain, and Ms K's GP says that Ms K was well when she made the decision and demonstrated capacity to understand what it meant. In the GP's view, Ms K had the capacity to make the advance decision. On this occasion the consultant decides that the advance decision is valid and applicable, and does not prescribe medication for Ms K's pain – even though he thinks it would be in her best interests.

When Ms K's condition improves, the consultant discusses with her whether she would like to change her mind about treatment for her physical pain. He explains why he believes she should take the medication and the importance of regularly reviewing advance decisions as views and circumstances may change over time due to a change in personal circumstances and/or the development of new treatments.

How does the Mental Health Act affect advance consent to an admission?

22.35 A person can give consent in advance to a set of arrangements that would otherwise amount to a deprivation of liberty. If a person subsequently lost the relevant capacity and needed to be admitted to hospital for treatment of mental disorder, their consent would remain valid and this would not be a deprivation of liberty. In such cases the LPS would not be available but the MHA might be an option. See chapter 12 for more detail.

Does the MHA affect the duties of attorneys and deputies?

22.36 In general, the MHA does not affect the powers of attorneys and deputies. But there are two exceptions:

- they cannot give consent on a patient's behalf for treatment under Part 4 of the MHA, where the patient is liable to be detained under the MHA (see 22.25–22.31 above), and
- they cannot take decisions:
    - about where a person subject to guardianship should live, or
    - that conflict with decisions that a guardian has a legal right to make.

22.37 Being subject to the MHA does not stop patients creating new Lasting Powers of Attorney (if they have the capacity to do so). Nor does it stop the Court of Protection from appointing a deputy for them.

22.38 In certain cases, people subject to the MHA may be required to meet specific conditions relating to:

- leave of absence from hospital
- a CTO
- conditional discharge

22.39 Conditions vary from case to case, but could include a requirement to:

- live in a particular place
- maintain contact with health services
- avoid a particular area.

22.40 If an attorney or deputy takes a decision that goes against one of these conditions, the patient will be taken to have gone against the condition. The MHA sets out the actions that could be taken in such circumstances. In the case of leave of absence or conditional discharge, this might involve the patient being recalled to hospital.

22.41 Attorneys and deputies are able to exercise patients' rights under the MHA on their behalf, if they have the relevant authority. In particular personal welfare attorneys and deputies may be able to apply to the Mental Health Review Tribunal (MHRT) for the patient's discharge from detention, guardianship or after-care under supervision.

22.42 The MHA also gives various rights to a patient's nearest relative. These include the right to:

- insist that a local authority social services department instructs an approved mental health professional to consider whether the patient should be made subject to the MHA
- apply for the patient to be admitted to hospital or guardianship
- object to an application for admission for treatment
- order the patient's discharge from hospital (subject to certain conditions)
- order the patient's discharge from guardianship.

22.43 Attorneys and deputies may not exercise these rights, unless they are themselves the nearest relative. If the nearest relative and an attorney or deputy disagree, it may be helpful for them to discuss the issue with the assistance of the patient's clinicians or an approved mental health professional. But ultimately they have different roles and both must act as they think best. An attorney or deputy must act in the patient's best interests.

22.44 It is good practice for clinicians and others involved in the assessment or treatment of patients under the MHA to try to find out if the person has an attorney or deputy. If necessary they can contact the OPG to find out this information (see chapters 8 and 9). To ensure clinicians and others involved know an LPA or deputyship order is in place, attorneys and deputies should contact either:

- the healthcare professional responsible for the patient's treatment (generally known as the patient's responsible clinician)
- the managers of the hospital where the patient is detained
- the person's guardian (normally the local authority social services department), or
- the person's supervisor (if the patient is subject to after-care under supervision

22.45 Hospitals that treat detained patients normally have a Mental Health Act administrator's office, which may be a useful first point of contact.

Does the MHA affect when Independent Mental Capacity Advocates must be instructed?

22.46 As explained in chapter 10, there is no duty to instruct an Independent Mental Capacity Advocate (IMCA) for decisions about serious medical treatment which is to be given under Part 4 of the MHA. Nor is there a duty to do so in respect of a move into accommodation, or a change of accommodation, if the person in question is to be required to live in it because of an obligation under the MHA. That obligation might be a condition of leave of absence or conditional discharge from hospital or a requirement imposed by a guardian or a supervisor.

22.47 However, the rules for instructing an IMCA for patients subject to the MHA who might undergo serious medical treatment not related to their mental disorder are the same as for any other patient.

22.48 The duty to instruct an IMCA would also apply as normal if accommodation is being planned as part of the after-care under section 117 of the MHA following the person's discharge from detention (and the person is not going to be required to live in it as a condition of a CTO). This is because the person does not have to accept that accommodation.

What are Independent Mental Health Advocates (IMHAs) and how are they different from Independent Mental Capacity Advocates (IMCAs)?

22.49 IMHA services provide a safeguard for patients who are subject to the MHA. IMHAs are specialist advocates who are trained specifically to work within the framework of the MHA and enable patients to participate in decision-making, for example, by encouraging patients to express their views and supporting them to communicate their views. They are commissioned by the relevant local authority. IMHAs should be independent of any person who has been professionally involved in the patient's medical treatment.

22.50 IMHA services do not replace any other advocacy and support services that are available to patients, including IMCAs, but are intended to operate in harmony with those services.

22.51 The same advocate may be qualified to act as an IMHA and an IMCA, although these are different roles.

What is the effect of section 57 of the Mental Health Act on the MCA?

22.52 Section 57 of the MHA states that psychosurgery (neurosurgery for mental disorder) requires:

- the consent of the patient, and
- the approval of an independent doctor and two other people appointed by the Mental Health Act Commission.

22.53 Psychosurgery is any surgical operation that destroys brain tissue or the function of brain tissue.

22.54 The same rules apply to other treatments specified in regulations under section 57. Currently, the only treatment included in regulations is the surgical implantation of hormones to reduce a man's sex drive.

22.55 The combined effect of section 57 of the MHA and section 28 of the MCA is, effectively, that a person who lacks the capacity to consent to one of these treatments for mental disorder may never be given it. Healthcare staff cannot use the MCA as an alternative way of giving these kinds of treatment. Nor can an attorney or deputy give permission for them on a person's behalf.

What happens when a person who lacks the relevant capacity needs to be deprived of liberty in hospital for assessment or treatment of mental disorder?

22.56 The Liberty Protection Safeguards provide the legal authority for the deprivation of liberty of a person in any setting (including hospitals), where that person lacks the relevant mental capacity. The Mental Health Act 1983 (MHA), in broad terms, provides for the detention of a person in hospital for assessment or treatment of their mental disorder, and for supervised care and treatment in the community.

22.57 There is therefore an interface when the MHA and the LPS regimes meet. For example, when a person needs to be deprived of their liberty in hospital for the assessment and or treatment of their mental disorder and either regime could be used, or where both regimes can be used alongside each other in the community. This section describes the interface, including in relevant cases, the considerations that practitioners must or should follow in deciding which regime is the most appropriate. It is important to remember that the interface only applies to a relatively small number of cases.

Hospital admission for a medical treatment of a mental disorder

22.58 In certain situations, both the LPS and the MHA could be relied upon to deprive a person of their liberty when they are admitted to hospital. A number of conditions must be met for this to be true. If an individual is aged 16 or over and:

- is suffering from a mental disorder (within the meaning of the MHA155), and needs to be assessed and/or treated in a hospital setting for that disorder (including for physical conditions related to that disorder) (and meets the criteria for an application for admission under sections 2 or 3 of the MHA – please see more information at paragraphs 22.62),
- lacks capacity to consent to being accommodated in the relevant hospital for the purpose of being given medical treatment for the mental disorder, and,
- does not object to being admitted to hospital, or to some or all the treatment they will receive there for mental disorder (including treatment for a physical condition associated with the mental disorder), and,
- has care treatment arrangements that may or will amount to a deprivation of liberty; and
- is not already being detained under the MHA, or subject to a one of the community powers under the MHA, and
- an attorney appointed under an LPA or a deputy (with valid and applicable powers) has not consented to the admission or any aspect of the medical treatment.

Then in principle, an authorisation under either the Liberty Protection Safeguards or detention under the MHA could both be available. Only in cases where all of the above apply can either the MHA or the LPS be used. It is important to note that a person cannot be detained under the MHA at the same time as being subject to an authorisation under the Liberty Protection Safeguards.

22.59 In order to determine whether either it would be possible to apply either regime, the person's capacity to consent to their admission in circumstances that amount to a deprivation of liberty should be assessed and recorded when they are admitted into hospital. If the person does not lack capacity, then the interface will not apply, and the MHA should be used. This only applies when the person is admitted to hospital for the treatment of a mental disorder or for a physical condition relating to a mental disorder. For all other admissions to hospital, it is not necessary to automatically to assess the person's capacity to consent to their admission. It may be necessary to assess it if there is reason to do so, based upon their medical condition or other circumstances. .

[155] https://www.legislation.gov.uk/ukpga/1983/20/section/1

22.60 In practice the two most difficult criteria to determine will be whether an application for detention could be made under section 2 or 3 of the MHA, and whether the person is not objecting.

How to decide if an application for detention under the MHA could be made

22.61 Section 2 of the MHA applies where a person is suffering from a mental disorder which requires detention in hospital for assessment, and that detention is in the interests of the person's health or safety or with a view to the protection of others. Section 3 applies where, a person is suffering from a mental disorder and needs treatment in hospital, it is necessary for the health or safety or the person or the protection of others to provide such treatment, and it would only be possible for the person to receive that treatment under detention, and appropriate medical treatment is available.

22.62 In order to determine whether an application for detention could be made under section 2 or 3 of the MHA, the starting point should be whether the criteria in section 2(2) or section 3(2) are met in the patient's case . The decision maker should then assume two things:

- if those criteria are met, that doctors have made the necessary medical recommendations to support the use of section 2 or 3 of the MHA, and,
- In determining whether the ground is met that treatment is available for the patient in section 3(2)(c) of the MHA, this treatment cannot be provided under the LPS

22.63 It should be noted however that just because an application under section 2 or 3 could be made, it is not necessarily the case that such an application will in fact be made. The principles set out in para 22.62 are purely for deciding whether the application could be made for the purposes of considering whether the interface between the two Acts applies.

How to decide if the person is not objecting

22.64 Decision-makers will need to consider whether or not the person is objecting to being in hospital for medical treatment of mental disorder, and/or to some or all of that treatment. If the person is in fact objecting, then the Liberty Protection Safeguards cannot be used, and the MHA should instead be considered.

22.65 The focus therefore is simply on whether or not the person objects, and not the reasonableness of the person's wishes and feelings. In many cases the person will be able to state whether or not they object. In other cases, this will not be clear cut. Decision-makers should err on the side of caution and, where there is a reasonable doubt that the person is not objecting, take the position that he or she is objecting.

22.66 In determining whether or not the person objects, regard must be had to all the circumstances (so far as they are reasonably ascertainable), including the following:

- the person's behaviour,
- the person's wishes and feelings, and
- the person's views, beliefs and values.

22.67 When considering the person's behaviour, it may be necessary to have regard to the following (this is not an exhaustive list):

- verbal and non-verbal behaviour.
- whether the person is being medicated for depression or sedated (as this could be hiding their objection).
- whether the person actively resists (e.g. trying to leave the place).
- whether the person takes preparatory steps to leave (e.g. packing bags).
- any records of behaviour identified as challenging and/or triggers for such behaviour if they are already an inpatient.

22.68 In determining whether or not the person objects, regard should be had to all the relevant circumstances. The person's previous circumstances can be taken into account, but only insofar as it is appropriate to have regard to them. For example, whilst the person may not be currently expressing a view, in the past they may have clearly indicated that they object to MHA detention.

22.69 In some cases, it may not become apparent whether or not the person is objecting until after the referral has been made for the Liberty Protection Safeguards or a MHA assessment. Decision makers may find out later that the person is in fact objecting or not, and this may mean that the current assessment process needs to be halted and a new referral made for the Liberty Protection Safeguards or MHA. If this happens, the assessments that have been prepared may be used or relied upon for the assessments under the other regime.

How to decide between the LPS and MHA

22.70 In cases where the criteria are met for section 2 or section 3 of the MHA, and the person is not objecting, decision-makers will need to decide which regime should be used to authorise the deprivation of liberty. In order to make this decision, decision-makers should consider which is the least restrictive way of achieving the proposed assessment or treatment, by adopting a fact sensitive approach and having regard to all relevant circumstances.

22.71 This decision should never be based on a general preference for one regime or the other, or because one regime is more familiar to the decision-maker than the other. Such considerations are not legally relevant and lead to arbitrary decision-making. In addition, decision-makers should not proceed on the basis that one regime is

generally less restrictive than the other. Both regimes are based on the need to impose as few restrictions on the liberty and autonomy of patients as possible.

22.72 In the particular circumstances of an individual case, it may be apparent that one regime is likely to prove less restrictive. If so, this should be balanced against any potential benefits associated with the other regime. In such circumstances, the LPS may be more appropriate. In part, this may be due to an intention to keep the person at the centre of the LPS process, which keeps them involved in the decisions relating to their deprivation of liberty.

22.73 Decision-makers should also consider whether an individual deprived of their liberty may regain the relevant capacity or may have fluctuating capacity. Such a situation is likely to indicate that use of the MHA to authorise a deprivation of liberty could be more appropriate than an LPS authorisation or Court of Protection order. This is because you cannot use the LPS to authorise arrangements for a person who does not lack the relevant mental capacity.

22.74 Hospitals should have policies in place to deal with circumstances where a disagreement results in an inability to take a decision as to whether the Liberty Protection Safeguards or MHA or should be used to authorise a deprivation of liberty. A clear decision-making process should be set out including how to access appropriate legal advice if required.

Community MHA patients and the Liberty Protection Safeguards

22.75 In some cases, a person may be under the powers of the MHA but not detained in hospital. These powers normally enable the person to receive care and treatment in the community and consist of:

- guardianship or a guardianship order,
- section 17 leave,
- a Community Treatment Order, and
- conditional discharge.

22.76 However, these powers cannot authorise a deprivation of liberty. Where the person is subject to one of these powers, in appropriate cases the Liberty Protection Safeguards can be used to authorise any deprivation of liberty as long as it does not conflict with any mental health requirements under these powers.

22.77 For example, the person may be subject to a Community Treatment Order where the conditions of the order specify that the person should live at a specified care home and attend a community medical centre for regular outpatient appointments. Where the person lacks the relevant capacity, and the arrangements at the care

home and for outpatient appointments would give rise to a deprivation of liberty, the Liberty Protection Safeguards can be used if necessary and appropriate.

22.78 In general, while patients are detained in hospital they can leave lawfully, even for a very short period, only if they are granted leave of absence by their responsible clinician under section 17 of the MHA. The clinician may make leave subject to any conditions which they consider necessary in the interest of the patient or for the protection of other people.

22.79 In many cases, section 17 (3) may give the authority to deprive a person of their liberty. This would happen where the responsible clinician has directed that the patient remains in the custody of someone else during their leave of absence, such as a member of the hospital staff or anyone else authorised in writing by the hospital managers. Aside from these cases, section 17 does not provide the authority for deprivation of liberty in the community and if the person lacks the relevant capacity, the Liberty Protection Safeguards should be considered in relevant cases.

