Ministry
of Justice

National Mental Capacity Forum

Annual Report 2023-2025

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> So here we are then.
>
> On an issue that goes to the core of our identity and the control that we have over our lives, we have a complex and bureaucratic system that is expensive and time consuming, but also offers meaningful protection only too little or too late for the vast majority of people who need it.
>
> Illegality is inevitable and widespread…
>
> It did not have to be this way. (Troke, 2024, p.461)[1]

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1 Ben Troke (2024) A Practical Guide to the Law of Deprivation of Liberty Minehead: Law Brief Publishing

Introduction

Much of this Annual Report has origins in discussions about the use of the Mental Capacity Act 2005 across England and Wales. Some sections include expanded or condensed versions of facts presented in the National Mental Capacity Forum's Annual Report of 2022-2023. In 2025-26, we are still not where we want to be, notwithstanding the case begun by the UK Supreme Court on 20 October 2025. The status quo remains less than perfect. The backdrop is one of persistent health and social care delivery constraints which have legitimated agendas once thought unimaginable. Questions that continue to exercise the Forum include:

- How do we change, modify, remedy, do better?
- How do we bring the MCA to a wider audience?

With lots of caveats, individually and as a Forum on a learning curve, we work within the expectations of the Forum's Terms of Reference.[2] Although the Forum is keenly attuned to the challenges of enhancing understanding of the MCA, it is realistic. It is engaged by individual experience because change is grounded in what may be learned from what happens to individuals whose decision-making is compromised; as well as from their families and practitioners who want to protect people's rights and ensure that decisions are made in their best interests.

Contents

The Forum identified four priorities for 2023-2025. They make up the principal sections of the report:

1. The Deprivation of Liberty Safeguards

2. A Consensus Statement concerning Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

3. Partnerships and Networks

4. Questioning Education and Learning

These priorities take their cues from the Forum's membership, its webinars and their audiences and the events in which the MCA will be impactful. In addition, it takes in ways in which the law has developed over the last year; and it reflects on Coroners' recent Prevention of Future Deaths reports within a 12-month timeframe.

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2 That is, to advocate for the MCA and its principles; to provide oversight across sectors; give recognition to the ideas, interests and concerns of people whose lives are affected by the MCA; to identify priorities for action; add to an MCA implementation evidence base; and make an Annual Report on progress

Once again, case studies bridge the experiences of individuals, those of their families and the professionals seeking to implement the MCA. They are not the cases which may be found on Bath Publishing's Court of Protection Hub since they involve learning that arises from the day to day, practices of particular professionals in particular settings. As such, they provide an incomplete mosaic in which identifiable trends come into view. The expectation is that they will enable new and probing transdisciplinary conversations for professionals – and prompt new case studies. These case studies are complemented with coroners' Prevention of Future Deaths reports which reference the mental capacity of their subjects.

This report could not have been drafted without the expertise and generosity of Forum members and friends. Particular thanks are extended to:

- Lucy Series for her overview of the Deprivation of Liberty Safeguards and reforms to the Mental Health Act;
- to all contributors to the case studies, that is, Lorraine Currie, Chelle Farnan, Sarah Ellis, Gwendolen Gilchrist, Annie Ho, Fiona Hutchison, Alex Ruck Keene, Kirsty Keywood, Wayne Martin, Betsan Morris, Jessica McWilliams, Lucy Series, Martin Sexton, the Speech and Language Therapy Mental Capacity Clinical Excellence Network, Ceri Ann Tegwyn, Anna Volkmer, Claire Webster and Adam Wilkinson;
- Kirsty Keywood for collaborating in the overview of coroners' Prevention of Future Deaths reports;
- Alex Ruck Keene for his expert overview of a year in Court of Protection cases;
- Timothy Bonnici, Michael Bradfield, Zoe Brummell, Bill Charles, Rebecca Cooke, Lorraine Currie, Bethan Edwards Newport, Chelle Farnan, Claire Higgins, Annelies Hillyer-Thake, Katharine Hunt, Alex Ruck Keene, Betsey Lau-Robinson, Jon Martin, Wayne Martin, Karen McCulloch, Aurora Piergiacomi, Mark Taubert, Jenny Thompson, Ben Troke and Tom Wood for their contributions to the Consensus Statement;
- Lorraine Currie for sharing her reflective learning and "back to the basics" overview of what is essential in the DoLS process;
- Wayne Martin for his scholarship and inspiration in shaping the webinars, and his report on the Essex Autonomy Project and National Mental Capacity Forum's Webinar Series, Season 3; and
- Colleagues in the Ministry of Justice and Department of Health and Social Care for their encouragement and support.

The report outlines trends and likely topics for future inquiries.

Margaret Flynn, Chair

The Deprivation of Liberty Safeguards

By Lucy Series

A fundamental task of the state is protecting the right to liberty. Liberty Protection Safeguards (LPS) were supposed to resolve the problems faced by people deprived of their liberty in settings other than hospitals and care homes; and those experienced by 16–17-year-olds, for example.

Over a decade ago, the House of Lords Select Committee on the Mental Capacity Act declared that the MCA's deprivation of liberty safeguards (DoLS) were 'not fit for purpose' and called upon the government 'start again'.[3] The DoLS were deemed complicated, costly, and yet failed to properly protect human rights. Less than a month later, the Supreme Court's *Cheshire West*[4] judgment adopted a much broader definition of 'deprivation of liberty', which meant that many more people were found to be deprived of their liberty and in need of safeguards to protect their human rights.

In the ten years since, the number of DoLS applications has increased from under 20,000 a year to over 350,000 in 2023-24.[5] Thousands more people are deprived of their liberty in situations where the DoLS do not apply, including people in supported living, 16-17-year-olds in care, and some people living with their families. A few thousand may get safeguards through the Court of Protection[6] or the new National Deprivation of Liberty Court[7] (for children), but the majority do not. Currently those who are deprived of their liberty outside of the DoLS may not be eligible for legal aid if there are concerns or disagreements about the arrangements. Supervisory bodies simply cannot keep up with administrative and resource

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[3] HOUSE OF LORDS SELECT COMMITTEE ON THE MENTAL CAPACITY ACT 2005 2014. Mental Capacity Act 2005: post-legislative scrutiny. HL Paper 139. TSO.

[4] P v Cheshire West and Chester Council and another; P and Q v Surrey County Council [2014] UKSC 19

[5] For England: NHS Digital 2024. Mental Capacity Act 2005, Deprivation of Liberty Safeguards - 2023-24. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments/2023-24

For Wales: Care Inspectorate Wales & Health inspectorate Wales 2024. National review of the use of Deprivation of Liberty Safeguards (DoLS) in Wales 2022-23. Available at: https://www.careinspectorate.wales/national-review-use-deprivation-liberty-safeguards-dols-wales-2022-23

[6] This is under the 'Re Z' procedure for non-contested applications, but could be under s16 welfare application for a more complex or contested case. The numbers of deprivation of liberty applications are published quarterly by the MINISTRY OF JUSTICE. 2023. Family Court Statistics Quarterly: September to December 2022 [Online]. https://www.gov.uk/government/statistics/family-court-statistics-quarterly-october-to-december-2022 .

[7] For a recent overview of the law relating to children and deprivation of liberty, including 16 and 17 year olds subject to the MCA, see: LAW COMMISSION 2024. Deprivation of liberty in the context of disabled children's social care: Research Paper

demands of the current system, leading the Joint Committee on Human Rights to observe in 2018 that they were left 'having to work out how best to break the law.'[8]

Between 2014-2017 the Law Commission consulted widely on how to reform the system and developed proposals for the Liberty Protection Safeguards (LPS), which aspired to be more flexible, 'proportionate' and streamlined into the services and organisations responsible for people's care. The LPS would apply in potentially any setting where a person could be deprived of their liberty, and provide administrative procedures for 16 and 17 year olds as well.[9] The Mental Capacity (Amendment) Act 2019 legislated for an 'adjusted' version of the LPS, and the previous government opened a consultation on regulations and a new draft Code of Practice to implement these changes and bring guidance on the MCA up to date.[10]

However, the implementation of the LPS, and adoption of a new revised Code of Practice, was repeatedly postponed. The results of the consultation are still unpublished, several years after it closed. There has been no report, no decisions, no updated guidance, and no clarity for the organisations that were expending considerable resources working towards implementation of the LPS. Organisations and professionals preparing to implement the LPS were left in limbo.