22.80 Where a patient's arrangements will amount to a deprivation of liberty whilst on section 17 leave, the responsible clinician should consider first whether it is possible for that deprivation of liberty to be authorised through the use of section 17(3). Only if that is not appropriate, and the patient lacks the relevant capacity, should consideration be given to using the Liberty Protection Safeguards. Cases where section 17 leave might not be appropriate include:

- If the arrangements giving rise to the deprivation are for the care and treatment of a physical disorder, unrelated to the person's mental disorder.
- Where the arrangements are being implemented in a family or domestic setting, and there is no-one willing to accept that the patient remains in their custody.
- Where the person or anyone else on their behalf, does not object to the arrangements being proposed or the treatment being provided on leave and no form of restraint is anticipated.
- Where the person has a long term or progressive condition, which is likely to mean they will always need to be deprived of their liberty, including after they are discharged from hospital. If may be better to use LPS in this scenario so the person is used to the process before they are discharged.

Cases where the Liberty Protection Safeguards cannot be used

22.81 There are a number of cases where the use of the Liberty Protection Safeguards is expressly prohibited. In such cases, decision makers will need to consider alternative steps, including the use of the MHA. These are discussed in turn below.

The person is detained in a hospital under the MHA

22.82 The Liberty Protection Safeguards cannot be used if the person is being detained in hospital under the MHA (or any other enactment made in England and Wales which has the same effect).[156] This would include rare cases where the person needs treatment for a physical health condition unrelated to their mental health condition, and the person needs to be deprived of their liberty in order to provide that treatment. In these cases an application to the Court of Protection could be made.

The Person could be detained under the MHA and is objecting

22.83 A person who lacks the relevant capacity may need to be deprived of their liberty in a hospital for the purpose of being given medical treatment for mental disorder. In some cases, the LPS cannot be relied upon.

The person is on section 17 leave or unconditional discharge and need admission

22.84 Where the person is on section 17 leave or subject to conditional discharge, and is not detained in hospital, the Liberty Protection Safeguards cannot be used to enable medical treatment for mental disorder in hospitals. The person would need to be admitted to hospital using the relevant MHA power.

The person subject to a CTO and needing hospital treatment for a mental disorder

22.85 When a person is subject to a Community Treatment Order, or similar, and requires arrangements that might amount to a deprivation of liberty, to enable medical treatment for a mental disorder in hospital, the Liberty Protection safeguards cannot be used to authorise the arrangements. The MHA must be used; normally the power of recall under section 17E.

Those subject to guardianship and needing hospital admission for a mental disorder

22.86 If the person is subject to guardianship under section 7 or section 37 of the MHA, and the arrangements are for hospital admission in order to provide medical treatment for mental disorder, the Liberty Protection Safeguards cannot be used if:

- the person is objecting to being in hospital for the treatment or objects to being given some or all of the treatment, or
- an attorney appointed under a LPA or a deputy (with valid and applicable powers) has not consented to these matters.
- if either (or both) of these apply, the use of the MHA should be considered.

[156] The relevant sections are ss 2, 3, 4, 35, 36, 37, 38, 44, 45A, 47, 48 and 51 of the MHA.

- if the person is not objecting to any matters, or an attorney or deputy has made a valid decision to consent to each matter to which the person objects, the arrangements can be authorised under the Liberty Protection Safeguards.

The MHA exclusion

22.87 A person with a learning disability can only be considered to have a mental disorder for the purposes of certain powers in the MHA (such as section 3, Community Treatment Orders and guardianship), without another mental disorder, where the learning disability is associated with one or both of the following further features:

- abnormally aggressive behaviour
- seriously irresponsible conduct.

22.88 If a person with a learning disability needs to be deprived of their liberty in hospital and is excluded from the MHA, an authorisation should be considered under the LPS. Even if the person is not excluded from the MHA, the LPS may still be appropriate to authorise their arrangements if they do not object. Decision makers should consider the points above to decide which legal framework is the most appropriate for that person.

23. What means of protection exist for people who lack capacity to make a decision for themselves?

This chapter describes the different agencies that exist to help make sure that people who lack capacity to make a decision for themselves are protected from abuse and neglect. It also explains the services those agencies provide and how they supervise people who provide care for or make decisions on behalf of people who lack capacity. Finally, it explains what somebody should do if they suspect that somebody is abusing an adult or young person who lacks capacity.

In this chapter, as throughout the Code, a person's capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

Quick summary

- Everyone has a role to play in safeguarding people who lack capacity. Always report suspicions of abuse or neglect of a person who lacks capacity to the relevant agency.

Concerns about a person who lacks capacity at risk of abuse or neglect

- If there is a good reason to suspect that someone has committed a crime against a person who lacks capacity, such as theft, physical or sexual assault or domestic abuse, contact the police.
- In addition, contact adult social care or children and young people's services, as relevant, so that they can work with the police and support the person at risk during the investigation.
- If someone is not being looked after properly, contact adult social care or children's services, as relevant.

Concerns about an attorney or deputy

- If someone is concerned about the actions of an attorney or deputy, they should contact the Office of the Public Guardian. Further details are in chapter 8 (attorneys) and chapter 9 (deputies).

Concerns about care or treatment

- Where there is a concern about the healthcare or social care provided to a person who lacks capacity, there are formal and informal ways of complaining about the care or treatment. See chapter 24 for further information.

Concerns about an appointee

- When someone is concerned about the collection or use of social security benefits by an appointee on behalf a person who lacks capacity, they should contact the relevant agency of the Department for Work and Pensions.

What is abuse?

23.1 The word ‘abuse’ covers a wide range of actions. In some cases, abuse is clearly deliberate and intentionally unkind. But sometimes abuse happens because somebody does not know how to act correctly or they haven’t had appropriate help and support. It is important to prevent abuse wherever possible. If somebody is abused or neglected, it is important to make enquiries about the concerns to establish what actions are required to safeguard the person (and possibly others).

23.2 Abuse is anything that goes against a person’s human and civil rights. This includes sexual, physical, verbal, financial and emotional abuse, and situations where there is domestic violence, modern slavery, discriminatory treatment, organisational abuse, neglect and self-neglect.

23.3 Abuse can be:

- a single act
- a series of repeated acts
- a failure to provide necessary care, or failure to take appropriate action.

23.4 Abuse can take place anywhere (for example, in a person's own home, a care home, a hospital, or another setting).

23.5 The main types of abuse are[157]:

Type of abuse	Examples
Physical	• Assault • Hitting • Slapping • Pushing • Misuse of medication • Restraint • Inappropriate physical sanctions
Domestic violence	Can be any of these types of abuse: • Psychological • Physical • Sexual • Financial • Emotional • So called 'honour' based violence • Forced marriage • Female genital mutilation
Sexual	• Rape, attempted rape or sexual assault • Inappropriate looking or touching • Any sexual activity that the person lacks the capacity to consent to • Sexual teasing or innuendo • Sexual harassment • Indecent exposure • Sexual photography • Subjection to pornography or witnessing sexual acts

[157] Care and support statutory guidance, available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance.

Psychological/emotional	• Emotional abuse • Threats of harm or abandonment • Deprivation of contact • Humiliation • Blaming • Controlling behaviour[158] • Intimidation • Coercion • Harassment • Verbal abuse • Cyber bullying • Isolation • Unreasonable and unjustified withdrawal of services or supportive networks • Threats to restrict someone's liberty
Financial/material	• Theft • Fraud • Internet scamming • Coercion in relation to financial affairs or arrangements, including wills, property, inheritance or financial transactions • Misuse or misappropriation of property, possessions or benefits
Modern slavery	• Slavery • Human trafficking • Forced labour and domestic servitude

Discriminatory	• Unequal treatment and harassment based on:
	  • race
	  • sex and gender reassignment
	  • age
	  • disability
	  • marriage and civil partnership
	  • sexual orientation
	  • religion or belief
	  • pregnancy and maternity

[158] A County Council v LW & Anor [2020] EWCOP 50 (22 July 2020), available at: http://www2.bailii.org/ew/cases/EWCOP/2020/50.html.

Organisational/institutional	• Neglect and poor care practice within an institution or care setting such as a hospital or care home, for example, or in relation to care provided in one's own home • Neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation • One-off incidents or ongoing ill-treatment
Neglect/acts of omission	• Ignoring medical, emotional or physical care needs • Failing to get healthcare or social care or educational services • Withholding necessities such as medication, food and heating
Self-neglect	• Neglecting to care for one's personal hygiene, health or surroundings, including behaviour such as hoarding

What legislation safeguards people who lack capacity from abuse or neglect?

23.6 Local authorities are the statutory lead for safeguarding children and adults. Those working with people who lack capacity should be familiar with the safeguarding procedures set out in the following legislation.

Adults

23.7 The Care Act 2014 and the Social Services and Well-being (Wales) Act 2014 provide legislative frameworks for safeguarding adults at risk from abuse or neglect in England and Wales. In England, guidance can be found in the Care and Support Statutory Guidance159. In Wales, guidance can be found in the statutory guidance

[159] Care and support statutory guidance, available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance.

and the Codes of Practice for the Social Services and Wellbeing (Wales) Act 2014160 and the Wales Safeguarding Procedures[161].

Children and young people

23.8 The Children Acts of 1989 and 2004 set out specific duties in relation to safeguarding children in England. The statutory guidance Working Together to Safeguard Children (2018)162 clarifies the core legal requirements on individuals and organisations in England to keep children and young people safe.

23.9 In Wales, the Social Services and Wellbeing (Wales) Act 2014 provides the legislative framework for safeguarding children. Guidance can be found in the statutory guidance and the Codes of Practice for the Social Services and Wellbeing (Wales) Act 2014 and the Wales Safeguarding Procedures.

What if someone thinks a person who lacks capacity may be at risk of abuse or neglect?

23.10 Anyone who thinks that a person who lacks capacity may be at risk of abuse or neglect should:

- contact the police if a crime is suspected
- contact the relevant local authority's adult or children's social services (see the local authority's website for up to date details)
- contact the Office of the Public Guardian if the apparent source of risk is an attorney or deputy (see paragraphs 23.23-23.26 below),
- seek advice from a relevant organisation163 or from Civil Legal Advice[164].

23.11 National or local safeguarding procedures (such as those governed by Safeguarding Adults Boards or Safeguarding Children Boards) will say who to contact and who should take action. But some abuse may be a criminal offence, such as physical assault, sexual assault or rape, theft, fraud and some other forms

[160] The Act and its wider legal framework (Wales), available at: https://socialcare.wales/hub/sswbact-legal-framework.

[161] Wales Safeguarding Procedures, available at: https://safeguarding.wales/.

[162] Working Together to Safeguard Children (July 2018), available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf.

[163] For example, Action on Elder Abuse https://www.thenationalcareline.org/AccessingHelp/ActionOnElderAbuse, Age UK https://www.ageuk.org.uk/.

[164] Civil Legal Advice, available at: www.gov.uk/civil-legal-advice.

of financial exploitation. It is essential that in these cases, the person who suspects abuse should contact the police urgently. The criminal investigation may take priority over all other forms of investigation. All agencies must work together to plan the best way to make enquiries and prevent possible abuse or neglect.

23.12 There may be a need to instruct an Independent Mental Capacity Advocate (IMCA) in safeguarding adults enquiries (see chapter 10). Some people who may need an IMCA in relation to adult safeguarding could also meet the statutory criteria for an advocate under section 68 of the Care Act 2014 in England, or the requirements for advocacy under Part 10 of the Codes of Practice for the Social Services and Well-being (Wales) Act 2014. When a local authority is arranging for an independent advocate in such circumstances, they would need to be clear whether they will be acting as an advocate for the purposes of the Care Act 2014 / Social Services and Well-being (Wales) Act 2014, as an IMCA, or as both.

What is the role of the Act in protecting people from abuse?

The Office of the Public Guardian

23.13 The Public Guardian (under section 57 of the Act), supported by staff of the Office of the Public Guardian (OPG), helps protect people who lack capacity by:

- setting up and managing a register of LPAs
- setting up and managing a register of EPAs
- setting up and managing a register of court orders that appoint deputies
- supervising deputies, working with other relevant organisations (for example, social services, if the person who lacks capacity is receiving social care)
- sending Court of Protection Visitors to visit people who may lack capacity to make particular decisions and those who have formal powers to act on their behalf (see paragraphs 23.14–23.15 below)
- receiving reports from attorneys acting under LPAs and from deputies
- providing reports to the Court of Protection, as requested, and
- dealing with representations (including complaints) about the way in which attorneys or deputies carry out their duties.

Court of Protection Visitors

23.14 The role of a Court of Protection Visitor is to provide independent advice to the court and the Public Guardian[165]. Visitors advise on how anyone given power under the Act should be, and is, carrying out their duties and responsibilities. There are two

[165] Guidance Public Guardian practice note (PN6): Court of Protection visitors and their role in preparing reports, available at: https://www.gov.uk/government/publications/public-guardian-practice-note-release-of-visitors-reports/court-of-protection-visitors-and-the-release-of-their-reports-web-version.

types of visitor: General Visitors and Special Visitors. Special Visitors are registered medical practitioners with relevant expertise. The court or Public Guardian can send whichever type of visitor is most appropriate to visit and interview a person who may lack capacity. Visitors can also interview attorneys and deputies and inspect any relevant healthcare or social care records. Attorneys and deputies must cooperate with visitors and provide them with all relevant information. If attorneys or deputies do not cooperate, the court can cancel their appointment, where it thinks that they have not acted in the person's best interests.

23.15 Court of Protection Visitors have an important part to play in investigating possible abuse. But their role is much wider than this. They can also check on the general

wellbeing of the person who lacks capacity, and they can give support to attorneys and deputies who need help to carry out their duties.

Scenario: Using a General Visitor

Ms Q made an LPA appointing her nephew as her financial attorney. She recently lost capacity to make her own financial decisions due to dementia, and her nephew now manages her financial affairs.

Ms Q's niece speaks to Ms Q who says that her nephew needed some of her money to pay off some debts. The niece is worried that the nephew is not managing Ms Q's financial affairs in Ms Q's best interests, and contacts the OPG to advise them of her concerns.

The OPG investigator asks Ms Q's nephew to send copies of her accounts and financial transactions. These show several transfers of over £10,000 each to Ms Q's nephew. OPG also sends a General Visitor to speak to Ms Q. and assess her capacity to understand the concerns raised.

The Visitor completes a mental capacity assessment to find out if Ms Q can deal with the concerns. She asks a series of questions to see if Ms Q can understand the concerns, retain and weigh information related to the concerns, and whether Ms Q can communicate her decision to the Visitor.

After the visit the Visitor submits her report containing her assessment to the OPG investigator. The report confirms that Ms Q lacks capacity to manage her financial affairs and deal with the concerns

Ms Q's nephew had not applied to the Court of Protection for authorisation of the gifts to himself. By gifting money to himself he has not been acting in Ms Q's best interests.

The OPG decides to make an application to the Court of Protection to discharge Ms Q's nephew as her attorney, as it has a reasonable belief that Ms Q's nephew has acted inappropriately.

How does the Public Guardian oversee LPAs?

23.16 An LPA is a private arrangement between a donor aged 18 or over and an attorney (see chapter 7). Donors should only choose attorneys that they can trust. The OPG provides information to help potential donors understand:

- the impact of making an LPA
- what they can give an attorney the authority to do
- what to consider when choosing an attorney.

23.17 The Public Guardian must make sure that an LPA meets the Act's requirements. Before registering an LPA, the OPG checks documentation. The Public Guardian does not usually get involved once somebody has registered an LPA – unless someone is worried about how an attorney is carrying out their duties. If concerns are raised about an attorney, the OPG works closely with organisations such as local authorities and the NHS to carry out investigations.

How does the Public Guardian supervise deputies?

23.18 Individuals do not choose who will act as a deputy for them. The court makes the decision. There are measures to make sure that the court appoints an appropriate deputy. The OPG then supervises deputies and supports them in carrying out their duties, while also making sure they do not abuse their position.