In autumn 2025 the UK Supreme Court began hearing a case that could have radical implications for the future of the DoLS, potentially revisiting or even reversing some of the impacts of *Cheshire West*. The case began by the Attorney General of Northern Ireland making a 'reference' to the Supreme Court, asking whether it could revise the Northern Irish Deprivation of Liberty Safeguards Code of Practice so that people aged 16 and over who lack capacity to make decisions about their care and treatment could give a valid consent to their confinement, through the expression of their wishes and feelings.[11]

Discussion of whether people who lack mental capacity could nevertheless give a 'valid consent' was briefly considered by the Joint Committee on Human Rights[12], and has its roots in idea connected with the UN Convention on the Rights of Persons with Disabilities (CRPD) that emphasises the importance in legal recognition of a person's will and preferences. The Attorney General's proposal was supported by the Lord Advocate of Scotland and the Mental Welfare Commission for Scotland. It was opposed by the charities Mencap, Mind and the National Autistic Society, and the Official Solicitor, on the basis that this would weaken protections for people who are (objectively) deprived of their liberty. The Department of Health and Social Care in England welcomed the opportunity to revisit the

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[8] JOINT COMMITTEE ON HUMAN RIGHTS 2018. The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards. HC 890, HL paper 161. P3

[9] LAW COMMISSION 2017. Mental Capacity and Deprivation of Liberty: Summary Law Com No 372. http://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/

[10] The consultation ran from March – June 2022, and the documentation is currently available online here: https://www.gov.uk/government/consultations/changes-to-the-mca-code-of-practice-and-implementation-of-the-lps

[11] The Supreme Court has further information about the case, and written submissions of the parties, here: https://www.supremecourt.uk/cases/uksc-2025-0042

[12] Joint Committee on Human Rights 2018. Legislative Scrutiny: Mental Capacity (Amendment) Bill. Twelfth Report of Session 2017–19, HC 1662 HL PAPER 208. Available at: https://publications.parliament.uk/pa/jt201719/jtselect/jtrights/1662/166202.htm

Cheshire West acid test but argued that the person's wishes and feelings were relevant to the 'objective element', rather forming a 'valid consent'.

It is currently unclear how the Supreme Court justices will decide, and we may not have a judgment until 2026. However, the week before the hearing the Department of Health and Social Care announced that it would – in 2026 – open a fresh consultation on Liberty Protection Safeguards.[13] The nature of both deprivation of liberty and safeguards is open for discussion, once again.

Pending changes to the Mental Health Act will impact on the Mental Capacity Act

In parallel to these developments under the MCA, there have been important changes to mental health law that will have an impact on the MCA. The independent review of the Mental Health Act 1983 (MHA), chaired by Sir Simon Wessely,[14] led to a Draft Mental Health Bill in 2022[15] which was reviewed by the parliamentary Joint Committee on the Draft Mental Health Bill.[16] The incoming Labour administration introduced the Mental Health Bill [HL] 2024-25[17] based on these earlier proposals, which is (at the time of writing) in its final Parliamentary stages. Some of the important changes in this Bill will indirectly affect the Mental Capacity Act 2005 and the DoLS.

A key aim of the Wessely review was to reduce the use of detention under the MHA. The Bill partly aims to do this by raising the risk thresholds for detention under sections 2 and 3 MHA, by introducing the concept of 'serious harm'. Although Sir Simon Wessely had recommended against it, the Draft Bill and the current Parliamentary Bill enacted proposals that have long been called for by many autism and learning disability campaigners to 'remove' learning disability and autism from the MHA. Specifically, the Bill prevents people from being detained for treatment under s3 of the MHA 'on the basis of autism or learning disability'.[18] The aim is to reduce the number of longer-term detentions of people with autism and/or learning disabilities under the MHA.[19] The Bill also contains a number of further measures to improve Care, Education and Treatment Reviews, and commissioning of services, for this population.

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[13] Department of Health and Social Care, 'Press release: Improved safeguarding and protections for vulnerable people' https://www.gov.uk/government/news/improved-safeguarding-and-protections-for-vulnerable-people

[14] WESSELY, S., GILBERT, S., HEDLEY, M. & NEUBERGER, J. 2018. Modernising the Mental Health Act: Increasing choice, reducing compulsion. Final report of the Independent Review of the Mental Health Act 1983.

[15] DEPARTMENT OF HEALTH AND SOCIAL CARE & MINISTRY OF JUSTICE 2022. Draft Mental Health Bill 2022. https://www.gov.uk/government/publications/draft-mental-health-bill-2022

[16] JOINT COMMITTEE ON THE DRAFT MENTAL HEALTH BILL 2023. Draft Mental Health Bill 2022. HC 696 HL Paper 128.

[17] https://bills.parliament.uk/bills/3884

[18] Mental Health Bill 2024-25, s3 and Schedule 1. Version as amended in public Bill Committee, dated 25 June 2025 https://publications.parliament.uk/pa/bills/cbill/59-01/0272/240272.pdf

[19] It is, however, possible that people with learning disabilities and/or autism could be detained on the basis of alternative psychiatric diagnoses. They would also continue to be detainable for assessment under s2 MHA or potentially under forensic sections of the MHA.

However, by taking people 'out of scope' of the MHA, people who are not considered at risk of 'serious harm' and people with learning disabilities or autism – thereby become eligible for detention under the MCA and DoLS instead. This is because of the complex rules governing the interface between the MHA and the MCA. The MHA was designed to have 'primacy' when deciding whether to use the MCA or the MHA to authorise detention in mental health settings, because it is generally regarded as having stronger 'safeguards' – including second opinions for medical treatment without consent, a more robust Code of Practice governing restrictive practices and care planning, easier access to a tribunal, and (for people detained under s3 MHA) free after-care when discharged.[20] The interface rules state that if a person is 'in scope' of the MHA (i.e. they *could* potentially be detained under s2 or s3 MHA) *and* they are 'objecting' either to being in hospital for mental health treatment, or some aspect of their treatment, then they are *ineligible* for DoLS, and therefore only the MHA could be used to authorise their detention.[21] By taking people *out* of the scope of the MHA, therefore, they can be detained in hospital for mental health treatment under the MCA DoLS, *even if they are objecting*.

It is possible, therefore, that these changes to the MHA could mean that more people with learning disabilities and autism end up detained in psychiatric settings (e.g. Assessment and Treatment Units) under the DoLS, instead of the MHA, with weaker safeguards and loss of eligibility for free after-care. The government, and the Joint Committee on Human Rights hopes that this will not happen.[22] The government has committed to 'monitoring' the numbers of autistic people and people with learning disabilities who are detained under the MCA and reporting these numbers to Parliament within a year of these clauses of the Bill coming into force.[23]

The present published data collections do not allow us to see how many people with autism and learning disabilities are *already* detained in mental health inpatient settings under the MCA DoLS. The official statistics on DoLS ceased publishing data on disability several years ago (although it still seems to be collected[24]), and at present collapses together residential care and inpatient data for 'mental health establishments'. The NHS England Assuring Transformation dataset now requests information about whether a person is 'formally detained under the Mental Capacity Act'[25], but it does not appear to publish this data. It is uncertain what to infer from this category, since most DoLS applications may not result in 'formal' authorisation because of backlogs. The Mental Health Services Data Set (MHSDS) also holds information about the numbers of people with autism and learning disabilities in mental health inpatient settings, and gathers detailed data on use of the MHA, but yet does

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[20] DN v Northumberland Tyne and Wear NHS Foundation Trust (2011) UKUT 327 (AAC), [18].

[21] This complex rule is articulated in Schedule 1A of the MCA, and its logics are replicated in slightly different language in Part 7 of the LPS Schedule AA1.

[22] Joint Committee on Human Rights 2025. Legislative Scrutiny: Mental Health Bill. HC 601 / HL Paper 126. London: Available at: https://committees.parliament.uk/publications/47961/documents/250837/default/

[23] Ibid, paragraph 51, p18.

[24] Department of Health and Social Care, 'Guidance: Deprivation of Liberty Safeguards (DoLS) data collection: guidance for councils with adult social services responsibilities' (published 28 August 2025) https://www.gov.uk/government/publications/deprivation-of-liberty-safeguards-dols-data-collection/deprivation-of-liberty-safeguards-dols-data-collection-guidance-for-councils-with-adult-social-services-responsibilities

[25] NHS England, 'Assuring Transformation data specification' (xls file) [Last edited on 24 February 2025] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/assuring-transformation/content

not gather data on the use of MCA DoLS.[26] The Care Quality Commission does, however, hold DoLS notifications data that could be used to quantify the number of people with autism and learning disabilities in inpatient mental health settings, however this dataset is incomplete.[27] In short, our data collection systems are currently poor at monitoring *who* the MCA is applied to – particularly in terms of disability – and for monitoring *how* mental health and learning disability services are using the MCA DoLS. There is an urgent need for improved data collection here; the fresh LPS consultation offers a good opportunity to revisit this.

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[26] NHS England, 'Technical Output Specification v1.1 (Amd 37/2022)' (xls file) [Last edited: 18 September 2025] https://digital.nhs.uk/data-and-information/information-standards/governance/latest-activity/standards-and-collections/dapb0011-mental-health-services-data-set

[27] Care Quality Commission (2025) The state of health care and adult social care in England 2024/25 https://www.cqc.org.uk/publications/major-report/state-care/2024-2025 (on page 156 QC explain that they received 185,000 DoLS notifications, which is around 55% the number of DoLS applications reported to NHS Digital.

Case Studies

The following case studies have been shared by Forum members and friends. People's names and any potentially identifying details have been changed. The combination of narratives and commentaries underline the complexity of individual lives; how the MCA's principles are given effect – or not - in familiar and less than familiar scenarios; the factors to be taken into account when substantive decisions are to be made; and what might be done to help individuals to attain capacity and be supported to participate in important decisions about where and how to live their lives.

Dai Thompson was targeted by County Lines gang members who took over his home to establish a base for their drug dealing – known as cuckooing. His house was in a poor state of repair. Mr Thompson's welfare benefits were being stolen by the gang members. However, he had been duped into thinking of the gang as his 'friends.'

There was an adult safeguarding intervention and, as a result, Mr Thompson reluctantly agreed to have a short stay in a care home. This became a longer-term stay, during which time the gang members were prosecuted and imprisoned for their actions. Nonetheless, since Mr Thompson's circumstances were so transformed, it appeared that he was being punished when, in reality, he was the victim.

A Deprivation of Liberty Safeguards (DoLS) authorisation was in place in the care setting and Mr Thompson was supported to make a s21A application to the Court of Protection. He wanted to go home. The application was successful and plans were put in place for a trial at home. When he returned home, the community Deprivation of Liberty application commenced. The Court acknowledged that the risks of Mr Thompson being a victim of cuckooing once again were very real since he lacked capacity in terms of his residence, care and contact.

Some of the gang members had licence conditions on release from prison. Together, these prevented them from approaching or communicating with Mr Thompson or from entering or being within 100 yards of his home. Had these conditions been breached they would have been returned to prison.

The community DoL order was agreed. It was declared to be in Mr Thompson's best interests to return to live in his home, subject to the Care and Support Plan and the local authority's monitoring of risks. The conditions were:

- Mr Thompson must allow carers to come into his home up to three times a day to ensure that his house is clean.
- The local authority social workers must be permitted to carry out an inspection of the property when required.
- Mr Thompson must allow the security cameras installed by the local authority to remain active and to allow the local authority to monitor visitors to the property.

- No one other than Mr Thompson can stay overnight at the property except with the written permission of the local authority.
- Mr Thompson should co-operate and provide access and information to the carers, social workers and the police on request about any visitors to his home.

Whilst these restrictions might appear unduly intrusive and excessive, Mr Thompson's safety was protected and he was also enabled to live at home, which was his greatest wish. The local authority acted as Mr Thompson's Deputy and decorated his property, making it comfortable for him once again. Mr Thompson is extremely happy to be back in his own home. It was where he had lived with his parents as a child, where he had cared for his mother and where he very much wanted to spend his later years.

Commentary

This is an example of the extensive use of the MCA alongside Care Act 2014 responsibilities to ensure protection and, ultimately, the empowerment of a man who had experienced small and large brutalities in his own home. Although it may have been tempting for the short-term solution of a care home placement to become permanent, this was not what Mr Thompson wanted. The professionals working with him acknowledged that his wish to return home was unwavering. Even though Mr Thompson lacked mental capacity to understand the intentions of people who described themselves as his friends, his wishes were uppermost throughout the safeguarding intervention, the social care assessment and the subsequent Court proceedings.

It is vital that best interests decision-making recognises the ongoing autonomy interests of service users. There are a range of interventions that are proposed in the Care Plan that impinge on Mr Thompson's privacy rights and the necessity and proportionality of these must be carefully weighed in the balance. Consideration ought to be given as to whether the condition for Mr Thompson to have written permission from the local authority in relation to any visitors, and to notify the carers, social workers, and the police about any visitors are necessary and proportionate in light of Mr Thompson's Article 8 ECHR rights and under his community Deprivation of Liberty.

John Dillon was sentenced to Imprisonment for Public Protection in 2010. At the time that his tariff expired he was imprisoned in a category B prison in the north of England.

By this time Mr Dillon was showing signs of significant cognitive impairment. He was able to address his basic needs but required prompting and support from staff and other prisoners. Mr Dillon did not appreciate the nature and impact of his cognitive impairment and believed that he had been poisoned.

Mr Dillon was assessed as lacking the mental capacity to make decisions about his care and support. He also lacked the capacity to instruct a representative for the Parole Board. He was provided with a litigation friend from the local advocacy agency.

Mr Dillon's social worker assessed his needs under the Care Act and acknowledged that it was difficult to assess the full range of Mr Dillon's abilities because he had been in prison for so long. It appeared that his cognitive impairment would continue to become more severe and make it more likely than not that Mr Dillon would require a fully supported environment from the point of his release.

The social worker worked in partnership with the Probation Service and the Offender Management team supporting Mr Dillon. They were concerned that he would need support on release and that there might also be issues of public protection. Mr Dillon had been convicted of violent offences and it was not possible to say for certain how he might react to a new environment on release from prison.

The social worker helped all partners to understand the Deprivation of Liberty Safeguards and how these might provide a legal framework for some of the restrictions that might need to be imposed on Mr Dillon. For example, it might be the case that some of the restrictions in place for Mr Dillon's best interests would also protect the public. However, Mr Dillon's support plan could not include any restrictions that were purely for public protection since the DoLS authorisation could not authorise this.

The Parole Board had to consider the risks that Mr Dillon might pose to others, as well as his own needs on release. Mr Dillon had not undertaken any behaviour change work whilst in prison and was no longer able to do so.   This meant that the Probation Service had no option but to assess Mr Dillon as posing a high risk to others. However, they acknowledged that this was not fully consistent with Mr Dillon's current situation.

Even though Mr Dillon was supported to attend the Parole Board hearing represented by his litigation friend, the Chair of the Board made a particular point of wanting to hear from Mr Dillon himself.

Having heard all the evidence, the Parole Board recommended that Mr Dillon should be released to the care home that that the social worker had identified.   A DoLS authorisation was put in place within the first week of his placement. Mr Dillon's social worker is keeping his support plan under review. The DOLS team will monitor any restrictions imposed on Mr Dillon and review his DoLS authorisation if any restrictions appear to be disproportionate.

Commentary

Although Deprivation of Liberty Safeguards are lawful only to the extent that they confirm detention in the person's best interests, the law adopts a somewhat expansive approach to identifying these.   Best interests' decisions can be lawfully made when they have the ancillary effect of also protecting the public. The courts have authorised deprivations of liberty or restraints under the MCA in view of the negative impacts for P of otherwise being at risk of future offending (*DY City Council v ZZ [2012] EWCOP B34*). However, it is vital to ensure that there is a proper identification of the risks to individuals themselves – pure "public protection" lies outside the scope of DoLS. The ongoing review of best interests to ensure that there is no less restrictive alternative that is also in Mr Dillon’s best interests is key in order to ensure proportionate interference with Mr Dillon’s rights.

Mary Haslem is in her late 50s. Although she presents as an articulate woman she has been known intermittently to adult mental health services over a few years. As a young teenager Ms Haslem socialized with men who were much older than her. Ms Haslem’s mother, a single parent, had sought the assistance of Children’s Services when Ms Haslem began to drink and stay out all night. At 18 years, Ms Haslem left the locality and her mother died soon afterwards. Ms Haslem had been brought up with little contact with relatives, since her mother had been estranged from them.

When Ms Haslem inherited her mother’s home she returned to live there. A distant cousin was the executor of her mother’s will. Ms Haslem’s early adult years were characterised by alcohol dependency and some violent relationships. On a bitterly cold day before the pandemic Ms Haslem’s neighbours’ rang 999. They were troubled that Ms Haslem was incoherent after having passed out near her house. She was distressed and disoriented and appeared unaware that her clothes were wholly unsuitable for the weather. She was taken to A&E and the Emergency Duty Team was informed. Ms Haslem was diagnosed with a chest infection. Since her home was damp, had no effective heating and was in a poor state of repair, an emergency placement was identified in a care home. It was believed that she had the capacity to make this decision although it is not clear who undertook the assessment and there was no documentation. It does not appear that less restrictive options were considered. In retrospect, it is likely that a “protection imperative” prevailed.

Ms Haslem presented as an extremely anxious woman who had seemed bewildered by her disorganised circumstances and the events that led to her hospitalisation. She has a diagnosed mental health condition and had been detained under s3 of the MHA on at least two occasions. As a result, the cousin encouraged Ms Haslem to consider a Lasting Power of Attorney so that decisions could be made about her property and affairs. This was duly registered with the Office of the Public Guardian.

Although a Deprivation of Liberty Safeguards referral was not made on Ms Haslem’s admission to the care home, the outcome of a poorly documented best interests meeting (to which her cousin was not invited), was inconclusive. It subsequently emerged that Ms Haslem’s cousin had sold her home. Ms Haslem did not appear to understand this. She became less communicative and more compliant with the care home’s customs and practices. There were still occasions when she asserted that she wanted to go home but these became less frequent. The professionals who were alerted to - in their view - the premature house sale, reflected that the cousin should have involved others but had probably acted from an instinct to protect Ms Haslem.