23.19 When a case comes before the Court of Protection, the Act states that the court should make a decision to settle the matter rather than appoint a deputy, if possible. It is easier for the court to make decisions in cases where a one-off decision is needed. Deputies are most likely to be needed for financial matters where someone needs continued authority to make decisions about the person's money or other assets. But the court may appoint a deputy for property and affairs or for personal welfare whenever it considers that it is in the person's best interests to do so[166] (see chapter 7).

23.20 The OPG may run checks on potential deputies if requested to by the court.

23.21 Deputies are accountable to the court. The OPG supervises the deputy's actions on the court's behalf, and the court may want the deputy to provide financial accounts or other reports to OPG. The OPG deals with complaints or concerns about the way deputies carry out their duties, working with other relevant agencies to investigate them.

[166] Re Lawson, Mottram and Hopton (appointment of personal welfare deputies) [2019] EWCOP 22, available at: https://www.bailii.org/ew/cases/EWCOP/2019/22.html

23.22 Chapter 9 gives detailed information about the responsibilities of deputies.

Scenario: Health and welfare deputy concerns

Mr L has an accident at work which causes an acquired brain injury and leaves him with complex long-term care needs.

His son applies to the Court of Protection and is appointed as his health and welfare deputy in order to manage his medical and other care needs.

Mr L's brother is worried that Mr L's son might be abusing his position as deputy. He says Mr L's son has prevented him and other family members from seeing Mr L. He says care staff in the residential home where Mr L lives report that Mr L's son has stopped taking Mr L out despite Mr L enjoying previous excursions.

Mr L's brother calls the OPG to report his concerns. The OPG sends a Court of Protection Visitor to meet Mr L and his son and assess the facts of the case. The Visitor asks Mr L and his son about Mr L's contact with other family members and outings from the home. Mr L says he would like to see his brother and other family members and go out more. Mr L's son says that he doesn't get on with Mr L's brother as he knows he has upset his father in the past. Mr L's son says he accepts that if Mr L wishes to see his brother then that should happen. Mr L's son says that he also accepts he hasn't taken his father out of late, and that this is due to his working incredibly long hours.

The Visitor's report sets out these points and recommends that the OPG increases its supervision activities regarding how Mr L's son carries out his deputyship duties, to enable him to improve. The OPG does this and may launch an investigation if concerned in future about Mr L's son's actions.

What happens if someone says they are worried about an attorney or deputy?

23.23 Many people who lack capacity are likely to get care or support from a range of agencies. Even when an attorney or deputy is acting on behalf of a person who

lacks capacity, the other carers still have a responsibility to the person to provide care and act in the person's best interests. Anybody who is caring for a person who lacks capacity, whether in a paid or unpaid role, and who is worried about how attorneys or deputies carry out their duties, should contact the OPG, which will investigate where it has jurisdiction to act. In an urgent situation someone with concerns may approach the Court of Protection for a decision about the person's welfare or finance, as an OPG investigation may take some time.

23.24 The OPG will not always be the most appropriate organisation to investigate all complaints. Depending on the concerns, it may investigate a case jointly with, for instance:

- social services, including children's services where relevant
- NHS bodies
- the police

23.25 Where it has no remit to act, the OPG will refer concerns about attorneys or deputies to the relevant agency. In certain circumstances it will alert the police about a case. When it makes a referral, the OPG will make sure that the relevant agency keeps it informed of the action it takes. It will also make sure that the court has all the information it needs to take possible action against the attorney or deputy.

23.26 Examples of situations in which a referral might be necessary include where:

- someone has complained that a welfare attorney is physically abusing a donor – the OPG would refer this case to the relevant local authority, under safeguarding adults procedures and, where relevant, the police
- the OPG has found that a solicitor appointed as a financial deputy for an elderly person has defrauded their estate – the OPG would refer this case to the police and the Legal Ombudsman167 and/or the Solicitors Regulations Authority[168]

23.27 The Fraud Act 2006 includes the offence of 'fraud by abuse of position', which may apply to a range of people, including:

- attorneys under a LPA or EPA, or
- deputies appointed by the Court of Protection to make financial decisions on behalf of a person who lacks capacity

[167] Legal Ombudsman, available at: https://www.legalombudsman.org.uk/.

[168] Solicitors Regulations Authority, available at: https://www.sra.org.uk/.

23.28 Attorneys and deputies may be guilty of fraud if they intentionally abuse their position, intend to benefit themselves or others, and cause loss or expose a person to the risk of loss. People who suspect fraud should report the case to the police.

How does the Act deal with ill treatment and wilful neglect?

23.29 The Act contains two criminal offences: ill treatment and wilful neglect of a person who lacks capacity to make decisions about their own care[169] (section 44). The offences may apply to:

- anyone caring for a person who lacks capacity – this includes family carers, healthcare and social care staff providing care in hospitals, care homes or in a person's home
- an attorney appointed under an LPA or an EPA, or
- a deputy appointed for the person by the court

23.30 These people may be guilty of an offence if they ill-treat or wilfully neglect the person they care for or represent if that person lacks capacity at the time[170]. Penalties range from a fine to a sentence of imprisonment (of up to five years) or both.

23.31 Ill treatment and neglect are separate offences. For a person to be found guilty of ill treatment, they must either:

- have deliberately ill-treated the person, or
- be reckless as to whether they were ill-treating the person or not[171]

23.32 It does not matter whether the behaviour was likely to cause, or actually caused, harm or damage to the victim's health.

23.33 A single act is sufficient to show ill-treatment[172].

[169] R v Hopkins; R v Priest [2011] EWCA Crim 1513, available at: https://www.mentalhealthlaw.co.uk/media/R_v_Hopkins%3B_R_v_Priest_%282011%29_EWCA_Crim_1513.pdf.

[170] Kurtz v R [2018] EWCA Crim 2743, available at: https://www.bailii.org/ew/cases/EWCA/Crim/2018/2743.html.

[171] See Case: R v Newington [1990] 91 Cr App R 247

[172] See Case: R v Holmes [1979] Crim LR 52

23.34 The meaning of 'wilful neglect' varies depending on the circumstances, but usually means that a person has deliberately failed to carry out an act they knew they had a duty to do[173]. This applies even if the person failed to act because they panicked[174].

23.35 These offences apply only to individuals and not to organisational abuse. However, there are specific criminal offences of ill treatment and neglect under the Criminal Justice and Courts Act 2015 which can apply to both individual workers and care providers, whether or not the individual being cared for has capacity[175].

Scenario: Reporting abuse

Ms N has Alzheimer's disease. Her son lives with her and is her personal welfare attorney. He makes the substantive decisions regarding Ms N's care as, while she can make simple day to day decisions such as what to eat or wear, she lacks the capacity to make more complex decisions about her care.

As her attorney Ms N's son arranges for a carer to visits Ms N everyday while he is at work. In time the carer sees that Ms N has bruises and other injuries which Ms N cannot explain, and notices that there are always empty spirits bottles in the kitchen recycling bin. The carer becomes aware that Ms N seems agitated when asked about her son or the alcohol and is reluctant to say anything. This leads the carer to suspect that Ms N's son may be assaulting his mother after drinking. She alerts the police and the local authority safeguarding team as well as the OPG.

There is a criminal investigation which leads to Ms N's son being charged with abusing his mother. The police inform the OPG of the outcome of their investigation and the Public Guardian applies to the court to cancel the LPA. The local authority makes arrangements for Ms N's ongoing care.

[173] *Ligaya Nursing v R* [2012] EWCA Crim 2521, available at: https://www.bailii.org/ew/cases/EWCA/Crim/2012/2521.html

[174] Case: *R v Patel* [2013] EWCA Crim 965

[175] Sections 20-5 Criminal Justice and Courts Act 2015, available at: https://www.legislation.gov.uk/ukpga/2015/2/section/20.

Who should check that staff are safe to work with the people they are caring for?

23.36 Employers are responsible for checking whether staff are safe to work with people they are caring for. This includes requesting a check via the Disclosure and Barring Service (DBS). Employers can request a more detailed check for certain roles, for example some roles in healthcare or social care for children or adults, or both[176].

Who is responsible for monitoring the standard of health and social care providers?

23.37 All health and social care providers covered by the Health and Social Care Act 2008 must register with the Care Quality Commission in England. Those covered by the Regulation and Inspection of Social Care (Wales) Act 2016 must register with the Care Inspectorate for Wales (CIW) or, if registered under the Care Standards Act 2000, with Healthcare Inspectorate Wales (HIW). These agencies make sure that care providers meet certain standards. They require registered care providers to have procedures to protect people from harm or abuse, and to have effective complaints procedures. They can take action if they discover dangerous or unsafe practices that could place people at risk. These agencies also report on observations about implementation of the Act.

23.38 If someone is concerned about the healthcare or social care provided to a person who lacks capacity, there are formal and informal ways of complaining about the care or treatment. See chapter 24 for further information.

What is an appointee, and who monitors them?

23.39 Where someone lacks capacity to manage their benefits the Department for Work and Pensions (DWP) can appoint someone (an appointee) to claim and spend benefits on a person's behalf if[177]:

- the person's only income is social security benefits and they have no property or savings

[176] Disclosure and Barring Service, available at: https://www.gov.uk/government/organisations/disclosure-and-barring-service.

[177] See information on 'Becoming an appointee for someone claiming benefits' at: https://www.gov.uk/become-appointee-for-someone-claiming-benefits.

- the person has not made a property and affairs LPA or an EPA, and
- the court has not appointed a property and affairs deputy

23.40 If the person has other income or property or savings, a deputy may need to be appointed (see chapters 7 and 9).

23.41 Before making an appointment the DWP checks that the prospective appointee is suitable and trustworthy and fully understands their responsibility to act in the person's best interests. It will investigate any allegations that an appointee is not acting appropriately or in the person's interests. It can remove an appointee who abuses their position. Concerns about appointees should be raised with the relevant DWP agency - the local Jobcentre Plus, the Disability Service or the Pension Service.

24. What are the best ways to settle disagreements and disputes about issues covered in the Act?

Sometimes people will disagree about a person's capacity to make a decision, what is in a person's best interests or a decision or action someone is taking on behalf of a person who lacks capacity.

It is in everybody's interests to settle disagreements and disputes quickly and effectively, with minimal stress and cost. This chapter sets out the different options available for settling disagreements. It also suggests ways to avoid letting a disagreement become a serious dispute. Finally, it sets out when it might be necessary to apply to the Court of Protection and when somebody can get legal funding.

Where arrangements amount or may amount to a deprivation of liberty, the person, and other individuals on their behalf, have a right to challenge proposed or authorised. They can also challenge the manner in which the Liberty Protections Safeguards (LPS) process has been implemented. Concerns about the arrangements can be raised at any time in the LPS process.

In this chapter, as throughout the Code, a person's capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

Quick summary

- When disagreements occur about issues that are covered in the Act, it is usually best to try and settle them before they become serious.
- Advocates may be able to help settle a disagreement by representing the person who lacks capacity and ensuring their voice is heard.
- Some disagreements can be effectively resolved by mediation.
- Where there is a concern about healthcare or social care provided to a person who lacks capacity, there are formal and informal ways of complaining about the care or treatment.

- When other methods of resolving disagreements are not appropriate, the matter can be referred to the Court of Protection.
- There are some decisions that should always be referred to the Court of Protection.

What disputes may arise in terms of the LPS?

- Anyone can raise a concern about the LPS process or about the arrangements, including the person and their Appropriate Person or IMCA.
- The Appropriate Person or IMCA should ascertain the person's wishes and feelings about the arrangements. If the person wishes to, they should be supported to make an application to the Court of Protection.
- In some cases, even if the person doesn't wish to, it may still be necessary for the Appropriate Person or IMCA to make an application to the court.
- The person or anyone else may have concerns about the way in which the LPS process is implemented. Responsible Bodies should have appropriate channels for dealing with such complaints.

What options are there for settling disagreements?

24.1 The terms 'disagreement' or 'dispute' is used here to reflect a situation where there are differing views. Disagreements about healthcare, social or other welfare services could be between:

- People who have assessed a person as lacking capacity to make a decision
- the person who has been assessed as lacking capacity to make a decision (see chapter 4 for how to challenge an assessment of lack of capacity)
- family members or other people concerned with the care and welfare of a person who lacks capacity
- healthcare or social care staff involved in providing care or treatment and who may have different views about what is in the best interests of a person who lacks capacity.

24.2 Or a decision may be finely balanced with differing, but legitimate views. Such decisions are difficult to agree rather than a 'dispute'.

Scenario: A disagreement about capacity

Ms T has early stage dementia and lives in sheltered accommodation, with a care worker visiting her daily to assist her with daily living. She has bipolar disorder and a community psychiatric nurse (CPN) is in regular contact.

Ms T is diagnosed with breast cancer and her GP and hospital oncology team discuss the diagnosis and treatment options with her. They assess her as having capacity to make the decision she makes, which is to not undergo treatment.

Over time the cancer progresses and Ms T's GP and community palliative care consultant, with the support of her care worker, suggest that she go to a hospice. She vehemently refuses.

The consultant is concerned that Ms T lacks capacity to make this decision as she has not demonstrated that she can use and weigh the relevant information. The GP and care worker share the view that although Ms T's decision to stay at home is unwise, she has capacity to make it, and her decision is consistent with her previous ones. The consultant and GP consult the CPN, who confirms Ms T's long expressed wish to stay at home no matter what. This enables Ms T's GP and consultant agree that Ms T has capacity to decide to stay at home. They agree, with Ms T, to increase the frequency of care worker visits and to monitor her pain relief.

24.3 In general, disagreements can be resolved by either formal or informal procedures, and there is more information on both in this chapter. Where it is not possible to reach agreement on what is in the best interests of the person who lacks capacity, an application may be made to the Court of Protection. Some disagreements can only be resolved by the Court of Protection (see chapter 7 for further information).

24.4 It is usually best to try and settle disagreements before they escalate. Often people settle them by communicating effectively and taking the time to listen and to address worries. Disagreements and difficulties in reaching consensus are often best settled informally, or sometimes through mediation. When professionals are in disagreement with a person's family, it is a good idea to start by:

- listening to, acknowledging and addressing worries

- setting out the different options in a way that is easy to understand
- inviting a colleague to talk to the family and offer a second opinion
- using an advocate to support and represent the person who lacks capacity
- offering to get independent expert advice
- arranging a case conference or meeting to discuss matters in detail
- where the situation is not urgent, allowing everybody time to think it over

24.5 Further guidance on how to deal with problems without going to court may also be available from Citizens Advice. Depending on their financial situation, people may also be entitled to publicly funded legal advice on alternatives to going to court (see section 24.24 – 24.29).

When is an advocate useful?

24.6 An advocate is an independent person that represents the individual's interests and ensures their voice is heard. The definition of advocacy set out in the Advocacy Charter (developed by the sector and adopted by most advocacy schemes) is as follows:

> *'Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy schemes work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and social justice'*[178]*.*

24.7 An independent advocate is not a mediator but may be able to help settle a disagreement by being independent of all those involved and representing the person only, whilst having an understanding of a person's rights and the policies/practice and law that govern decision-making. Most advocacy services are provided by the voluntary sector and are arranged at a local level. They act independently of any professional or public body involved with the person.

24.8 Using advocates can help people (including those who have been assessed as lacking capacity) to remain at the heart of decision-making by ensuring they access their own representation and ensure their voice is heard. Advocates can help people:

- say what they want
- ensure their rights are upheld
- represent their interests
- get the services or other resources they need

[178] See Quality Advocacy, at: https://qualityadvocacy.org.uk/

24.9 Advocates may also be involved in supporting the person during mediation (see paragraphs 24.10–24.16 below) or helping with complaints procedures. Sometimes people have a legal right to an advocate, for example:

- where the Mental Capacity Act requires the involvement of an Independent Mental Capacity Advocate (IMCA) (see chapter 10)
- where the Mental Health Act requires the involvement of an Independent Mental Health Advocate (IMHA) (see chapter 22)
- where a social care advocate is required under the Care Act 2014 or the Social Services and Wellbeing (Wales) Act 2014
- when making a formal complaint against the NHS (see paragraph 24.17)

When is mediation useful?

24.10 Mediation can be effective in all areas covered by the Act, from medical treatment to disputes about welfare and questions about property and affairs. A mediator helps people to come to an agreement that is acceptable to all parties, helping to solve a problem at an early stage. There are different forms of mediation appropriate to different circumstances, including formal and informal mediation. Some may have an associated cost. The Civil Mediation Council179 can help people find professional mediators.

24.11 Mediation offers a wider range of solutions than the court, and it may be less stressful for all parties, more cost-effective and quicker. People who come to an agreement through mediation may be more likely to keep to it, because they have taken part in decision-making. It must be kept in mind throughout any mediation process that the agreement reached must be in the best interests of the person who lacks capacity. In some circumstances the decision reached may need an application to be made to the Court of Protection to approve the decision reached or the action agreed.

24.12 Mediators are independent, with no personal interest in the outcome of a case. They do not make decisions or impose solutions. The mediator will decide whether the case is suitable for mediation. They will consider the likely chances of success and the need to protect the interests of the person who lacks capacity, which must always be a priority. There may be a fee associated with the mediator's work.

24.13 Any case that can be settled through negotiation is likely to benefit from mediation. It is most suitable when people are not communicating well or not understanding each other's point of view. It can improve relationships and prevent future disputes,

[179] Civil Mediation Council, available at: https://civilmediation.org/

so it is a good option when it is in the person's interests for people to have a good relationship in the future.

24.14 In mediation, everybody needs to take part as equally as possible so that a mediator can help everyone involved to focus on the person's best interests. It might also be appropriate to involve an advocate to help represent the wishes, feelings and beliefs of the person who lacks capacity. Where the person needs or would benefit from an advocate but is not entitled to a statutory advocate, a deputy or attorney can instruct an advocate on the person's behalf as part of any other financial best interests decision-making.

24.15 Healthcare and social care staff may also take part in mediation processes. But it may be more appropriate to follow the relevant healthcare or social care complaints procedures (see paragraphs 24.17).

24.16 Legal aid may be available to fund mediation for people who meet the qualifying criteria (see paragraphs 24.24–24.29). Mediation could potentially cover a wide range of issues, including health and welfare, financial and property matters. Legal aid would only cover the legally-aided person's share of a mediator's costs, and would generally be limited to specific rates set out in legal aid legislation.

Scenario: Using mediation

Ms R has dementia and everyone concerned with her welfare agrees that she lacks capacity to decide where she should live. She lives with her son, however, her daughter has found a care home where she thinks her mother will get better care. Her brother disagrees. Ms R has no welfare Lasting Power of Attorney.

Ms R is upset by this family dispute, which has been ongoing for a year. During this time Ms R's condition has deteriorated, and she now requires care during the day and overnight. With a view to trying to resolve matters without needing to recourse to the Court of Protection, her son and daughter decide to try mediation to find a way through the dispute, as they are now no longer able to discuss the matter between them without significant disagreement, and it is starting to affect both of their personal lives, in addition to their relationship with their mother.

The mediator considers that Ms R is able to communicate her feelings, and asks that she is represented by an IMCA at the mediation. The local authority is an interested party due to Ms R's care needs, and wishes to attend. Ms

R's children decide to attend and sit in separate rooms, with the mediator shuttling between rooms. During the sessions, the mediator listens to each of Ms R's children, the local authority and Ms R's IMCA. This helps her understand their concerns and what they would like to achieve for Ms R. They then can focus on potential solutions that are in Ms R' best interests and that address their concerns.

After a full day of discussions, an agreement is reached that Ms R should continue to live with her son, but with an increased package of care in place to address her increased care needs. All parties agree to review the situation in six months to see if the care home might then be better for Ms R, and the review date is diarised by the local authority. The agreement reached is reflected in a written record which is signed by all parties.

Procedures for raising concerns or complaints

24.17 Raising concerns or making a complaint about healthcare or social care provided to a person who lacks capacity is separate to a disagreement or dispute about what is in the person's best interests under the MCA. Where there is a concern about the healthcare or social care provided to a person who lacks capacity, there are formal and informal ways of complaining about the care or treatment.

Complaints about healthcare or treatment	• **The NHS provides guidance for complaints about a patient's healthcare or treatment[180].** • **If a person is not happy with the outcome, they can take their case to the Parliamentary and Health Service Ombudsman[181] in England, or the Public Services Ombudsman for Wales[182].** • **When making a complaint, it may also be appropriate to inform the Care Quality Commission[183] (CQC) in England or the Health Inspectorate Wales[184] (HIW) as the independent regulators for health care. While they do not investigate individual complaints, these agencies will use the information provided to help inform decisions on when, where and what to inspect to make sure that care providers meet certain standards.**
Social care	• A service provider's own complaints procedures should set out how to make a complaint and what to do with a complaint that cannot be settled locally. • For services contracted by a local authority, it may be more appropriate to use the local authority complaints procedure[185]. • If the person making the complaint is not satisfied, they can contact the Local Government and Social Care Ombudsman[186] in England or the Public Services Ombudsman for Wales[187]. • When making a complaint, it may also be appropriate to inform the Care Quality Commission (CQC) in England or the Care Inspectorate Wales (CIW) as the independent regulators for social care. While they do not investigate individual complaints, these agencies will use the information provided

[180] NHS Complaints;

For England – https://www.nhs.uk/using-the-nhs/about-the-nhs/how-to-complain-to-the-nhs/.

For Wales – http://www.wales.nhs.uk/sites3/Documents/932/Healthcare%20Quality%20-%2030166_Putting%20Things%20Right_a5%20leaflet_English_WEB%20VERSION%20-%20FINAL%20-%202017%2003%2001.pdf.

[181] Parliamentary and Health Service Ombudsman (PHSO), can be found at: https://www.ombudsman.org.uk/.

[182] Public Services Ombudsman for Wales, can be found at https://www.ombudsman.wales/.

[183] Care Quality Commission (cqc.org.uk),can be found at: https://www.cqc.org.uk/

[184] Healthcare Inspectorate Wales (hiw.org.uk), can be found at: https://hiw.org.uk/.

[185] In Wales, further guidance to handling complaints and representations by local authority social services can be found at: https://gov.wales/sites/default/files/publications/2019-05/a-guide-to-handling-complaints-and-representations-by-local-authority-social-services.pdf.

[186] Local Government and Social Care Ombudsman can be found at: https://www.lgo.org.uk/.

[187] Public Services Ombudsman for Wales can be found at: https://www.ombudsman.wales/.

	to help inform decisions on when, where and what to inspect to make sure that care providers meet certain standards.
Healthcare and social care	• Where a complaint covers a number of providers, or both healthcare and social care, local authorities and the NHS must work together to agree which organisation will lead on the complaint[188]. • If a person is not happy with the outcome, they can take their case to the Parliamentary and Health Service Ombudsman or the Local Government and Social Care Ombudsman in England, or the Public Services Ombudsman for Wales.
Education provision	• The school, service or provider's own complaints procedure should be followed. Further information on what to do if complaints cannot be settled can be found on gov.uk. • If a person disagrees with a decision a local authority has made in relation to a young person's special educational needs, an appeal can be made to the Special Educational Needs (SEND) Tribunal in England or the Special Educational Needs Tribunal for Wales (SENTW).
Other welfare issues	• In England, the Housing Ombudsman[189] deals with complaints about social landlords (housing associations and local authorities) and voluntary members (some private landlords and letting agents) in England. • The Public Services Ombudsman for Wales deals with complaints about registered social landlords. • Complaints about local authorities may be referred to the Local Government and Social Care Ombudsman in England or the Public Services Ombudsman for Wales. They look at complaints about decisions on council housing (if not covered by the Housing Ombudsman), social services, Housing Benefit and planning applications.

What is the best way to handle disagreement about a person's finances?

24.18 If there is disagreement about what is in the person's best interests in relation to their finances (for example, dispute over the amount of money a person who lacks

[188] In Wales, guidance setting out how organisations should work together to handle complaints that cover healthcare and social care can be found at https://gov.wales/sites/default/files/publications/2019-05/a-guide-to-handling-complaints-and-representations-by-local-authority-social-services.pdf

[189] Housing Ombudsman can be found at: https://www.housing-ombudsman.org.uk/ .

capacity should pay their carer or whether they should sell their house), the advice in this chapter should be followed to try and come to an agreement. If the parties are unable to agree, an application to the court can be made to make the decision.

24.19 There is a difference between a disagreement about what is in the person's best interests and a concern about someone handling the money of a person who lacks capacity inappropriately. If there is concern about the actions of an attorney appointed under a Lasting Power of Attorney or a deputy appointed by the court, the most appropriate action would be to contact the OPG for further advice and guidance (chapters 8, 9 and 23).

24.20 In cases where the person in question is not an attorney or deputy, it may be appropriate to make a safeguarding referral to the relevant local authority. For example, there may be a concern that a carer may be using the money of a person who lacks capacity inappropriately or without proper authority. The local authority will then ascertain whether it has a duty, under Section 42 of the Care Act 2014 or Part 7 of the Social Services and Well-Being Wales Act 2014, to make proportionate enquiries in response to a concern about the possible abuse or neglect of an adult at risk.

How can the Court of Protection help?

24.21 Chapter 7 sets out the circumstances in which an application must be made to the Court of Protection, as well as those where an application may be required. These include situations covered by this chapter in which it is not possible to resolve a doubt or disagreement about an issue within the scope of the Act.

24.22 In every case in which the alternative mechanisms set out in this chapter for resolving disputes or disagreements about a person's capacity or best interests are being considered, it is important to strike the balance between seeking to reach consensus and not stifling a genuine dispute. Only the Court of Protection is able to give a definitive decision about a person's capacity or their best interests.

24.23 It is also important that a person deprived of their liberty under an LPS authorisation is not prevented from exercising their right to challenge the authorisation before the court even if others do not think that they will succeed in their challenge. See paragraphs 24.30-24.53 on challenging an LPS authorisation.

Will public legal funding be available?

24.24 Depending on their financial situation, people may be entitled to:

- publicly funded legal advice (legal help) from accredited solicitors or advice agencies

- legal representation before the Court of Protection in some health and welfare cases (See chapter 7).

When can someone get legal help?

24.25 Legal help is a type of legal aid (public funding) that pays for advice and assistance on legal issues, including those affecting a person who lacks capacity. But it does not provide representation for a court hearing.

24.26 To qualify for legal help, applicants must show that:

- they satisfy the means test, showing that the individual earns less than a specific amount and does not have savings or other financial assets in excess of a specific amount
- they satisfy the merits test, meaning they would benefit sufficiently from legal advice to justify the amount it costs

24.27 Legal help can include:

- advice and guidance on the Mental Capacity Act and the person's rights
- help from a solicitor or other representative in writing letters
- in exceptional circumstances, getting a barrister's opinion, and
- assistance in preparing and supporting an application to the Court of Protection.

24.28 People cannot get legal help for making a Lasting Power of Attorney (LPA) or an advance decision to refuse treatment. But they can get general information from the OPG and may be eligible for help with paying LPA registration fees or the OPG's deputy supervision fees. The OPG cannot give legal or specialist advice. For example, it cannot advise someone on what powers they should delegate to their attorney under an LPA. People can, however, obtain legal help for advice on other matters to do with LPAs and advance decisions, for example to assist with resolving a dispute about the way an LPA is being used.

24.29 Where a dispute is to be heard in the Court of Protection, public funding for legal representation may be available. Information on when someone qualifies for legal representation in the Court of Protection is available in chapter 7.

Who can raise concerns about arrangements, the Liberty Protection Safeguards process, or the authorisation?

24.30 Where arrangements that amount or may amount to a deprivation of liberty are proposed, the LPS process should be triggered. At any time, the person can raise concerns about the proposed arrangements, the LPS process or the authorisation. Those caring for or close to the person should be alert to any indication from the

person that they have a concern. See paragraphs 24.39-24.47 for more information on identifying when the person may have a concern.

24.31 A number of individuals are likely to know the person and may be involved in the LPS process. At any point in the process, any one of these individuals may wish to raise a concern about either the proposed arrangements or the authorisation. These individuals include (but are not limited to):

- An Independent Mental Capacity Advocate (IMCA)
- An Appropriate Person
- Any person acting under a Lasting Power of Attorney or an Enduring Power of Attorney
- Any Court Appointed Deputy
- A family member or friend or someone else close to the person
- Someone who is caring for the person (either on a paid or unpaid basis)
- Anyone providing treatment to the person
- A health or social care professional
- Anyone else who is interested in the person's welfare

24.32 Any person or organisation can apply to the Court of Protection without permission, where it concerns the LPS. This includes the person or their Appropriate Person or IMCA. The individual considering bringing the matter to court may be seeking to challenge the authorisation, for example if they don't think the authorisation conditions are met. They may also wish to challenge matters such as the length of the authorisation period or what the authorised arrangements relate to. The right to apply to the court applies irrespective of whether decision makers think this is appropriate or is not in the person's best interests. Please see more information on the role of the court, and what cases it can consider, in chapter 7.

24.33 An important reason for applying to the Court of Protection will often be because the person wishes to challenge the authorisation. In some cases, the person may need assistance to do so. The starting point should be to consider if the person wishes or would wish to apply to the Court of Protection.

24.34 If, for example, the IMCA or Appropriate Person has reason to believe that the person is unhappy with the arrangements at any time, they should seek to ascertain the person's wishes and feelings regarding what steps to take. If the person wishes to challenge the arrangements, the IMCA or Appropriate Person should support the person to bring this challenge to the Court of Protection. It may also be necessary to make an application to the court even if the person does not wish to do so or is unable to express their wishes and feelings, please see below for more information.

24.35 The Responsible Body must publish information about the right to make an application to the Court of Protection under section 21ZA, and this should include

information about how to final legal representation. Responsible Bodies should ensure that the legal professionals in this list have a mental capacity accreditation with the Law Society. If the person, including where the IMCA or anyone else is acting as the person's litigation friend, or their Appropriate Person, is bringing an application under section 21ZA they are entitled to non-means tested legal aid. Anyone else who is making an application under 21ZA will need to satisfy a means tested for legal aid.

24.36 The Court may also consider cases when reliance is being placed on section 4B of the Act. When an application is made to the court in relation to the reliance of section 4B, whilst a decision about an LPS authorisation is being made, there is no means test for legal aid for the person or their Appropriate Person. Any other applications made to the court in relation to section 4B do not meet the requirements or non-means tested legal aid. Further information about the Court of Protection is provided in chapter 7. Further information about Section 4B is provided in chapter 19.

24.37 The right to apply to the court is an important safeguard for the person's Article 5 human rights. This Article states that every person has the right to liberty and protects people from unlawful detention. Everyone is entitled to take proceedings on the lawfulness of their detention which must be decided speedily by a court.

24.38 The LPS process has been designed to ensure full compliance with Article 5. It should be recognised that there could be reason to think that the person would wish to make an application even though they say they do not want to do so. For example, the person may be reluctant to be seen to challenge decision makers, but the authorisation is infringing on their rights under the Article. It is therefore important in these cases that the authorisation is brought before the Court of Protection, even if the person themselves doesn't recognise any need or express a wish to bring the matter to the court. This is to protect the person's Article 5 rights.

24.39 See paragraphs 24.49 to 24.53 below for more information on the concerns that may be raised.

Recognising when a person wishes to challenge or is unhappy with the arrangements

24.40 The IMCA or Appropriate Person should maintain regular contact with the person throughout the period of the authorisation. If the person has concerns about the arrangements, the IMCA or Appropriate Person can support the person to make a complaint, raise an adult safeguarding concern, request a review, or apply to the court.