Commentary

Although an attorney is constrained by the legal framework of the MCA, and Ms Haslem's cousin may have believed that she was acting in Ms Haslem's best interests, there was no discussion about the scope of the LPA, for example. Section 4 of the Act makes clear the importance of collaboration in making a best interests decision and it is difficult to fathom how a best interests' decision about Ms Haslem's future accommodation and financial interests could lawfully have been reached without consulting Ms Haslem's care team or indeed Ms Haslem. If Ms Haslem is indeed deprived of her liberty, her ongoing detention is without legal foundation unless and until a DoLS authorisation has been sought and granted. If she retains capacity to do so, Ms Haslem may also revoke the lasting power of attorney she has created. If Ms Haslem lacks capacity, however, there is a possibility that the Court of Protection could revoke it if the attorney has not acted in Ms Haslem's best interests.

Leo Joseph is 38 and has resided in a care home for around 15 years. Mr Joseph has Lennox Gastaut Syndrome, a severe form of epilepsy, and he was experiencing an increase in his seizure activity and recovery time. In turn, this contributed to an increase in agitated and physical outbursts directed at other residents. His mother is a single parent and although she lives around 50 miles from the care home, she visited once a week and called the care home every other day to speak to her son.

As a social worker, I was asked to review his care plan to look at whether his needs had increased. During the process of getting to know him, I contacted his mother. She was wary of adult social care, having had poor experiences in the past. This included times when her knowledge of her son and what brings out the best in him was disregarded. She was aware and concerned that her son was having more frequent outbursts. In her view, he would not cope well with moving to another service and she was nervous and troubled at this prospect.

In getting to know something of Mr Joseph's communication needs, I learned about the days when he is more alert and days that he is not. I came to an understanding of what made him happy and the causes of some of his frustrations. It was clear that Mr Joseph was very sensitive to noise levels, yet he lived in a busy home with peers who could be very noisy.

Mr Joseph's need for quiet became the focus of my discussions with his mother. We talked about the likelihood of other homes being able to support his complex epilepsy and ensure his need to be in a quieter place. Also, I talked about mental capacity and shared information about what a mental capacity assessment involved. A visit to Mr Joseph's mother at her home helped me understand how things were when they lived together as well as the kinds of decisions Mr Joseph was able to make for himself. For example, he would not tolerate hot food, preferring to wait and eat food that had cooled.

Finally, it became possible to talk about Mr Joseph's options with his mother. I explained that I had assessed Mr Joseph as lacking capacity to make a decision to leave his care home and, separately, to confirm where he wanted to live. We discussed the merits of a small number of other care homes and she undertook to visit these places before we made a best interests' decision. Mr Joseph eventually moved, having tolerated and then enjoyed some introductory visits. He has since settled extremely well, his agitation has diminished and his mother's visits have increased because Mr Joseph's new home is closer to her.

Commentary
Mr Joseph's circumstances underline the significance of our relationships. His social worker foregrounded the MCA principle: An act done, or decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made in his best interests (s1(5)). Discussions with Mr Joseph's mother and support staff confirmed that it was unlikely that Mr Joseph would acquire the capacity to make a decision about his accommodation needs but that efforts to assess capacity should nevertheless be attempted and at times and in circumstances where Mr Joseph was most alert. It was appropriate to consult with Mr Joseph's mother because of her experiential knowledge of supporting Mr Joseph. Although Mr Joseph's behaviour in his care home might have been seen by some as 'challenging' and therefore warranting greater restrictions, the social worker in fact got to the bottom of what was causing his increased agitation and was able to ensure there was no need for such restrictions.

At the beginning of **Bettina Acuto**'s career she was known as a "high achiever, an inspiration to young women of colour." Aside from a brief period as a young teenager when she appeared to go off the rails, she became sufficiently focused to do well at school and was ambitious for herself. She did not appear to have had much encouragement from her family. At least two of her siblings became known to the police. Ms Acuto attributed her school success to a teacher who encouraged her to read and become involved in music and drama.

Ms Acuto was excited to be accepted at a prestigious university. She rarely went home, opting instead to work and study at the university at the end of the terms and during the summer holidays. She studied hard and secured a good degree. Although Ms Acuto did not have close friendships she began a relationship with a man in her year which survived beyond university. Neither had had prior relationships.

Ms Acuto worked full-time for the Civil Service after university. Her relationship came to an end when she became pregnant. Ms Acuto withdrew and isolated herself after the birth of her child and barely acknowledged the congratulatory cards and messages she received from work colleagues. When she developed physical health problems, she did not want any tests to establish the cause, and to her GP it appeared that her mental health deteriorated. Ms Acuto resisted a diagnosis of post-natal depression and refused to have further contact with the medical practice. At the end of her maternity leave she left work and began to live on her savings. The nurse who continued to check on her baby reported that Ms Acuto appeared to lose all sense of personal control, ambition and self-esteem. Mental health and social care professionals became involved once her neighbours were alerted to her increasingly self-neglecting behaviours. Initially, since her baby's development did not appear to be at risk, professionals believed that she had made some "unwise decisions" but had the mental capacity to decide how she lived. There was no documented mental capacity assessment in relation to this decision. Very soon it became clear that Ms Acuto's baby ceased to thrive and when she emphatically refused to cooperate with the midwife, the baby was removed.

Professionals speculated that Ms Acuto was bereaved and shamed by her partner's desertion. She stayed within the confines of her bedroom and completely disengaged from services. She refused to allow access to her home and ceased to respond to phone calls. When she was eventually hospitalised under section 3 MHA (1983), her self-neglect had resulted in irreversible physical health challenges.

Commentary

Ms Acuto's circumstances illustrate the importance of prompt assessments and early intervention to prevent further deterioration. That the law recognises that a person is 'allowed' to make 'unwise' decisions where the person has capacity to do so. An unwise decision does not obviate professionals' responsibility to assess capacity (Re JB [2021] UKSC 52). Failing to do so may itself be an infringement on a person's human rights, especially if it leaves them at risk of inhuman or degrading treatment, or there is a risk to their life. This situation also shows the importance of information sharing between agencies. In this case, the health professionals involved with Ms Acuto such as her GP practice or nurse could have made an earlier safeguarding referral to the local authority if they were concerned that Ms Acuto was not engaging or if they had concerns for the welfare of her child. Although the MCA does not accommodate separate consideration of the best interests of the infant prior to birth, a raft of child protection responsibilities were engaged once Ms Acuto gave birth.

At 60 years old, **Mr Samuel James** was transferred to a stroke rehabilitation ward. This followed a left middle cerebral artery infarct resulting in weakness to the right side of his body. He had a history of frontoparietal and occipital lobe infarcts – associated with disorientation, loss of coordination, and problems with his sight. In addition, Mr James had type 2 diabetes and was known to be depressed. He was independent before his stroke, having previously lived alone in a flat. His friends reported that he had become depressed following a recent bereavement and they were concerned that he wasn't 'taking care' of himself. They expressed concerns about his ability to decide on his discharge destination.

Mr James's stroke resulted in a moderate fluent aphasia, a language impairment, with difficulties understanding auditory information, word finding difficulties and the production of jargon. His significant visual impairment was exacerbated by pre-existing cataracts. He was fully mobile and able to complete self-care tasks with prompting from another person.

In our speech and language therapy sessions, he relied heavily on auditory and tactile cues which was difficult at times due to his aphasia. He was able to communicate and express himself using supportive communication strategies. That is, he was given time to process information and respond and spoken information was simplified.

Mr James's main priority was to return to his flat. However, the multidisciplinary rehabilitation team expressed concern about his ability to access help and manage tasks such as self-care and shopping. When the time came for discharge planning, a mental capacity assessment was completed. Mr James demonstrated his capacity to decide on his discharge destination and he decided to return home. He demonstrated an understanding of the possible risks and agreed that care support could minimise these risks.

Following Mr James's decision, the speech and language therapist worked closely with the occupational therapist, psychologist and social worker and arranged twice Mr daily care visits. The Red Cross delivered Mr James's shopping and referrals were made to the Stroke Association and a local charity for people with visual impairment. Some members of the team believed that a return home would constitute an unsafe discharge and questioned the assessment of Mr James's capacity to decide where he wanted to live. One person stated that he "could not possibly go home" because of his aphasia.

Colleagues were reassured that all practicable steps had been taken to ensure Mr James was supported during this assessment. These included the speech and language therapist co-working with the social worker. The assessment was undertaken in a private, quiet room with no background noise or distraction. In addition, total communication resources such as large images and single word text/choices (in the light of Mr James's visual difficulties) were used; auditory information was simplified and repeated. Prior to the assessment, Mr James visited his property with several team members and photos were taken to add context to the mental capacity assessment. Mr James was also able to access emotional support from his close friend throughout the assessment process. Time was taken prior to the mental capacity assessment to establish ways of communicating that worked best for Mr James. Supporting his understanding and expression were prioritised by the speech and language therapist and the social worker.

Commentary

This is an excellent example of professionals seeing a person's seemingly unwise decision and using this as an opportunity to explore whether Mr James had the capacity to make that decision. In this respect, it contrasts with the professional approach in Ms Acuto's case earlier where the unwise decision was not looked at more closely. The aids put in place to support Mr James during the capacity assessment were clearly important to help him participate as fully as possible, and to therefore ensure that the professionals assessing his capacity got an accurate a picture as possible as to his ability to make the decision. Wales' Social Services and Well-being assessment duties were engaged.

Hannah Hurst's family was a source of pride. Her and Bill's adult children had left home and two of the three had started their own families. A son and his family lived abroad, another lived with his young family several hours' drive away and their daughter lived close to her brother.

The milestone of Mr Hurst's early retirement heralded a new phase in their lives. Their plans included adaptations to their home, holidays with family and friends and learning a language. Ms Hurst was shocked when he said he was going to see the doctor. Eventually, CT scans revealed inoperable tumours. Palliative care was not in their plans.

Mr Hurst seemed to acquire a deeper appreciation of his life and welcomed visits from the family, his friends and former colleagues. He would tell people that he was glad of the advance notice because he was able to tell his family how much they meant to him. Ms Hurst was less buoyed by the support offered by friends and family.

Ms Hurst was 48 when her husband died. She was not consoled by the conversations with him that his illness made possible or by the promise of family visits and continued contact with friends. Over time her adult children noticed a reluctance to spend time with them and her grandchildren. She explained that she was getting old and no longer had the energy or ambition for travelling. However, she always asked about their health. It was as if she feared that they too may become ill. She explained that it wasn't just her husband who developed cancer, there were other relatives on both sides of the family who had developed terminal illnesses.

Spending time with Ms Hurst became difficult for her friends. She was listless, became indifferent to her appearance and the state of her home and she began to catastrophize events. From being the principal planner in her family, Ms Hurst had no plans. The loyalty of friends was tested over the three years following her husband's death. One life-long friend offered to accompany her to see her doctor but she became angry and asked the friend not to visit again. This friend, who had been in contact with Ms Hurst's children, advised that Ms Hurst required professional help. During hurried visits, her children made contact with health and social care professionals. Together they discussed the uneven course of people's grief and were not especially engaged by growing evidence of Ms Hurst's self-neglect. Ms Hurst stated that she would refuse entry to social workers and safeguarding practitioners and emphatically refused to be assessed for home care support. To the anguish of her children, Ms Hurst's right to private and family life was respected. It was believed that her decision to live in increasing squalor was "informed," albeit without an assessment of her mental capacity.

Ms Hurst's death four years after her husband's was shocking for her family. She had not left her home for an estimated period of six months. A post-mortem examination revealed that Ms Hurst was severely malnourished and dehydrated.

Commentary

Ms Hurst's circumstances profile the challenges that arise when mental capacity and adult safeguarding law intersect. Whilst people with capacity are free to decline the contact and support of friends, family and professionals, there is considerable importance in continuing to engage with a reluctant person. Ms Hurst's refusal to engage may not, in fact, have been capacitous and/or may have been the result of a mental health condition for which Mental Health Act admission might have been an option. Unless someone makes a legally valid, advance refusal of medical treatment under the MCA, their present refusal should not be treated as applying to future decisions. The adult safeguarding duty to make enquiries to determine if a person is at risk of abuse or (self-)neglect does not depend on whether a person has capacity to refuse to participate in that safeguarding enquiry; is an ongoing responsibility and operates alongside mental capacity law. There would also have been a need to assess Ms Hurst's needs under the Care Act 2014 here. Even if she had refused an assessment, section 11 would require the local authority to still assess these needs if professionals believed she lacked capacity to refuse or if she was experiencing abuse or neglect, including self-neglect. The person's capacity to decide to engage in the making of the enquiries and /or to accept any interventions proposed is very relevant at the stage of working out how to discharge the duty. It is not relevant to the question of whether or not the duty to investigate is engaged.

Concluding reflections

These case studies are real and of such a familiar type that they are likely to bring to mind people whose circumstances are similar. There is a persistent danger that treatment and support will be imposed on unwilling and uncooperative individuals, most particularly if there is no one to recall and describe their "past and present wishes." Adults with learning disabilities, in particular, may be disadvantaged because there may be no reliable, documented account of their wishes before they were deemed to have lost the capacity to make certain decisions. The case studies encompass practical experience and insight into mental capacity practice.

Coroners, Prevention of Future Deaths Reports and Mental Capacity Concerns

by Kirsty Keywood and Margaret Flynn

Introduction

This section considers the role of Coroners, the Prevention of Future Deaths Reports (PFD) and questions surrounding mental capacity.

Coroners' PFD reports are issued under the Coroners and Justice Act 2009[28] and the Coroners (Investigations) Regulations 2013.[29] PFD reports are publicly available via the Coroners Tribunals and Judiciary website. The reports recommend future action but do not specify the action to be taken. The recipient of a PFD report must respond in writing within 56 days from the date the report was sent. The response of individuals, organisations, local authorities, government departments and their agencies must set out the corrective actions proposed and their timetable, or the reasons why no action will be taken. PDF reports have been collated since 2008. During 2013, the Chief Coroner noted:

> …mental health-related deaths and deaths in custody feature prominently. A number of reports focus on communication issues particularly between different agencies and departments within hospitals and the importance of training for staff responsible for caring for patients at risk of self-harm. Reports across all categories of deaths identify communication and the lack of procedures and protocols or the failure to follow them as major concerns.[30]

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[28] 7(1) Where—

(a) a senior coroner has been conducting an investigation under this Part into a person's death,

(b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and

(c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have power to take such action.

(2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it.

(3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner.

[29] These set out the procedures that apply to Prevention of Future Deaths' reports and responses.

[30] Chief Coroner (2013) Summary of Reports to Prevent Future Deaths (formerly Rule 43 Reports) First Report 1 April 2013-30 September 2013, Chief Coroners' Office.

According to the Preventable Deaths Tracker,[31] between 2013 and 2023, 4763 PFD reports were published. Necessarily, the majority of PFD reports are situation- and organisation- specific, although a few have wider implications of relevance to mental capacity.[32]

This section considers the 17 PFD reports which were published between January 2023 and April 2024, in which coroners cited the deceased person's mental capacity. This exercise underlines the limited understanding of the Mental Capacity Act 2005 across sectors, professionals and organisations. It is important to note, however, that although coroners cited the mental capacity of the people whose deaths were the focus inquests, references to mental capacity issues in the recommendations are scant. There are three principal findings concerning mental capacity:

- Inattention to the perspectives and potential input of family members and informal caregivers is evident in a number of the PFD reports issued
- Inadequate or entirely absent capacity assessments; and
- Inadequate investigations resulting from a death and/or evidence of learning as a result of these.

These findings are elaborated below, following an overview of the 17 people whose deaths are the focus of this section.

Mohammed Akramuzzaman[33]

Mr Akramuzzaman died of hypothermia and alcohol related ketoacidosis. A member of public had raised concerns about his health. He was at a railway station. British Transport Police attended promptly and asked if Mr Akramuzzaman wanted to go to hospital. The

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[31] Learning from Prevention of Future Deaths reports - Patient Safety Learning (accessed 6 September 2024).

[32] There are caveats: in 2023, there were 581,363 deaths recorded in England and Wales.32 This statistic arises from the legal requirement to certify and register deaths within five days of a death occurring. If there is reasonable cause to suspect that a person has died: a violent or unnatural death; a sudden death of which the cause is unknown; in a prison, police custody or other type of state detention e.g. under the Mental Health Act 1983, or in an immigration removal centre, then the coroner is required to hold an inquest. Around half of all deaths in England and Wales are referred to coroners. If a doctor is able to provide a Medical Certificate of Cause of Death which allows a death to be registered, a coroner may take no action. Accordingly, the number of inquests opened in 2023 was 36,855 – a fraction of the number of deaths recorded. There is no provision for legal aid for representation at an inquest. The asymmetry of numerous barristers representing commercial interests and a service's reputation, for example, in contrast to a frequently unrepresented, bereaved family is stark. Not all coroners make specific PFD recommendations, leaving individual organisations to determine what actions may be taken. Finally, although the coroner has the power to report the circumstances of a case to the appropriate authority with a view to remedial action being taken to avoid or reduce the likelihood of future fatalities, there is no follow-up. Further, since there is no requirement on appropriate authorities to take any action at all, there are no specific legal consequences for failing to do so, although such failings might give rise to human rights breaches. See, e.g. https://www.theguardian.com/commentisfree/2024/oct/08/the-guardian-view-on-the-coroners-role-if-deaths-can-be-prevented-they-should-be (accessed 9 October 2024)

[33] https://www.judiciary.uk/prevention-of-future-death-reports/mohammed-akramuzzaman-prevention-of-future-deaths-report/

officers left Mr Akramuzzaman after he had simply nodded that he was alright and shaken his head that he did not want medical treatment. They never actually heard him speak. They did not attempt to see if he could stand. This was an unsatisfactory capacity determination as the coroner noted:

> "I appreciate that if Mr Akramuzzaman had mental capacity then he could not be forced to go to hospital, but it is difficult to see how he could have been assessed properly following just a nod and a shake of the head". Medical care and a warmer environment would probably have averted death. One officer attending formed the view that this was a drug 'comedown' which other officers didn't question or evaluate. The coroner cited defensive conduct during inquest: "I was told that the BTP officers had reflected a lot about this incident in the time since, and had learnt a lot. However, when giving their evidence they struck me as defensive, and they were unable to point to any specific learning or any changes in their procedures following Mr Akramuzzaman's death...Whilst I readily accepted that the officers had talked about Mr Akramuzzaman since his death, I did not gain the impression of a culture of learning."