24.41 If the person is able to verbally communicate their wishes and feelings, about the arrangements or authorisation, they may express that they want to apply to court.

Even if the person has capacity to issue proceedings, they may still need assistance and if so, the Appropriate Person or IMCA should support the person to make the application. The threshold for capacity to issue proceedings is lower than the threshold for having capacity to conduct court proceedings. It simply requires the person to understand that the court has the power to decide whether the person ought to be subject to the arrangements or not.

24.42 In some cases, the person may not be happy with the arrangements or the authorisation but may be expressing that they do not wish to challenge it. Where this is the case, someone such as the IMCA or Appropriate Person may need to challenge the arrangements in court because, if the person is unhappy with the arrangements or authorisation, then their Article 5 rights are likely to be at risk.

24.43 Likewise, if the person is not able to communicate their wishes and feelings, they may still be unhappy with the arrangements and be expressing this through their behaviour in a way that indicates they would want to apply to the court. Where this is the case, the IMCA or Appropriate Person should be alert to any behavioural indications that this may be the case and bring the challenge to the Court of Protection on behalf of the person if appropriate. The IMCA or Appropriate Person should also consider what the wishes and feelings would be if the person had the relevant capacity.

24.44 In considering the person's verbal expressions, regard should be had to:

- any statements made by the person about their wishes and feelings in relation to issuing proceedings;
- any statements made by the person about their residence and care;
- any verbal expressions by the person of their emotional state;
- the frequency with which the person objects verbally to their placement or asks to leave;
- the consistency of their expressed wishes or emotional state; and
- any potential alternative reasons behind their expressed wishes or emotional state.

24.45 In considering the person's behaviour, regard should be had to:

- the possible reasons for their behaviour;
- whether the person is being sedated or medicated (as this may dull any behaviours that suggest an objection);
- whether the person actively tries to leave the place;
- whether the person takes preparatory steps to leave the care home, for example, packing bags;
- the person's demeanour and relationship with staff;
- any records of challenging behaviour and the triggers for such behaviour;

- whether the person's behaviour is a response to particular aspects of the care arrangements or to the entirety of those arrangements; and
- "passive objections" which evidence wishes and feelings without expressing a challenge verbally, including stopping eating and drinking, becoming introverted, self-harm, disengaging.

24.46 In order to determine the person's wishes and feelings, the Appropriate Person or IMCA should be alert to different stimuli that may alter the person's behaviour. It may be, for example, that the person appears to be unhappy with the arrangements but through further investigation the IMCA discovers they have started taking a new medication that may have altered their behaviour, and that in reality this was the case of their unhappiness. In such cases, further investigation may need to be undertaken about whether a court application is needed. Before determining that the person wishes to challenge the authorisation, the Appropriate Person or IMCA should, where appropriate, consider speaking to those involved in the person's care and treatment to determine if there could be another reason for their verbal expressions or behaviour.

24.47 Likewise, sometimes the person's behaviour and expressed wishes might be inconsistent. In such cases, the Appropriate Person or IMCA, or others involved in the person's care, should consider all the circumstances to conclude whether or not the person would wish for an application to be made or whether there is a need to apply to court for another reason.

24.48 If a person wants to challenge their authorisation and is not receiving necessary representation and support from an Appropriate Person or IMCA, the Responsible Body should ensure their case is brought to court if necessary.

24.49 Even if the person has capacity to bring proceedings, it may well be that they lack the capacity to conduct proceedings and will still require an Accredited Legal Representative or litigation friend to conduct the proceedings on their behalf. In many cases, where a litigation friend is required, the person's Appropriate Person or IMCA can act in this role. If there is no one else suitable and willing to do so, then the Official Solicitor may be invited to act.

What challenges may be raised against the arrangements, an authorisation, or the LPS process?

24.50 The person and others, for example an individual or organisation on their behalf, has a right to challenge the proposed or authorised arrangements, or the manner in which the LPS process has been enacted. The Responsible Body should ensure that there are appropriate channels for individuals to raise such concerns, including through standard complaints processes. Each concern should be considered

promptly, and any necessary action taken. Information about how to make a complaint should be included within the information that Responsible Bodies publish and be available through care providers.

24.51 If, following completion of the assessments and determinations, and consultation, there is reason to believe that the person does not wish to reside or receive care or treatment in a place, the case must be referred to an AMCP for pre-authorisation review. See chapter 18 for more information on the role of an AMCP and further advice on when it is reasonable to believe that the person does not wish to reside or receive care or treatment in a place.

24.52 Additionally, at any stage, either during the authorisation process or once an authorisation is in place, anyone listed in paragraph 24.32 can raise concerns about the LPS process. For example, in order to ensure the person is treated fairly, a domiciliary care worker may see interactions between the person and their Appropriate Person and have concerns about the way in which the Appropriate Person is representing and supporting the person. In which case, they should raise concerns with the Responsible Body.

24.53 Every effort should be made by the Responsible Body to resolve disagreements and challenges informally, if possible and appropriate. Concerns and challenges may be brought to the Responsible Body at any time before the authorisation, including through the consultation and care planning process, or once an authorisation is in place. In some cases, the Responsible Body may seek advice from an AMCP, without referring the case for an AMCP pre-authorisation review, before deciding how to proceed.

24.54 If the person, or the individual raising the concern, is not satisfied with the conflict resolution process or the proposed resolution, there are number of ways they can take this forward. These include:

- making a complaint through the official complaints system of the Responsible Body. If the issue is not resolved through internal complaints procedures, it may be appropriate to make a complaint to the relevant Ombudsman.
- raising a safeguarding concern under the local safeguarding adults or children board multi-agency safeguarding procedures (if it is believed the person is at risk of abuse or neglect).
- requesting a review of the care and support plan or the authorised arrangements, or both.
- making an application to the Court of Protection to challenge the authorisation, please see chapter 7 for more info.

What to do if someone raises concerns about another matter during the LPS process

24.55 During the LPS process, the person or others may raise concerns about other matters, which are not part of the process. This can include concerns about the care and treatment itself, or other proposed restrictions, such as limits on family contact, which relate more to the person's Article 8 rights, rather than their Article 5 rights. Although such matters are outside the Liberty Protection Safeguards process, if they are raised, they may be considered as part of the Necessary and Proportionate assessment (See chapter 16 for more information).

25. What rules govern access to information about a person who lacks capacity?

This chapter gives guidance on what personal information about someone who lacks capacity people involved in their care have the right to see, and how they can access that information. This chapter is only a general guide and does not give detailed information about the law. Nor does it replace professional guidance or the guidance of the Information Commissioner's Office on the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 (DPA) (this guidance is available on its website190). Where necessary, people should take legal advice.

This chapter is mainly for people such as deputies and attorneys who care for or represent someone who lacks capacity to make specific decisions and in particular, lacks capacity to allow information about them to be disclosed. Professionals have their own codes of conduct, and they may have the support of information specialists in their organisations.

In this chapter, as throughout the Code, a person's capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

Quick summary

The personal information someone might be able to see about someone who lacks the capacity to give consent will depend on:

- whether the person requesting the information is acting as an agent (a representative recognised by the law, such as an attorney or deputy) for the person who lacks capacity or whether there is a relevant court order in place
- whether disclosure is in the best interests of the person who lacks capacity or whether there is another lawful reason for disclosure
- what type of information has been requested

An attorney or a deputy can ask to see information concerning the person they are representing, as long as the information helps them to make decisions, they have

190 https://ico.org.uk/

the legal authority to make. An attorney, where necessary, should be consulted on decisions outside of their remit.

Where a person has no legal authority to request information about someone who lacks capacity, whether they can access or share it will depend on the situation.

Healthcare and social care staff may disclose information about somebody who lacks capacity only when it is in the best interests of the person concerned to do so, or when there is some other, lawful reason for them to do so.

What laws and regulations affect access to information?

25.1 Sensitive and confidential information is regulated by:

- The GDPR and DPA 2018
- the common law duty of confidentiality
- professional codes of conduct on confidentiality
- the Human Rights Act 1998 and European Convention on Human Rights, in particular Article 8 (the right to respect for private and family life), which means that it is only lawful to reveal someone's personal information if:
    - there is a legitimate aim in doing so
    - it is necessary in a democratic society, and
    - the kind and amount of information disclosed is in relation to the need

How can someone access information on behalf of someone else?

25.2 Article 15 of the GDPR gives everyone the right to see personal information that an organisation holds about them. They may also authorise someone else to access their information on their behalf. The person holding the information has a legal duty to release it. So, where possible, it is important to try to get a person's consent before requesting to see information about them. In this case giving the organisation holding the information the person's consent should mean someone is able to access or share the information as agreed by the person.

25.3 Doctors and lawyers cannot ordinarily share information about their clients, or that clients have given them, without the client's consent. Sometimes it is fair to assume that a doctor or lawyer already has someone's consent. For example, patients do not usually expect healthcare staff or legal professionals to get consent every time they share information with a colleague – but staff may choose to get clients'

consent in writing when they begin treating or acting for that person. But in other circumstances, doctors and lawyers must get specific consent to 'disclose' information (share it with someone else).

25.4 Public authorities may have their own professional codes and guidance on the disclosure of information (for example, the General Medical Council, Law Society and the Solicitors Regulation Authority). Health and social care staff should also follow the 'Caldicott Principles', which ensure information that can identify a patient is protected and only used when appropriate to do so.

25.5 A person may have the capacity to agree to someone seeing their personal information, even if they do not have the capacity to make other decisions. In some situations, a person may have previously given consent (while they still had capacity) for someone to see their personal information in the future.

25.6 If someone's capacity changes from time to time, the person needing the information may want to wait until that person can give their consent. Or they may decide that it is not necessary to get access to information at all, if the person will be able to make a decision on their own in the future.

25.7 However, it may be necessary to access personal information about a person who lacks the capacity to give consent.

25.8 People caring for, or managing the finances of, someone who lacks capacity may need information to:

- assess the person's capacity to make a specific decision
- determine the person's best interests
- make appropriate decisions on the person's behalf

25.9 The information they need varies depending on the circumstances. For example:

- Someone providing full-time care for their elderly parent will make decisions based on their experience and knowledge of the parent.
- A deputy may need information from other people. For instance, if they are deciding whether a person needs to move into a care home, or whether they should sell the person's home, they might need information from family members, the family doctor, the person's bank and their solicitor to make sure they are making the decision in the person's best interests.

25.10 The personal information someone might be able to see about someone who lacks the capacity to give consent will depend on:

- whether the person requesting the information is acting as an agent (a representative recognised by the law, such as a deputy or attorney) for the person who lacks capacity or whether there is a relevant court order in place
- whether disclosure is in the best interests of the person who lacks capacity or whether there is another lawful reason for disclosure, and
- what type of information has been requested.

25.11 Where the person has legal authority to request the information, they can access and share information where this is allowed under the authority they have. They may need to show either the original or certified copy of the authority and identification if requested. Types of legal authority that will allow the person to manage affairs, access information and make decisions for a person who lacks capacity include Lasting Power of Attorneys, Enduring Power of Attorneys (created before 1 October 2007) and Court of Protection deputyships.

25.12 Where the person has no legal authority to request the information, whether they can access or share it will depend on the situation. In some cases, they may not be able to access the person's information. However, if they have a valid reason for needing to, such as representing the person in a complaint about care or an application for NHS continuing healthcare funding, they may be able to. If they need to, they can share information with organisations even when they cannot access the person's information.

When can attorneys and deputies ask to see personal information?

25.13 An attorney or a deputy can ask to see information concerning the person they are representing, as long as the information helps them to make the decisions they have the legal authority to make. In some circumstances this might mean a property and affairs attorney requesting certain health records if such records will help the attorney make a financial decision on the donor's behalf. For information relating to other areas, the attorney or deputy may need to apply to the Court of Protection.

25.14 Having seen the appropriate authority, the person holding the information should be able to release it.

25.15 The attorney or deputy must treat the information confidentially and should be extremely careful to protect it. If they fail to do so, the court might cancel the LPA or deputyship.

25.16 Requests for personal information must be in writing. In most cases an organisation cannot charge a fee to comply with a subject access request. However, they can charge a "reasonable fee" for the administrative costs of complying with the request if it is unfounded or excessive; or an individual requests further copies of their data

following a request. An attorney or deputy may be able to reimburse themselves out of the person's funds for any fee that they are required to pay, as long as the request for information is properly made and in the best interests of the person who lacks capacity. Complaints about a failure to comply with the GDPR should be directed to the Information Commissioner's Office[191].

What limitations are there?

25.17 Attorneys and deputies should only ask for information that will help them make a decision they need to make on behalf of the person who lacks capacity. For example, if the attorney needs to know when the person should take medication, they should not ask to see the entire healthcare record. The person who releases information must make sure that an attorney or deputy has legal authority, and they may ask for proof of identity and appointment. When asking to see personal information, attorneys and deputies should bear in mind that their decision must always be in the best interests of the person who lacks capacity to make that decision.

25.18 The attorney or deputy may not know the kind of information that someone holds about the person they are representing. So sometimes it might be difficult for them

Scenario: Giving attorneys access to personal information

Mr Y is in the later stages of Alzheimer's disease. His son is responsible for Mr Y's personal welfare under a Lasting Power of Attorney. Mr Y has been in residential care for a number of years. But his son does not think that the home is now able to meet his father's current needs as his condition has recently deteriorated.

Mr Y's son asks in writing to see his father's records. He wants specific information about his father's care, so that he can make a decision about his father's best interests. But the manager of the care home refuses, saying that the Data Protection Act stops him releasing personal information.

Mr Y's son explains that he can see his father's records, because he is the personal welfare attorney and needs the information to make a health and welfare decision. The GDPR requires the care home manager to provide access to personal data held on Mr Y.

The care home manager agrees to share the records which Mr Y's son needs to make the health and welfare decision.

[191] Information Commissioner's Office, can be found at: https://ico.org.uk/.

to make a specific request. They might even need to see all the information to make a decision. But again, the 'best interests' principle applies (see chapter 5).

25.19 The deputy or attorney may find that some information is held back (for example, when this contains references to people other than the person who lacks capacity). This might be to protect another person's privacy if that person is mentioned in the records. It is unlikely that information relating to another person would help an attorney make a decision on behalf of the person who lacks capacity. The information holder might also be obliged to keep information about the other person confidential, or there might be another reason why the other person does not want information about them to be released. Under these circumstances, the attorney does not have the right to see that information.

25.20 An information holder should not release information if doing so would cause serious physical or mental harm to anyone, including the person the information is about. This applies to information about healthcare, social care and education.

25.21 The Information Commissioner's Office can give further details on:

- how to request personal information
- restrictions on accessing information
- how to appeal against a decision not to release information
- how to make a complaint if information is wrongly disclosed

When can someone see information about healthcare or social care?

25.22 Healthcare and social care staff may disclose information about somebody who lacks capacity only when it is in the best interests of the person concerned, or when there is some other lawful reason to do so.

25.23 The Act's requirement to consult relevant people when working out the best interests of a person who lacks capacity will encourage people to share the information that makes a consultation meaningful. But people who release information should be sure that they are acting lawfully and that they can justify releasing the information. They need to balance the person's right to privacy with what is in their best interests or the wider public interest192 (see paragraphs 25.28–25.29 below).

[192] See *S v Plymouth City Council* [2002] EWCA Civ 388, available at: https://www.bailii.org/ew/cases/EWCA/Civ/2002/388.html

25.24 Sometimes it will be fairly obvious that staff should disclose information. For example, a doctor would need to tell a new care worker about which drugs a person needs or what allergies the person has. This is clearly in the person's best interests.