Regina Ademiluyi[34]

Ms Ademiluyi, aged, 82, had multiple health needs and a diagnosis of vascular dementia. Her day to day to care had been provided by the local authority but Ms Ademiluyi's daughter assumed responsibility for commissioning this by way of direct payments. It emerged that no care was provided to Ms Ademiluyi following that change. Her health deteriorated, resulting in malnutrition, grade four pressure sores and ultimately her death. The inquest found that the Local Authority and health professionals did not act appropriately in identifying and reporting safeguarding concerns and there was no attempt to assess her mental capacity. In consequence, it was not clear on what legal basis Ms Ademiluyi's daughter was given control over the direct payments and care provision by the local authority had ceased.

Christopher Sidle[35]

Mr Sidle had a diagnosis of schizophrenia. He died from head injuries incurred when he jumped out of a moving taxi. During his most recent episode of psychosis, Mr Sidle's engagement was sporadic and his condition deteriorating. Despite this, he was not considered suitable for inpatient admission or continued support from the Home Treatment Team. It was noted by the Coroner that:

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[34] https://www.judiciary.uk/prevention-of-future-death-reports/regina-ademiluyi-prevention-of-future-deaths-report/

[35] https://www.judiciary.uk/prevention-of-future-death-reports/christopher-sidle-prevention-of-future-deaths-report/

> “There remains a lack of understanding with regard to assessing a person’s mental capacity to make decisions and to fully and properly record the rationale for making decisions."

Patrick Soames[36]

In the last month of his life, Mr Soames experienced a profound deterioration in his mental state, resulting in multiple episodes of self-harm followed by presentation at Accident and Emergency. It is reported that he declined to engage with psychiatric services and had capacity to do so. Fragmented service responses prevented the sharing of information to build a clearer picture of risk:

> “Five NHS Trusts and three police forces in different geographic areas had contact with Patrick in the final month of his life and each thereby gained some information about the risk to him. However, that information was by reason of the agencies falling into different geographic areas. There was no single effective global focus for the information being acquired piecemeal about Patrick’s pattern of serious self-harming behaviour. The various agencies were significantly impeded in forming a single clear picture of Patrick’s pattern of behaviour (which was particularly necessary in circumstances where he was not engaging and therefore not assisting in providing a complete history himself)."

Christopher Smith[37]

Mr Smith was in prison and had a diagnosis of schizo-affective disorder. His health deteriorated substantially over seven days and it is reported that he was refusing medication for his mental health condition. No mental capacity assessment was undertaken to determine the basis for Mr Smith’s treatment refusal. Clinical observations of his health were undertaken through a hatch and not through direct observation and examination in his cell. Mr Smith was diagnosed with Neuroleptic Malignant Syndrome (NMS) when he was eventually admitted to hospital. He died as a result of a deep vein thrombosis embolism brought about by NMS. The coroner noted that

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[36] https://www.judiciary.uk/prevention-of-future-death-reports/patrick-soames-prevention-of-future-deaths-report/

[37] https://www.judiciary.uk/prevention-of-future-death-reports/christopher-smith-prevention-of-future-deaths-report/

> "accounts detailing Christopher's decline over the course of a week; from a young, fit, engaging and polite gentleman, to a man who could not speak, eat, or properly stand, were harrowing for all to hear, not least his family. These accounts were supported by CCTV footage demonstrating Christopher's extreme vulnerability on account of his acute ill health. I remain unable to comprehend how, in the face of Christopher's clear need for urgent medical assistance, this was not facilitated for him by those charged with the responsibility for his care, at a time when Christopher was unable through illness to ask for help. This was a clear case of the most serious neglect contributing to Christopher' tragic death."

Three key issues were raised in the PFD report: a failure to provide clinically safe care in the prison; a failure of the NHS Trust to supply information to the coroner in a timely manner; and a lack of candour in responding to deaths. On this latter point, it was noted by the coroner:

> "without exception, each witness from the healthcare trust accepted some level of failing in the care they provided to Christopher. Yet none of the witness statements submitted in advance of the inquest contained any such reflection of what went wrong or what should have happened. Despite a Direction from the court that the Head of Healthcare was to submit a statement "nailing colours to the mast" as to what the genuine issues of care were i.e. what policies were in place at the material time and whether care had departed from those policies, a candid statement satisfying this Direction was not forthcoming. This left the Coroner and the other Interested Persons, especially Christopher's family, at a distinct disadvantage in identifying the actual issues, because of an overwhelming unwillingness to act in an open and honest manner, contrary to the expectations of a state agency when engaging in an inquest. If staff are either unwilling, or are not given the opportunity, to reflect on what went wrong in an open and honest manner, then the Trust cannot seek to learn from events at the earliest opportunity, and these issues of concern will persist, leading to further deaths."

Shirley Ashelford[38]

Ms Ashelford had a diagnosis of multiple sclerosis and used a hoist to get in and out of bed. She had previously reported problems to the local authority relating to the hoist getting stuck and leaving her suspended. Ms Ashelford died by asphyxiation when her breathing was cut off by the hoist. She had been assessed and was found to have mental capacity to decline assistance with using the hoist. Concern was expressed in the PFD that there may be a lack of information shared with Ms Ashelford, her family, the local

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[38] https://www.judiciary.uk/prevention-of-future-death-reports/shirley-ashelford-prevention-of-future-deaths-report/

authority and the occupational therapy team about the risk of positional asphyxia and ways in which this may be mitigated.

Bency Joseph[39]

Ms Joseph died from a traumatic head injury, resulting from her jumping out of her window at home. Ms Joseph presented at Accident and Emergency with severe psychotic symptoms. She had no prior mental health diagnosis or symptoms. Ms Joseph had been given one sub-therapeutic dose of lorazepam given a MHA assessment and discharged with a referral to the Home Treatment Team. She was considered not to have the capacity to form a decision to take her own life and was discharged pending review by the Home Treatment Team. Requests to prescribe emergency medication by the Home Treatment Team and by her family were unheeded.

Floyd Carruthers[40]

Mr Carruthers was serving a sentence of imprisonment at the time of his death. He had a diagnosis of paranoid schizophrenia and was also fitted with a pacemaker. Details of initial admission and identification of the pacemaker did not result in the expected assessment of that device. An extremely cursory mental health assessment was undertaken through the prison door - lasting one minute. Mr Carruthers declined health input and the nurse deemed that he had capacity to refuse. In the final few days of his life, Mr Carruthers stopped leaving his room. Eventually, an alert was raised and he was taken to hospital where he was diagnosed with sepsis. The coroner stated:

> "My concern is that while there is a national policy dealing with safeguarding to include instances of self-neglect, no adequate training exists at either national or local level to ensure the effective implementation of that policy… my concern is that the existing safeguarding escalation process is either inadequate, inappropriately trained or both."

The importance of assessing capacity when ‘respecting’ decisions to refuse care is well-documented, yet there is no specific reference to this in the response to the PFD report by the Governor at HMP Birmingham.

Carole Mather[41]

Ms Mather, age 66, died as a result of hypothermia. She had history of poor mental health and alcohol dependency. She discharged herself from hospital against medical advice. The doctor who assessed Ms Mather as having the mental capacity to make this decision

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[39] https://www.judiciary.uk/prevention-of-future-death-reports/bency-joseph-prevention-of-future-deaths-report/

[40] https://www.judiciary.uk/prevention-of-future-death-reports/floyd-carruthers-prevention-of-future-deaths-report/

[41] https://www.judiciary.uk/wp-content/uploads/2024/04/Carole-Mather-Prevention-of-future-deaths-report-2024-0190_Published.pdf

was unaware of her mental health history. There was no referral to on-call psychiatry. The coroner highlighted the challenges of assessing the mental capacity of people who are chronically dependent on alcohol, especially when their executive capacity is compromised. The lack of "overarching guidance…which specifically addresses the application of legal frameworks" to alcohol dependence was also noted.