25.25 Other information may need to be disclosed as part of the process of working out someone's best interests. This is likely to be lawful if disclosure is required in order for a professional to be able to meaningfully consult so as to make a best interests decision. For example, a social worker might decide to reveal information about someone's past when consulting a close family member about the person's best interests. But staff should always bear in mind that the Act requires them to consider the wishes and feelings of the person who lacks capacity. In both these cases, staff should only disclose as much information as is relevant to the decision to be made.

25.26 Section 58(5) of the Act gives the Public Guardian the right to examine and take copies of health records or any record held by local authorities relating to social care. This is to help assist with the Public Guardian's statutory duties, such as dealing with complaints about how an attorney/deputy is exercising their powers.

25.27 Section 35(6) of the Act gives IMCAs the right to examine, and take copies of, any records that the person holding the record thinks are relevant to the IMCA's investigation (for example, clinical records, care and support plans, social care assessment documents or care home records). It is also likely that disclosure of information to other statutory advocates will be lawful if such information is required to enable them to discharge their functions.

Scenario: Sharing appropriate information

Mr J has learning disabilities. The residential home where he lives is about to close. His care team carries out a thorough assessment of his accommodation needs. They assess Mr J as lacking capacity to make a decision about his next home, but involve Mr J in the assessment as much as possible, using the support of an Independent Mental Capacity Advocate to ascertain his wishes and feelings and reach a decision in his best interests. Following the assessment, Mr J's care team decide to place him with carers in an adult placement scheme.

The new carers ask to see Mr J's case file, so that they can provide him with appropriate care in his best interests. Mr J's current care manager seeks Mr J's consent to disclosure of his notes, but after supporting him as much as possible to be able to make the decision himself, she assesses Mr J as lacking capacity to make the decision. She recognises that it is appropriate to provide the carers with sufficient information to enable them to act in Mr J's best interests. She decides it is not

appropriate for them to see all the information on the case file. As Mr J has been at the care home for a long time, much of the information in the file relates to past needs Mr J had many years previously and is not relevant to his current care needs.

The care manager therefore decides to disclose only currently relevant information from the file about Mr J's care needs.

25.28 Sometimes a person's right to confidentiality will conflict with broader public concerns. Information can be released if it is in the public interest, even if it is not in the best interests of the person who lacks capacity. It can be difficult to decide in these cases, and information holders should consider each case on its merits. The NHS Code of Practice on Confidentiality193 gives examples of when disclosure is in the public interest. Other bodies also provide guidance, for example the General Medical Council for doctors. Disclosure in the public interest includes situations where disclosing information could prevent, or aid investigation of, serious crimes, or prevent serious harm, such as the spread of an infectious disease. It is then necessary to judge whether the public good that would be achieved by the disclosure outweighs both the obligation of confidentiality to the individual concerned and the broader public interest in the provision of a confidential service.

[193] Confidentiality: NHS Code of Practice, can be found at: https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice

25.29 For disclosure to be in the public interest, it must be proportionate and limited to the relevant details. Healthcare or social care staff faced with this decision should seek advice from their legal advisers. It is not just things for 'the public's benefit' that are in the public interest. Disclosure for the benefit of the person who lacks capacity can also be in the public interest (for example, to stop a person who lacks capacity, or someone else, suffering physical or mental harm).

What financial information can be shared?

25.30 It is often more difficult to get financial information than it is to get information on a person's welfare. A bank, for example, may not:

- know the individual concerned
- be able to make an assessment of the person's capacity to consent to disclosure
- be aware of the carer's relationship to the person

25.31 So it is less likely than a doctor or social worker to be able to judge what is in a person's best interests as well as being bound by duties to keep client affairs confidential. An attorney or a deputy, appointed to manage the person's property and affairs, will generally have the authority (because of their appointment) to obtain all relevant information about the person's property and affairs. Others wanting financial information are likely to need to apply to the Court of Protection for access to that information.

Is information still confidential after someone shares it?

25.32 Whenever a carer gets information, they should treat the information in confidence, and they should not share it with anyone else, unless there is a lawful basis for doing so. In some circumstances, the information holder might ask the carer to give a formal confirmation that they will keep information confidential.

25.33 Where the information is in written form, carers should store it carefully and not keep it for longer than necessary. In many cases, the need to keep the information will be temporary. So the carer should be able to reassure the information holder that they will not keep a permanent record of the information.

What is the best way to settle a disagreement about personal information?

25.34 A carer should always start from the position of the person themselves making the decision to consent to the sharing of information. If, even after support to make the

decision, the person lacks capacity to consent, the carer should ask the information holder for the relevant information and explain why they need it. They may need to remind the information holder that they have to make a decision in the person's best interests and cannot do so without the relevant information.

25.35 This can be a sensitive area and disputes will inevitably arise. Healthcare and social care staff have a difficult judgement to make. They might feel strongly that disclosing the information would not be in the best interests of the person who lacks capacity and would amount to an invasion of their privacy. This may be upsetting for the carer who will probably have good motives for wanting the information. In all cases, an assessment of the interests and needs of the person who lacks capacity should determine whether staff should disclose information.

25.36 If a discussion fails to settle the matter, and the carer still is not happy, there are other ways to settle the disagreement (see chapter 24). The carer may need to use the appropriate complaints procedure. Since the complaint involves elements of data protection and confidentiality, as well as best interests, relevant experts within the relevant organisation should help deal with the complaint.

25.37 In cases where the disagreement cannot be resolved, the carer can apply to the Court of Protection for the right to access to the specific information. The court would then need to decide if this was in the best interests of the person who lacks capacity to consent. In urgent cases, it might be necessary for the carer to apply directly to the court without going through the earlier stages.

26. How does the Act affect research projects involving a person who lacks or may lack capacity?

It is important that research involving people who lack or may lack capacity can be carried out, and that it is carried out properly. Without it, we would not improve our knowledge of the causes, treatment and care of people with impairing conditions or our understanding of their perspectives and experiences.

This chapter gives guidance on involving people who lack capacity to consent and people who need support to consent to take part in research. It sets out:

- how to support people to make a decision about whether or not to take part in research
- the legal requirements people must meet if their research project involves somebody who lacks capacity
- the specific responsibilities of researchers and what should happen if a research participant loses capacity during a research project

This chapter applies to research in relation to people aged 16 and over. There is NHS guidance on consent for children and people aged 16 and 17[194].

In this chapter, as throughout the Code, a person's capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

Quick summary

Where there is reason to doubt whether a person has capacity to consent to participate in research, researchers are responsible for determining whether or not the person is able to give informed consent.

If a person lacks capacity to consent to their involvement, the Act makes provision to protect them. The Act's provisions for research that includes people who lack capacity to consent to their involvement cover:

[194] Research involving children (19 March 2018), can be found at; https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/research-involving-children/.

- when research can be carried out
- the ethical opinion and research approval process
- respecting the wishes and feelings of people who lack capacity
- other safeguards to protect people who lack capacity
- how to engage with a person who lacks capacity
- how to engage with carers and other relevant people

The research provisions in the Act apply to all research that is intrusive. 'Intrusive' means research that would be unlawful if it involved a person who had capacity but had not consented to take part. The provisions do not apply to Clinical Trials of Investigational Medicinal Products (CTIMPS).

What is 'research'?

26.1 The Act does not have a specific definition of 'research'. The UK Policy Framework for Health and Social Care Research states:

> 'Research is defined as the attempt to derive generalisable or transferable new knowledge to answer or refine relevant questions with scientifically sound methods.'[195]

26.2 Research may:

- provide information that can be applied generally to an illness, disorder or condition
- demonstrate how effective and safe a new treatment is
- add to evidence that one form of treatment works better than another
- add to evidence that one form of treatment is safer than another
- examine wider issues (for example, the factors that affect someone's capacity to make a decision)

[195]UK Policy Framework for Health and Social Care Research (30 October 2020) https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/

26.3 Researchers must state clearly if an activity is part of someone's care and not part of the research. Sometimes experimental medicine or treatment may be performed for the person's benefit and be the best option for their care. In these cases, it may be difficult to decide whether treatment is research or care. Where there is doubt, the researcher should seek legal advice.

26.4 The Health Research Authority provides guidance on the policies, standards and legislation that apply to research[196]. Its decision tool can help determine what counts as research[197].

Why does the Act cover research?

26.5 Because the Act is intended to support people who may lack capacity, it protects people who take part in research projects but lack capacity to make decisions about their involvement. It makes sure that researchers respect their wishes and feelings. The Act does not apply to research that involves clinical trials of medicines as these are covered by other rules.

26.6 Researchers are responsible for ensuring that participation in research takes place on the basis of informed consent. All research involving people who have an impairment of, or disturbance in the functioning of, their mind or brain must be conducted in accordance with the principles of the Act (see chapters 1 and 2).

How can research involving people who lack capacity help?

A researcher undertakes observational research into how effectively local authority social services involve people in planning their care and support. He plans to observe local authority social worker meetings with clients and carers or support workers to discuss their support plans.

He wants to ensure his sample is representative of the broad range of people that social services supports, including people with more severe cognitive impairments affecting understanding and communication. This means that some potential participants may lack the mental capacity to consent to participate in the research. The research would be less

[196] Policies, Standards and Legislation, can be found at; https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/.

[197] www.hra-decisiontools.org.uk/research

effective if he did not include this group, because they may present distinct challenges for involvement in support planning.

The researcher is confident that this research will ultimately benefit people with similar impairments because it will provide recommendations on ways to involve this population more effectively. He believes the risks of participating are negligible but has taken steps to identify any that might occur and minimise these.

The researcher seeks consent to observe the support planning meetings from the social workers whose work he will be observing, as well as any carers or other supporters who may attend. Where he feels that a participant may have difficulties understanding the accessible versions of the information sheets and consent forms he has prepared, he takes advice from the social worker and any carers on the best way to communicate with the person to support their understanding. If, after talking to the person about it, he considers that they do not have the mental capacity to consent to participate, but nothing indicates that they would not wish to participate or do not want him present, then he approaches any carers of the person as a 'personal consultee' for their view on the person's wishes and feelings about participation in research. If the person has no carer that would be appropriate to consult, then he speaks with the social worker as a 'nominated consultee'. If at any point during the observation the researcher senses that his presence is making the participant feel distressed or anxious, or that they do not want him there, then he leaves the room and removes their data from the study.

What assumptions can a researcher make about capacity?

26.7 Researchers should assume that a person has capacity, unless there is reason to believe that they lack capacity to make a specific decision (see chapter 2). When seeking informed consent, all reasonable steps must also be taken to support the person to make their own decision and enable them to give informed consent. Chapter 3 explains steps that should be taken which may help someone make a decision for themselves. The person has the right to make decisions that others might not agree with, and they have the right not to take part in research.

26.8 Having taken all reasonable steps to support the participant's decision-making, researchers may have reason to believe that a participant may lack the capacity to consent to participate in research. If so, they are responsible for determining whether or not the person is able to give informed consent. This may mean that they themselves undertake a capacity assessment or it may be appropriate to seek the opinion of an expert assessor or a third party who knows the person well.

26.9 If the researchers wish to include a person who they have established lacks the capacity to consent to participate in the research, they must follow the procedures

laid down in sections 30-34 of the Act, including seeking authorisation from an authorised statutory Research Ethics Committee (REC – see 26.20).

26.10 If the researchers do not wish to include people who lack capacity in their research, then they do not need to follow the Act's processes and seek authorisation from a statutory REC. However, they should explore carefully with their university or departmental ethics committee any sensitive issues that may arise around capacity assessment or excluding some people from participating in research.

What research does section 30-33 of the Act cover?

26.11 Because the Act is intended to assist and support people who may lack capacity, it makes special provision in section 30-33 to protect people who take part in research projects but lack capacity to make decisions about their involvement. These provisions enable participation in research for those who lack the capacity to consent, providing certain requirements in the Act are met.

26.12 It is expected that most researchers who ask for their research to be approved under these provisions will be health or social care researchers. However, they can cover more than just health and social care research.

26.13 The special provisions in the Act apply to research that:

- Is 'intrusive' (if a person taking part had capacity, the researcher would need to get their consent to involve them)
- Involves people who are unable to decide whether or not to agree to take part in the research (i.e. they lack capacity to consent) as a result of an impairment of, or a disturbance in the functioning of, their mind or brain and
- is not a clinical trial covered under the Medicines for Human Use (Clinical Trials) Regulations 2004.

26.14 Not all research is intrusive research. 'Intrusive' means research that would be unlawful if it involved a person who had capacity but had not consented to take part. Intrusive research which does not meet the requirements of the Act cannot be carried out lawfully in relation to people who lack capacity.

26.15 There are circumstances where no consent is needed to lawfully involve a person in research. These apply to all persons, whether they have capacity or not:

- Sometimes research only involves data that has already been anonymised (it cannot be traced back to individuals). Confidentiality and data protection laws do not apply in this case.

- Under the Human Tissue Act 2004, research that deals only with human tissue that has been anonymised does not require consent (see paragraphs 26.83–26.86). This applies to both those who have capacity and those who do not. But the research must have ethical approval, and the tissue must come from a living person[198] .
- If researchers collected human tissue samples before 31 August 2006, they do not need a person's consent to work on them. But they will normally have to get ethical approval.
- Regulations[199] made under section 251 of the NHS Act 2006 (formerly known as section 60 of the Health and Social Care Act 2001200) allow people to use confidential patient information without breaking the law on confidentiality by applying to the Confidentiality Advisory Group (CAG) for approval from the Health Research Authority[201].

26.16 The decision about whether or not a person who lacks capacity should participate is not a best interests decision in the terms of section 4 of the Act because taking part in research does not usually result in direct benefit to the participant. In addition, nobody can give consent to take part on behalf of a person who lacks capacity. Instead, the research provisions in the Act ensure that researchers follow the person's wishes and feelings when deciding whether or not they should take part. These provisions do not apply to research that involves clinical trials of medicines, because these are covered by other rules[202].

26.17 Researchers must also separately consider the lawful basis for processing the data resulting from their research in compliance with the Data Protection Act 2018 and UK GDPR. As including someone in research is likely to be with the intent of

[198] Human Tissue Act 2004 section 1(9), can be found at; - https://www.legislation.gov.uk/ukpga/2004/30/pdfs/ukpga_20040030_en.pdf.

[199] Health Service (Control of Patient Information) Regulations 2002 Section I. 2002/1438. as amended by Section 117 of the Care Act 2014, available at; https://www.legislation.gov.uk/uksi/2002/1438/contents/made.

[200] Section 60 of the Health and Social Care Act 2001 was included in the NHS Act 2006 which consolidated all the previous health legislation still in force - National Health Service Act 2006 (legislation.gov.uk), can be found at; https://www.legislation.gov.uk/ukpga/2006/41/contents.

[201] The CAG was established by the Health Research Authority on 01 April 2013 to assess applications against the Health Service (Control of Patient Information) Regulations 2002. It provides independent expert advice to the Health Research Authority and Secretary of State for Health and Social Care on whether an application to process patient information without consent should or should not be approved, further information can be found at; https://www.hra.nhs.uk/about-us/committees-and-services/confidentiality-advisory-group/legal-frameworks/.

[202]The Medicines for Human Use (Clinical Trials) Regulations 2004, as amended by The Medicines for Human Use (Clinical Trials) and Blood Safety and Quality (Amendment) Regulations 2008, available at;https://www.legislation.gov.uk/uksi/2008/941/contents/made

processing their personal data, these considerations should be evaluated at the outset of a project. The Information Commissioner's Office provides further guidance on UK GDPR[203].

Who is responsible for making sure research involving a person who lacks capacity meets the Act's requirements?

26.18 Responsibility for meeting the Act's requirements lies with:

- the researchers and their institutions carrying out the research (see paragraphs 26.36–26.73) and
- the 'appropriate body', as defined in regulations made by the Secretary of State (for regulations applying in England) or the National Assembly for Wales (for regulations applying in Wales) (see paragraph 26.20-26.21).

How can research involving a person who lacks capacity get ethics approval?

26.19 Research covered by the Act cannot include people who lack capacity to consent to the research unless:

- it has the approval of 'the appropriate body', and
- it follows other requirements in the Act to:
    - respect the wishes and feelings of the person, and any objections they might make (or would make if able to) about participation in the research
    - consider the views of carers and other relevant people, and
    - treat the person's interests as more important than those of science and society (this is not the same as the 'best interests' principle in the rest of the Act)

26.20 An 'appropriate body' is an organisation that can approve research projects. In England the 'appropriate body' must be a Research Ethics Committee (REC) recognised by the Secretary of State204. In Wales, the 'appropriate body' must be a Research Ethics Committee recognised by the National Assembly for Wales[205].

26.21 All NHS RECs in England and Wales are recognised. In addition, there is a national Social Care REC which is recognised as an appropriate body. All of these RECs

[203] Guide to Data Protection, can be found at; https://ico.org.uk/for-organisations/guide-to-data-protection/
[204] Mental Capacity Act 2005 (Appropriate Body) (England) Regulations 2006, can be found at; - https://www.legislation.gov.uk/uksi/2006/2810/made.

[205] Mental Capacity Act 2005 (Appropriate Body) (Wales) Regulations 2007, available at; https://www.legislation.gov.uk/wsi/2007/833/introduction/made.

operate under the auspices of the Health Research Authority (HRA)[206]. Researchers submit applications for HRA REC review through the Integrated Research Application System[207]. They have to indicate on the application form that they plan to undertake intrusive research involving adults lacking capacity to consent for themselves. When this option is selected, applications are automatically routed for review by a flagged REC. This process may take longer than university or other RECs, and this should be factored into research planning and applications for funding.

Factors considered by flagged HRA RECs

26.22 The appropriate body can only approve a research project if the research is linked to:

- an impairing condition that affects the person who lacks capacity, or
- the treatment of that condition (see paragraph 26.32-26.33)

and:

- there are reasonable grounds for believing that the research would be less effective if only people with capacity are involved, and
- the research project has made arrangements to involve consultees to advise on the person's wishes and feelings and involvement in the research, and to follow the other requirements of the Act

26.23 If these criteria are not met, the person should not be included in the research. Researchers must justify the inclusion of adults unable to consent for themselves. They should not try to include people who lack capacity in their research simply to create a representative sample, or for ethical reasons related to equity or social inclusion.

26.24 Research must also meet one of two requirements:

- The research must have some chance of benefiting the person who lacks capacity, as set out in paragraph 26.30-26.31 below. The benefit must be in proportion to any burden caused by taking part; or

[206] Health Research Authority (hra.nhs.uk), available at; https://www.hra.nhs.uk/.

[207] Integrated Research Application System, can be found at; https://www.myresearchproject.org.uk/Signin.aspx.

- The aim of the research must be to provide knowledge about the cause of, or treatment or care of people with, the same impairing condition, or a similar condition.

26.25 If researchers are relying on the second requirement, the Act sets out further requirements that must be met:

- the risk to the person who lacks capacity must be negligible
- there must be no significant interference with the freedom of action or privacy of the person who lacks capacity, and
- nothing must be done to or in relation to the person who lacks capacity which is unduly invasive or restrictive (see paragraphs 26.35 below).

26.26 An impairing condition:

- is caused by (or may be caused by) an impairment of, or disturbance in the functioning of, the person's mind or brain
- causes (or may cause) an impairment or disturbance of the mind or brain, or
- contributes to (or may contribute to) an impairment or disturbance of the mind or brain.

26.27 The requirements above reflect the benefit-burden trade-off researchers are required to consider when justifying the involvement of people lacking capacity in research. This consideration is not the same as a best interests decision in the terms of section 4 of the Act and therefore the statutory principle of best interests decisions does not apply in this context. Instead, the research must meet the requirements as set out above and researchers should follow the person's wishes and feelings when deciding whether they should take part.

Research that only involves people who have capacity

A charity commissions a researcher to find out what people with learning disabilities think about the services they receive, and how the charity can expand their service provision. The researcher decides that the best way to make sure disabled people's voices are heard in this research is to interview them about their views and experiences.

The researcher thinks that her research can be carried out effectively if she only includes people who have capacity to decide take part in her research. To make her research as accessible as possible, she creates easy read participant information sheets and consent forms. She uses process consent approaches, where she talks through the information with potential participants to help them to understand what will happen during and after the research. She designs the research so that participants can have a supporter or personal assistant present to help them if they want to.

The researcher gains ethical approval from her University Research Ethics Committee. When conducting the research, she presumes that volunteers have capacity to take part in her research, but checks carefully that they can retain, use and weigh the information in her participant information form to come to their decision about whether or not to take part, and to consent to the processing of data from the research for different purposes.

Balancing the benefit and burden of research

26.28 It is important that research involving people who lack capacity is carried out. Without it, we would not improve our knowledge of the causes, treatment and care of people with impairing conditions or our understanding of their perspectives and experiences. We would know little about the experiences and views of those directly affected by the Act.

26.29 It is therefore important that, where the person wishes to do so, their participation in research is facilitated and their contributions valued. Some people may lack the capacity to consent but may still wish to speak to researchers about their experiences and researchers should do their best to facilitate this.

Direct benefits of taking part in research for a person who lacks capacity to consent

26.30 Potential benefits of research for a person who lacks capacity could include:

- developing more effective ways of treating a person or managing their condition

- improving the quality of healthcare, social care or other services that they have access to
- discovering the cause of their condition, if they would benefit from that knowledge
- reducing the risk of the person being harmed, excluded or disadvantaged
- Providing them with the opportunity to express their views and experiences about the issues that affect their lives.

26.31 Benefits may be direct or indirect (for example, the person might benefit at a later date if policies or care packages affecting them are changed because of the research). It might be that participation in the research itself will be of benefit to the person in particular circumstances. For example, if the research involves interviews and the person has the opportunity to express their views, this could be considered of real benefit to a particular individual.

Providing knowledge about causes, treatment or care of people with the same impairing condition or a similar condition

26.32 It is possible for research to be carried out which doesn't actually benefit the person taking part, as long as it aims to provide knowledge about the causes, treatment or care of people with the same impairing condition, or a similar condition. 'Care and treatment are not limited to medical care and treatment. For example, research could examine how day-to-day life in prison affects prisoners with mental health conditions.

26.33 In research aimed at understanding the causes, treatment and care of a condition, it is the person's condition that must be the same or similar, and not necessarily the underlying cause. Research involving people with similar conditions with different causes may produce valuable evidence for the participant's condition. For example, research into ways of supporting people with learning disabilities to live more independently might involve a person who has an acquired brain injury. But its findings might help people with similar learning disabilities with different causes.

Including people who lack capacity in research

A charity is undertaking research and would like the views of people who lack capacity, as well as people with capacity, to be included in the research, so that they can ensure that they understand the perspectives of all service users.

The researcher designs an additional set of information sheets and consent forms for use by consultees. She applies to the Social Care Research Ethics Committee for ethical approval to conduct research including people who lack capacity to consent. She makes clear in her application for approval that the research is linked to learning disability and that the research would be less effective if only participants with capacity to consent to participate took part. In this case, the research would be less effective because it would leave out the experiences of a group of service users.

The research also meets the MCA requirements that the research has the potential to benefit participants directly, and to benefit others with similar impairments. If the research was only of benefit to others, the researcher would also need to show that her research meets additional privacy conditions, and that any risks to participants are negligible.

Even though the researcher asks consultees for their consent for people with learning disabilities to take part, she also seeks assent from the participants themselves, using her easy read research materials.

26.34 Any risk to people involved in this category of research must be 'negligible'. This means that a person must be very unlikely to suffer any harm or distress by taking part. Researchers must consider risks to psychological wellbeing as well as physical wellbeing.

26.35 Research in this category also must not affect a person's freedom of action or privacy in a significant way, and it should not be unduly invasive or restrictive. What will be considered as unduly invasive will be different for different people and different types of research. For example, in psychological research some people may think a specific question is intrusive, but others would not. Actions will not usually be classed as unduly invasive if they do not go beyond the experience of daily life, a routine medical examination or a psychological examination.

Qualitative research involving people lacking capacity

A professor intends to explore the value of group music therapy for adults with profound intellectual disabilities. She plans to conduct short interviews with music therapists following the therapy sessions in order to gain insight into their experiences of participating in the activity.

As part of her protocol, the professor intends to ask the therapists their views on whether the music therapy session has had a positive impact on their clients' quality of life.

The Research Ethics Committee is concerned that the therapists will be speaking for their clients, and that giving proxy responses about personal experiences will not provide meaningful data. The professor revises her protocol and decides to recruit people with disabilities participating in the music therapy into her project. She recognises that these people are likely to lack the capacity to consent to participate in her research. Therefore the professor thinks about how she can collect valid data from people with disabilities about their experiences of participating in music therapy when these people may not understand that they received therapy.

The professor decides that using inclusive data collection tools, including open interview questions, and collecting non-verbal responses using 'Talking Mats' and the construction of collages that incorporate images and symbols, will enable her to capture the experiences of people with disabilities accurately. The Research Ethics Committee is satisfied that this approach will enable data to be collected that provides knowledge about the care of people with profound intellectual disabilities, whilst exposing these participants to negligible risk.

What responsibilities do researchers have when involving a person who lacks capacity?

26.36 Before starting the research, the research team must make arrangements to:

- obtain approval for the research from the 'appropriate body'
- get the views of any carers and other relevant people before involving a person who lacks capacity in research (see paragraphs 26.42-26.44) (There is an exception to this consultation requirement in situations where urgent treatment needs to be given or is about to be given).
- respect the objections, wishes and feelings of the person
- place more importance on the person's interests than on those of science and society

26.37 The research proposal must give enough information about what the team will do if a person who lacks capacity needs urgent treatment during research and it is not possible to speak to the person's carer or someone else who acts or makes decisions on behalf of the person (see paragraphs 26.74-82).

Consult others for advice about the presumed wishes of the person who lacks capacity

26.38 Once it has been established that a person lacks capacity to agree to participate (see paragraphs 26.7 to 26.10 on assessing capacity), before they are included in research the researcher must consult with specified people in accordance with section 32 of the Act to determine whether the person should be included. Consultees do not provide consent to researchers for the research to go ahead with the involvement of the person lacking capacity. They advise the researcher about whether the intentions of the research are in accordance with what they think the person lacking capacity would have wanted. It is the researcher's responsibility to make the final decision about whether the person lacking capacity is included in the research on the basis of this judgement.

26.39 As well as a consultee, researchers should involve the person themselves in the decision-making process. Although a person lacks capacity to consent, they may have views affecting the decision, and researchers should ensure they follow the person's wishes and feelings when deciding whether they should participate.

Who can researchers consult?

26.40 The researcher must take reasonable steps to identify someone to consult (the consultee). Two types of consultees can be asked to advise about the presumed wishes of the person who lacks capacity:

- A 'personal consultee' (e.g. a relative or unpaid carer)
- A 'nominated consultee' (e.g. a GP or social worker who is not involved with the research)

26.41 Researchers should always attempt to involve a personal consultee in preference to a nominated consultee.

Personal consultee

26.42 A 'personal consultee' must be involved in the person's care, (but not caring for them in a professional capacity or for remuneration), interested in their welfare and willing to help. They do not need to be an attorney under a registered Lasting Power of Attorney or a deputy appointed by the Court of Protection. A person is not prevented from being consulted if they are an attorney or deputy, but that person

must not be acting in a professional or paid capacity (for example, the person's solicitor). Remuneration does not cover family members receiving some of the person's pension or other benefits as a payment towards their share of the household expenses.

26.43 The researcher must take into account previous wishes and feelings that the person might have expressed about who they would, or would not, like involved in future decisions. Those involved in caring for the person in a professional capacity may be able to help the researcher select someone appropriate to consult.

26.44 A number of people may be capable of acting as a personal consultee, but they should be someone whom the person who lacks capacity would trust with important decisions about their welfare. Usually it will be someone with a close personal relationship with the potential subject, spouse or partner, adult child or parent. Other relatives or a close friend or past carer may be considered. If a potential consultee does not feel able to take on the role, they may suggest that someone else does, or ask that a 'nominated consultee' (see paragraph 26.45-26.46) be appointed.

Nominated consultee

26.45 Where there is no-one who meets the conditions mentioned at paragraphs 26.42 to 26.44, the researcher must nominate a person to be consulted. This is known as a 'nominated consultee'. The person who is nominated must have no connection with the research project.

26.46 The arrangements for nominating a consultee should be clearly addressed when seeking approval from the REC. This will enable the REC to consider the variety of circumstances where a readily identifiable personal consultee might not be available. Examples include:

- where no family member or friend is willing and able to act as consultee
- where the family or friends live a long distance away and/or are not in frequent contact with the person who lacks capacity
- where the regular carers of the person who lacks capacity are doing so for payment or in a professional capacity (e.g. care home staff or nurses)
- where someone is acting in a professional role (e.g. their GP or solicitor)

Which care staff or healthcare professionals can act as nominated consultees?

26.47 While someone with a professional relationship to the person lacking capacity must not be a personal consultee, it does not bar them from being the nominated consultee. It is therefore possible that a member of the care team or the GP of the person who lacks capacity could act as the nominated consultee, provided that they had no connection with the research project. It would be for the researcher to satisfy the REC that the arrangements were appropriate to the nature of the study. An

example might be a person in a care home who has no close family but is close to a member of the care home staff. In this case, the member of the care home staff could be approached to act as a nominated consultee. However, it would not be appropriate to approach a member of the care home staff if the research was being sponsored by the care home or if the home and its staff had an organisational interest in the outcome of the research.

26.48 In some healthcare settings, a doctor or healthcare professional primarily responsible for the medical treatment of the person who lacks capacity might be the most appropriate nominated consultee. This person must have no connection with the project (see below) and be free from potential influence, such as being junior to a member of the research team. Researchers should refer to the Research Governance Frameworks for Health and Social Care and other relevant professional codes, including guidance from the General Medical Council. These have general safeguards against conflicts of interest and other forms of professional misconduct.

What does 'no connection with the project' mean?

26.49 A nominated consultee must have no connection with the project. In deciding whether someone is 'connected with the project', researchers should consider a wide range of possible connections to the particular study. For example, the consultee should not be someone who is involved or has a financial or professional interest in the progress of the research. They should not be under the influence of the research team, either professionally or personally (e.g., a junior member of staff whose career might be influenced by a senior member of the research team). They should also not have wider connections such as direct links to the funding of the study or with the REC that approved the project. However, some connections will be irrelevant. It is unnecessary, for example, to exclude people whose only connection is working in the same hospital or local authority as the researcher, or living in the same street. It is also likely to be irrelevant if the consultee has an indirect professional interest in the outcome of the research or if they are employed by a local authority or hospital that has an indirect organisational interest in the research. Researchers should consider the nature of a person's possible connection with a project as this arises.

26.50 Guidance from the General Medical Council, General Social Care Council and professional bodies gives further advice on preventing conflicts of interest and other forms of professional misconduct.

What does 'reasonable steps' mean?

26.51 The researcher is required to take reasonable steps to identify a person who is able to act as consultee. This means that the researcher has a degree of flexibility, in accordance with the approval from the REC, about the extent to which it is

necessary to approach distant or remote relatives or friends. However, the researcher should not be unduly influenced by considerations of time and convenience in deciding whether a personal consultee is available or willing to act. In some circumstances, it will be possible to establish that the person who lacks capacity has no close relatives who are in regular contact and that it would be more appropriate to identify a nominated consultee who has regular contact with the person who lacks capacity. Depending on the nature of the research, the researcher will need to consider the arrangements for identifying a new consultee if the original consultee becomes unwilling or unable to be consulted during the study.