In response, the Department of Health and Social Care noted:

> "…Generally speaking, if a person has mental capacity to make a decision to discharge themselves from hospital, their decision must be respected.
>
> If a patient was found to not have the mental capacity to discharge themselves, and they are or will be deprived of their liberty, then the hospital may need to consider whether to use the Deprivation of Liberty Safeguards (DoLS), under the Mental Capacity Act 2005. The DoLS can authorise the deprivation of liberty of a person being accommodated in a hospital or care home for the purpose of providing care or treatment. Any such restrictions placed on a person in these circumstances must be in their best interests and necessary and proportionate. Decision makers should therefore make full consideration as to whether less restrictive options, such as appropriate support packages, can be implemented in place of DoLS authorisation.
>
> You also raised concerns about the lack of guidance that is available for health and social care practitioners to address the application of legal frameworks to protect patients with a chronic dependence on alcohol. All bodies with legal duties under the MCA's Deprivation of Liberty Safeguards must continue to operate these safeguards to ensure the rights of people without the relevant mental capacity are protected. Practitioners are required to stay up-to-date with the relevant case law." [3 June 2024]

Aaron Deeley[42]

Mr Deeley's death at 43 was attributed to *"suicide contributed to by neglect"* while in hospital for physical treatment and awaiting a Mental Health Act assessment. He had made several previous suicide attempts. Mr Deeley had no access to mental health professionals at the hospital and there was some confusion concerning the one-to-one observations of a person awaiting a Mental Health Act assessment who was also subject to a DoLS authorisation. His discharge paperwork was sent to the wrong GP address. The coroner noted:

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[42] https://www.judiciary.uk/prevention-of-future-death-reports/aaron-deeley-prevention-of-future-deaths-report/

> “a lacuna for patients awaiting Mental Health Act assessment and requiring simultaneous physical healthcare when a significant risk has been identified such that a patient may require detention for their own safety.”

Elvon Morton[43]

Mr Morton, age 38, experienced extensive co-morbidity with kidney disease, obesity and angina. He had presented at hospital four times in four years with pain from gall stones. When Mr Morton called 999 he was taken to hospital and treatment began. However, when he took steps to self-discharge it was decided he did not have the capacity to do so. Mr Morton was sedated to facilitate a scan and further treatment. He died from a heart attack, occasioned in part by the administered sedation. The inquest found that the associated documentation relating to mental capacity and medical treatment was poor/ non-existent. Some clinicians were unaware that he had declined treatment. *“The decision to sedate was flawed.”* Additionally, there was no *“evidence of investigation, reflection and remediation…”*

Donna Levy[44]

Ms Levy, age 51, was housebound. Her infected pressure ulcers were attributed to self-neglect. She was incontinent, had oedematous lower limbs, cellulitis, and long, infected toenails. Ms Levy had been provided with domiciliary care twice daily. She declined personal care and her health deteriorated. No action was taken by the District Nurses, Community Matron or GP, bar the submission of “safeguarding reports.” Prior to her hospital admission, Ms Levy “was believed to have capacity” but no assessment was undertaken or considered. She was not referred to mental health services, and no Trust investigation resulted. She died from sepsis.

Jake Baker[45]

Mr Baker, age 19, had a learning disability and type 1 diabetes. He had not been trained to manage his diabetes independently. Since Mr Baker did not live with his family, his relatives did not know when to seek emergency medical assistance. Further, there was no risk assessment concerning unsupported contact with his family. When he turned 18, Mr Baker’s personal advisor’s Pathway Plan did not seek support from the diabetes service; he did not have the support of an adult social work team; and there were un-minuted

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[43] https://www.judiciary.uk/prevention-of-future-death-reports/elvon-morton-prevention-of-future-deaths-report/

[44] https://www.judiciary.uk/prevention-of-future-death-reports/donna-levy-prevention-of-future-deaths-report/

[45] https://www.judiciary.uk/prevention-of-future-death-reports/jake-baker-prevention-of-future-deaths-report/

meetings. He died as a result of complications resulting from inadequate management of hyperglycaemia. It was noted that *“No capacity assessment was undertaken in relation to Jake’s ability to make a decision to go home unsupported.”*

The coroner expressed concern that:

> “Mental Capacity Act training is not mandatory in children’s services, and the adult services have no audit of the effectiveness of the mandatory training provided and how it is being used in practice. There is therefore a risk that erroneous assumptions as to capacity will continue to be made.”

Elsie Leaver[46]

Ms Leaver’s death at 89 resulted from suicide by overdose, contributed to by neglect. She had an *“extensive psychiatric history complicated by overdose and suicidality.”* Ms Leaver was deemed to have *“reduced mental capacity”* during her most recent hospital admission. Her bag was not searched at the point of transfer to another hospital or when she arrived there. Ms Leaver’s family notified nursing staff of her suicidality, and yet a clinician sought no advice from psychiatric liaison. It was when Ms Leaver threatened to self-discharge that her psychiatric history was sought. She took an overdose at the hospital. The Coroner noted that there had been no holistic assessment or inquiry with relatives and no self-harm risk assessment. It was noted that a search for medication *“could have been undertaken even against her permission when she had reduced capacity in her best interests.”*

Mohammed Elaboudy[47]

At age 34, Mr Elaboudy died by suicide. It was noted that *“his mental state and capacity to form an intention are unclear.”* He had a diagnosis of paranoid schizophrenia and had multiple in-patient stays in the UK and overseas. He had made previous attempts to take his own life. Mr Elaboudy had declined to take his anti-psychotic medication. Despite multiple relapses and suicide attempts, Mr Elaboudy had no face-to-face appointments. There was no documented rationale for this arrangement. There was no route for Mr Elaboudy’s family to report concerns, care coordination was absent and the frequency/thresholds for MDT discussions were questioned.

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[46] https://www.judiciary.uk/prevention-of-future-death-reports/elsie-leaver-prevention-of-future-deaths-report/

[47] https://www.judiciary.uk/prevention-of-future-death-reports/mohamed-ellaboudy-prevention-of-future-deaths-report/

Kenneth Ripon[48]

Mr Ripon, age 47, died following a fall at a railway station. He had a history of mental health challenges, including self-harm and command auditory hallucinations. Mr Ripon's family actively sought professional help. He was admitted to hospital on three occasions during mental health crises. Although Mr Ripon had felt unsafe at home he was discharged without an assessment or contact with his family. It emerged that incomplete information had been available to the clinicians. There were failings in clinical record keeping, lack of comprehensive mental state examination including his mental capacity, and lack of family involvement.

It is the deaths of these 17 adults, which is set out in primary source material, that we elaborate on the principal findings cited earlier.

1. The inattention to the perspectives and potential input of family members and informal caregivers is evident in a number of the PFD reports issued. Their perspectives are valuable for a number of reasons: they may shed light on a person's decision-making capacity, such that a capacity assessment ought to be completed; offer important information that may inform the sorts of interventions that might be most appropriate if the person is found to lack capacity; and communicate changes in cognitive functioning or wellbeing that might require reconsideration of capacity and best interests. In a number of PFD reports, it is clear that vital 'warning signs' around mental capacity or a patient's declining health status noted by families were not attended to by services. For example, **Elsie Leaver**'s family alerted staff to her suicidality to no effect; **Mohammed Elaboudy**'s family did not know where to report their concerns; and family's efforts to secure help for **Kenneth Ripon** were unattended. The case of **Regina Ademiluyi** reminds us, however, that not all family influence is beneficial. The potential for family to make highly damaging decisions concerning a person's care must not be overlooked.

2. In a number of the PFD reports issued, capacity assessments were inadequate or completely absent. Critical decisions by professionals appear to be poorly documented, if they are minuted at all. Many did not benefit from capacity assessments and in one case, services had not received training in the use of the Mental Capacity Act 2005. In most of the cases triggering a PFD Report, capacity to refuse care and treatment was presumed, even in the face of people's circumstances being potentially harmful and, in some circumstances, exceptionally bleak. In one case, incapacity seemed to be presumed from the person's non-compliance with assessment and treatment. It is at best unclear and at worst highly doubtful that credible assessments had established whether **Mohammed Akramuzzaman**, **Floyd**

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[48] https://www.judiciary.uk/prevention-of-future-death-reports/kenneth-rippon-prevention-of-future-deaths-report/

Carruthers, **Elsie Leaver**, **Mohammed Elaboudy** and **Kenneth Ripon** had the mental capacity to refuse care or to take their own lives. Whilst the Mental Capacity Act 2005 starts with a presumption of capacity, it is imperative that questions are asked about the legality of a person's choice-making, particularly where an apparent refusal of care may result in harm to the person or their death. Such decisions call into question the responsibility of state agencies to safeguard the right to life and the right to protection from inhuman or degrading treatment. Whilst neither of these are absolute and neither triumphs over a person's choice in all situations, the state has a positive obligation under the Human Rights Act 1998 to attend to the needs of those whose decision-making abilities may be limited by impaired cognitive functioning. For example, **Jake Baker** ought not to have been allowed home without an assessment of his mental capacity and the offer of training in diabetes management for him and his family. Relatedly, there is limited recognition of the actions that ought to follow a determination of (in)capacity or best interests. In some instances, much less restrictive and traumatic interventions ought to have been contemplated in a best interests' assessment (e.g. **Elvon Morton).** Arguably a DoLS authorisation could have been considered for **Carole Mather** and a Community DoL for **Donna Levy**, resulting in a robust appraisal of their incapacity and best interests.