What must a personal consultee do?

26.52 A personal consultee must themselves have capacity at the relevant time and be prepared to be consulted by the researcher about the possible involvement in the project of the person who lacks capacity. This means that they must be willing to do it and able to understand the information provided about the project.

26.53 The Act does not specify what information consultees should be provided with, but it should be similar to the patient information leaflet that would be given to a person with capacity who was being asked to join a research project. The REC should be satisfied that the information given to a consultee is accurate, thorough and easy to understand. The information they receive should not be coercive and should make clear that they are not obliged to undertake the role of consultee if they do not wish to do so.

26.54 In addition to the normal participant information leaflet it will also be necessary to explain to the personal consultee that they are being asked to advise on whether the person who lacks capacity should take part in the project. For example, they should consider whether the person who lacks capacity would be content to take part or whether doing so might upset them. The consultee must also give their opinion on what the past and present wishes and feelings the person who lacks capacity would have been about taking part in the study. This may include whether the person previously expressed specific or general support for research of this nature when they had capacity, or were otherwise able to indicate their views.

26.55 The researcher must then use this information to make the final decision about whether the person lacking capacity is included in the research.

26.56 If the consultee advises that the person would not have wanted to take part, then the researcher must abide by this. However, the consultee is bound by the normal duty of care to act responsibly and in good faith when advising on the past and present wishes and feelings.

26.57 In practice, it may be helpful to remind the consultee that they are not being asked for their own personal views on participation in the specific project, or research in

general. It is also useful to emphasise that the consultee is not being asked to consent on behalf of the person who lacks capacity. The consultee must set aside any views they may have about the research and consider only the views and interests of the person who lacks capacity.

26.58 A consultee should be asked to consider the broad aims of the research, the risks and benefits and the practicalities of what taking part will mean for the person who lacks capacity. The consultee should consider the past and present views of the person who lacks capacity on the overall nature of the research. It is also essential to consider their present views and wishes. For example, the study might involve activities in the afternoon when the person who lacks capacity is most tired so would find it a strain, or conversely it might involve an activity that the person who lacks capacity particularly enjoys. At any stage, the consultee can advise the researcher that the person who lacks capacity would not want to remain in the project, and their advice must be respected by the researcher.

26.59 A person who has agreed to act as a consultee may find it helpful to have independent advice about their role, and it is good practice to ensure that this can be provided. Suitable independent sources of advice might be people who have undertaken the general preparation to act as a nominated consultee.

What are the duties of the nominated consultee?

26.60 The nominated consultee is required to perform the same role as a personal consultee (see above) in advising the researcher about the participation of the person who lacks capacity. The nominated consultee will need to receive relevant information about the project. They must also consider how the wishes and interests of the person who lacks capacity would incline them to decide if they had the capacity to make the decision.

26.61 The nominated consultee may not know the person who lacks capacity. In determining what the person's wishes and feelings about the research would be if they had capacity, the nominated consultee should attempt to seek views from any family, friends or carers who may not be willing or able to act as a personal consultee. Where appropriate, other professional colleagues with an interest in the person who lacks capacity's welfare or condition, such as members of the care team not involved in the research, may be approached for a view. The nominated consultee will have to consider any possible potential or perceived conflict of interest in the outcome of the research when weighing up the views of family, friends or carers.

26.62 In some cases, the duty of the nominated consultee to seek views on the person's presumed wishes and feelings will have to be balanced against a duty of confidentiality regarding sensitive aspects of the condition that the person who lacks capacity is in. Examples include research involving mental health or sensitive

matters relating to the care of young adults with a learning disability. See chapter 25 for general advice on confidentiality and duties under the Act. The REC will wish to be satisfied about arrangements regarding confidentiality when giving approval.

Role of local research organisations

26.63 In order to support research involving those who lack capacity it is good practice for research-active trusts, social care organisations, universities or charities to identify local mechanisms to provide access to people suitable to act as nominated consultees under the Act. For example, the care organisations involved in leading the research – trusts or local authorities – could liaise with others in local research networks, local authorities and patient or consumer groups near to where the research is to be conducted to establish a suitable panel of people who can act as nominated consultees. In light of the local circumstances, suitable arrangements may be needed to cater for consultees to be available out of office hours (e.g. research in emergency situations). The National Institute for Health Research (NIHR) Clinical Research Network[208] and Applied Research Collaborations (ARCs)[209] can also offer advice on local implementation of plans to support the identification of potential nominated consultees.

26.64 There is no requirement for the panel of potential consultees to belong to a specific profession. Examples of potential nominated consultees might include other clinical staff or lay persons not connected with the project, social workers, non-executive members of the trust board, hospital chaplains or other spiritual advisers, Caldicott guardians or patient advocates. For social care organisations, other alternatives might be for a manager of a unit or service to identify staff who can act as a nominated consultee, in accordance with the other requirements of this guidance and the local research governance framework.

26.65 There will also be a role for the research organisation, working with the appropriate REC or clinical ethics committee, in ensuring that the panel has the appropriate training and support. The information, and prior training, should draw attention to the requirements of this Code.

26.66 The local arrangements should also cover the provision of advice and support to personal consultees and nominated consultees advising on research projects in their organisation. The information given to a consultee should also clarify their legal obligations under the Act.

[208] The National Institute for Health Research (NIHR) Clinical Research Network, available at; https://www.nihr.ac.uk/explore-nihr/support/clinical-research-network.htm

[209] The National Institute for Health Research (NIHR) Collaborating in applied health research, available, at: https://www.nihr.ac.uk/explore-nihr/support/collaborating-in-applied-health-research.htm.

What other safeguards does the Act require?

26.67 The decision about whether or not a person who lacks capacity should participate is not a best interests decision in the terms of section 4 of the Act. Instead, the research provisions in the Act ensure that researchers follow the person's wishes and feelings when deciding whether or not they should take part. Even when a consultee has advised that they think a person can take part in research, the researcher should still consider the person's wishes and feelings.

26.68 The person may have made an advance statement of about their wishes to be included in research, or not to be included. This should be taken into account by the researcher, but it does not amount to consent.

26.69 Researchers must:

- not do anything the person who lacks capacity objects to
- not do anything to go against any advance decision to refuse treatment or other advance statement the person has previously made expressing preferences about their care or treatment
- assume that the person's interests in this matter are more important than those of science and society

26.70 A researcher must withdraw someone from a project if:

- they indicate in any way that they want to be withdrawn from the project (for example, if they become upset or distressed), or
- any of the Act's requirements are no longer met

26.71 In some cases, it may be appropriate to pause a research intervention to allow the person time before deciding on whether they should be permanently withdrawn from a project. For example, it may take time to establish whether a person has become distressed by taking part in the research, or for some other reason.

26.72 In some circumstances, it may be important to consider whether a person's objection is specific to the research or to the care or treatment they are receiving. For example, a person may be receiving care or treatment in their best interests that they object to, but may be keen to tell researchers about their experience and so may not object to research on the care or treatment.

26.73 As well as the safeguards set out in the Act, the Data Protection Act 2018 and UK GDPR also contain safeguards for the processing of personal data from research. Where a researcher is processing personal data from the research under the Data Protection Act, these safeguards must be complied with.

What happens if urgent decisions are required during the research project?

26.74 Anyone responsible for caring for a person must give them urgent treatment if they need it. In some circumstances, it may not be possible to separate the research from the urgent treatment. A research proposal should explain to the appropriate body how researchers will deal with urgent decisions which may occur during the project, when there may not be time to carry out the consultations required under the Act. For example, after a patient has arrived in intensive care, the doctor may want to chart the course of an injury by taking samples or measurements immediately and then taking further samples after some type of treatment to compare with the first set.

26.75 Special rules apply where a person who lacks capacity is getting, or about to get, urgent treatment and researchers want to include them in a research project. If in these circumstances a researcher thinks that it is necessary to take urgent action for the purposes of the research, and they think it is not practicable to consult someone about it, the researcher can take that action if:

- they get agreement from a registered medical practitioner not involved with the research, or
- they follow a procedure that the appropriate body agreed to at approval stage

26.76 The medical practitioner may have a connection to the person who lacks capacity (for example, they might be their doctor). But they must not be involved in the research project in any way. This is to avoid conflicts of interest.

26.77 In the case of research taking place in a healthcare setting, for example in Accident and Emergency or an Intensive Care Unit, the researcher should take steps to identify in advance appropriate doctor(s) to cover out-of-hours emergencies. Any doctor identified to agree to the inclusion of a person in an approved project must have no other connection with the project. As indicated elsewhere in the guidance, they must be provided with appropriate information about the nature of the study, the inclusion and exclusion criteria and their duties under the Act.

26.78 In research situations outside a healthcare organisation, for example those involving paramedics, it may be possible that a personal consultee is available at the scene. However, it may not be reasonable to expect that person to immediately absorb information and advise on the enrolment of the person who lacks capacity into an approved study, especially as clinical information must take priority. In such cases, the REC should agree when approving the study the arrangements to be taken by the paramedic or other nominated individual in deciding whether to enrol that person.

26.79 Any such decision should take due account of the views, however expressed, by the person being treated or by their family or friends who are with them.

26.80 In the absence of any information to the contrary, it is justifiable for a doctor or other healthcare professional to assume that a potential subject would wish to receive an intervention that has the greatest chance of saving their life or improving (or minimising detriment to) their health. Where there is genuine uncertainty about the relative benefits or harms of the standard treatment and the research treatment (equipoise), it may be reasonable to assume (other things being equal) that a potential subject would wish to enter the approved research project.

26.81 This exception to the duty to consult only applies:

- for as long as the person needs urgent treatment, and
- when the researcher needs to take action urgently for research to be valid

26.82 It is likely to be limited to research into procedures or treatments used in emergencies. It does not apply where the researcher simply wants to act quickly. As soon as the emergency is over, arrangements must be made to seek consent in the usual manner or to seek advice from a consultee on the continued participation of the person who lacks capacity in the study. As above, this should not compromise the provision of important clinical information, which must take priority over the consultation regarding any research.

What happens for research involving human tissue?

26.83 A person with capacity has to give their permission for someone to remove tissue from their body, for example, taking a biopsy (a sample) for diagnosis or removal of tissue in surgery. The Act allows the removal of tissue from the body of a person who lacks capacity, if it is in their best interests (see chapter 5).

26.84 People with capacity must also give permission for the storage or use of tissue for certain purposes, set out in the Human Tissue Act 2004, (for example, transplants and research). But there are situations in which permission is not required by law:

- research where the samples are anonymised and the research has ethical approval[210]
- clinical audit
- education or training relating to human health

[210] Section 1(9) of the Human Tissue Act 2004, is available at:- https://www.legislation.gov.uk/ukpga/2004/30/contents.

- performance assessment
- public health monitoring
- quality assurance

26.85 If an adult lacks capacity to consent, the Human Tissue Act 2004 says that tissue can be stored or used without seeking permission if the storage or use is:

- to get information relevant to the health of another individual (for example, before conducting a transplant), as long as the researcher or healthcare professional storing or using the human tissue believes they are doing it in the best interests of the person who lacks capacity to consent
- for a clinical trial approved and carried out under the Medicines for Human Use (Clinical Trials) Regulations 2004, or
- for intrusive research:
    - after the Mental Capacity Act came into force
    - that meets the Act's requirements, and
    - that has ethical approval.

26.86 Tissue samples that were obtained before 31 August 2006 are existing holdings under the Human Tissue Act. Researchers can work with these tissues without seeking permission. But they will still need to get ethical approval. Guidance is available in the Human Tissue Authority Code of Practice on consent[211].

What if a person has capacity when research starts but loses capacity?

26.87 Some people with capacity agree to take part in research but may then lose capacity before the end of the project. All research (excluding clinical trials carried out under clinical trial regulations) that started after the coming into force of the Act in 2007 must comply with the terms of the Act212, including in relation to continued participation of someone who has lost capacity during the research.

26.88 The Mental Capacity Act 2005 (Loss of Capacity During Research Project) (England) Regulations 2007 and the Mental Capacity Act 2005 (Loss of Capacity during Research Project) (Wales) Regulations 2007 apply to tissue and data collected before the loss of capacity of a person who gave consent before 31 March 2008, to join a project that started before 1 October 2007. They set out conditions to be complied with in order to allow researchers to continue research in this situation. Where the regulations apply, research can only continue if the project already has

[211] Human Tissue Authority, available at: www.hta.gov.uk

[212][212] Mental Capacity Act 2005 re: research, available at: https://www.legislation.gov.uk/ukpga/2005/9/part/1/crossheading/research

procedures to deal with people who lose capacity during the project. The research does not have to be linked to an impairing condition of the person; have the potential to benefit that person; or aim to provide knowledge relevant to others with the same or a similar condition. An appropriate body must have approved the procedures, and the researcher must follow the procedures that have been approved.

26.89 The regulations do not cover research involving direct intervention (for example, taking of further blood pressure readings) or the taking of further tissue after loss of capacity. Such research must comply with sections 30 to 33 of the Act to be lawful.

26.90 When a participant loses capacity the researcher must:

- seek out the views of someone involved in the person's care or interested in their welfare and if a carer can't be found they must nominate a consultee (see paragraphs 26.42–26.46)
- respect advance decisions and expressed preferences, wishes or objections that the person has made in the past
- treat the person's interests as more important than those of science and society

26.91 The appropriate body must be satisfied that the research project has reasonable arrangements to meet these requirements. The consultee should be provided with information about the project and with information on the nature of the consent given by the participant when they joined (or re-consented) to their samples being collected.

26.92 The role of the consultee is similar to that in other research situations. They must advise on whether the research subject would want to allow samples or identifiable data collected before loss of capacity to continue to be used in the study. The fact that the person who lacks capacity had originally consented to join the research project, and the extent to which future incapacity was considered at that time, will be important. However, the researcher must consider advice from the consultee that continued involvement in the study would be contrary to the wishes of the person who lost capacity. For example, the person may have originally consented to their medical records being accessed, but following the onset of a severe medical condition, the consultee may advise that if the person were aware of the continued use of their data they would want to withdraw such access.

26.93 Any future collection of samples or data would require the project to be approved separately in accordance with the Act.

26.94 If at any time the researcher believes that procedures are no longer in place or the appropriate body no longer approves the research, they must stop research on the person immediately.

26.95 If researchers believe it is possible that participants may, during the research project, lose capacity to consent to participate, they should plan in advance for the data contributed by that participant. Information about what will happen to data collected from that participant before they lose capacity should be included in participant information leaflets, and consent gained for the continued storage and analysis of that data where appropriate.

Losing the capacity to consent during a research project

A doctor is planning a longitudinal study of dementia care that aims to understand how quality of life is influenced by changing domiciliary care interventions as people's cognitive abilities change.

The doctor decides that his project needs to capture quality of life data even when the person becomes more severely affected by the disease. He acknowledges that his participants are likely to lose the capacity to continue to consent to participate in the latter stages of the study.

The doctor includes a specific section in the participant information sheet about what will happen if the person loses the capacity to continue to consent to participate in the project. He also includes a separate statement on the consent form where the person with dementia is asked to confirm whether he or she would agree with continuing to participate in the research project if they are judged to lack capacity to consent. He intends to check that this statement still applied at regular intervals throughout the course of the project, adopting a 'process model' of consent.

The doctor also recognises that he needs to fulfil the consultee requirements of the Mental Capacity Act, if any of the participants in the research lack capacity or when they lose capacity during the project. He prepares a consultee information sheet and a form where the consultee is asked to advise on whether the person who lacks capacity should continue to take part in the project. Specifically, he includes a question about whether there are any reasons to think that the person with dementia's initial statement that they would agree to continue participating is no longer valid.

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