3. There are in many cases inadequate investigations resulting from a death and/or evidence of learning as a result of these (e.g. **Elvon Morton**). In the case of **Mohammed Akramuzzaman** and **Christopher Smith**, there is concern that at the time of the inquest, there had been little evidence of learning from the fatal events. In the case of **Christopher Sidle**, there is a mismatch between the evidence presented to the investigation and that presented at the inquest. In the case of **Bency Joseph** the Trust's internal investigation did not involve the family, which had important insights into Mr Joseph's circumstances. It is particularly alarming that by the time of an inquest there remains considerable failings relating to candour, professional reflection, and transparency.

Court of Protection – A Year in Cases

By Alex Ruck Keene

There have been no Supreme Court cases directly considering the Mental Capacity Act 2005 in the past 12 months, but there have been two important Court of Appeal cases. *In Hemachandran & Anor v Thirumalesh & Anor* [2024] EWCA Civ 896, the Court of Appeal made clear that the fact that a person does not appear to believe what they are being told by a professional does not necessarily mean that they lack capacity to make the relevant decision. It is a flag that the situation needs considering further, but no more. The Court of Appeal also confirmed that capacity is not a medical matter, i.e. it is not necessary for there to be a confirmed diagnosis in order to reach a conclusion that a person has an impairment or disturbance in the functioning of their mind or brain. This is particularly important in situations where there are proper reasons to think that there may be, but the formal diagnostic procedure has not yet been completed. For instance, the person has not yet been able to get the appointment with the dementia clinic.

In *Re A (Covert Medication: Residence*) [2024] EWCA Civ 572, the Court of Appeal considered the difficult issues of covert medication and truth-telling. It also reaffirmed that the Court of Protection is required to take decisions between options which are actually available, rather than acting as a 'supervisory' court remaining involved on an ongoing basis on all aspects of care planning relating to a person before them.

There are a large number of reported cases from the lower courts (although it is important always to remember that these are the tip of the iceberg – most cases are heard by District Judges, 'Tier 1 judges' of the Court of Protection, and only very few of their decisions are ever reported). Most of the reported decisions can be best seen as worked examples of the application of the MCA to difficult situations, but some have a wider relevance.

Capacity

The Vice-President of the Court of Protection, Theis J, emphasised in *Re ZZ (Capacity)* [2024] EWCOP 21 the need to make sure that approaching capacity in a decision-specific way does not lead to incoherence. This can be a particular problem in the context of residence and care, where information about care needs should usually be considered as part of the relevant information to making a decision about residence. Theis J also had to grapple with the issue of capacity to engage in sexual relations, an issue of real legal – and practical – complexity.

Re DY (Capacity) [2024] EWCOP 4 is a helpful and powerful example of the potential for a person's capacity to change, and for the need for those around to respond accordingly.

Gwynneth Knowles J also made clear that, in her view “it would be beneficial if expert capacity assessors ensured that, as a matter of routine, they cross-checked their conclusions by looking at the wider canvas about how a person functioned and, if possible, by speaking to those who knew the person being assessed well. This is of particular importance when their conclusions may be at variance with previous capacity assessments.” One consequence of doing this is that it may well be possible to flush out whether the situation is one where the person genuinely has fluctuating capacity (which is frequently stated if there are differing views of capacity), or whether it is a case of the same person being looked at by different people – with different perspectives – at different times.

Best interests

The former Vice-President of the Court of Protection, Hayden J, took an unusual course in *Rotherham and Doncaster and South Humber NHS Foundation Trust v NR* [2024] EWCOP 17. In this case, he concluded that the woman in question lacked capacity to make a decision about the termination of her baby, but declined to say whether either having or not having the termination was in her best interests. Rather, his decision had the consequence that those who might be called upon to act upon her wishes and feelings (whether or not they were to have a termination) should take those wishes and feelings as determinative. This might be thought to be a particularly creative use of the powers of the Court of Protection.

The case name *AA (Withdrawal of Life-Sustaining Treatment: No Best Interests Decision*) [2024] EWCOP 39 perhaps says it all. Henke J refused to make a determination that withdrawal of life-sustaining treatment was in the best interests of the person where her treating Trust had made clear during the course of the proceedings – and after her condition had deteriorated – that there was only one option that it considered clinically appropriate. Where that is the case, she emphasised, the Court of Protection has no role, because the decision is a purely clinical one.

Deprivation of Liberty

Poole J made clear the practical consequences of the continued delay to the implementation of the Liberty Protection Safeguards in *Re PQ (Court Authorised DOL: Representation During Review Period*) [2024] EWCOP 41 (T3). At present, the Deprivation of Liberty Safeguards only provides the necessary procedure to authorise deprivation of liberty in a limited number of situations (the person has to be in a care home or hospital, and to be 18 or over). In all other situations, the authority of the Court of Protection has to be required, and in *Re PQ*, Poole J made clear that this means that, save in ‘rare’ cases, there needs to be representation of the person throughout the life of the authorisation; the decision then examines the practical and, in particular, the funding, consequences.

In *Re HC* [2024] EWCOP 24, Victoria Butler-Cole KC (sitting as a Deputy Tier 3 Judge) noted the irony of the fact that she was being invited to give substitute consent to a confinement to which the person in question was (albeit incapitously) agreeing to willingly.

The judge was bound by the decision of the Supreme Court in *Cheshire West* to hold that a person has to have capacity applying the test in the MCA 2005 to be able to consent to confinement, but the facts of the judgment do show some of the more striking consequences of that approach.

Property and Affairs

In *TA v The Public Guardian* [2023] EWCOP 63, Lieven J confirmed that a certificate provider must consider the donor's capacity to grant the lasting of power of attorney in question, because otherwise the Court of Protection could not be satisfied (in the event of a challenge) that the attorney actually had that capacity. And in *Irwin Mitchell Trust Corporation v PW* [2024] EWCOP 16, Senior Judge Hilder emphasised just how important it is for property and affairs deputies to guard against the potential for conflicts of interest. She held that a law firm appointed as property and affairs deputy for a person with impaired decision-making capacity could not appoint a wholly-owned subsidiary to act as investment manager for a significant part of their money.

Finally, a case not decided in England and Wales, but a very important case in the context of decision-making capacity, especially in emergency situations. In *Pindo Mulla v Spain* [2024] ECHR 753, the Grand Chamber of the European Court of Human Rights conducted a review of how the state's obligation to secure life operates in the context of medical treatment decisions. The case concerned a Jehovah's Witness, and the court emphasised the importance of the right to refuse treatment as an aspect of Article 8(1) ECHR. However, it also emphasised the importance of the state's obligation to secure life, and the fact that, where there is doubt about whether the person has capacity to make the decision about potentially life-sustaining treatment, it is vital that doubt is resolved."

Developing a Consensus Statement about "Do Not Attempt Cardiopulmonary Resuscitation" (DNACPR) – A Consolidated Draft

Compiled by Margaret Flynn

> The PICU [Paediatric Intensive Care Unit] team knows she received over forty minutes of roadside CPR before the paramedics successfully resuscitated her heart. They are also aware that no matter how expertly CPR is performed, it is crude, rudimentary and cannot come close to achieving the propulsive power of the human heart. CPR provides only 10 to 30 per cent of the normal blood flow to the heart and 30 to 40 per cent of normal blood flow to the brain, even when delivered according to guidelines. This means that the longer a person experiences cardiac arrest, the greater the chances that the tissues of the brain – being exquisitely sensitive to, and hungry for, oxygen – will suffer hypoxic damage…
>
> (Clarke, 2025, p99-100)[49]

Background

The idea of a consensus statement to support clinicians and other healthcare professionals faced with complex decisions concerning cardiopulmonary resuscitation (CPR) was hatched at the Essex Autonomy Project's Summer School of 2022. Very poor practice concerning DNACPR recommendations achieved particular prominence during the pandemic. Karen Chumbley, Alex Ruck Keene and Wayne Martin explored the clinical, legal and ethical challenges surrounding this topic at the Summer School. DNACPR was also the focus of the Forum's initial webinar of 2022. This drew particular attention to the context and the significance, or even absence, of organisations' DNACPR policies and education resources. It is of interest that, unlike England, Wales and Scotland have national DNACPR policies.

This section could not have been drafted without the time, goodwill and discerning perspectives of many people. A special note of appreciation is extended to: Timothy Bonnici, Michael Bradfield, Zoe Brummell, Bill Charles, Rebecca Cooke, Lorraine Currie, Bethan Edwards Newport, Chelle Farnan, Claire Higgins, Annelies Hillyer-Thake, Katharine Hunt, Alex Ruck Keene, Betsey Lau-Robinson, Jon Martin, Wayne Martin,

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[49] Rachel Clarke (2025) *The Story of a Heart.* Leicester, Charnwood

Karen McCulloch, Aurora Piergiacomi, Mark Taubert, Jenny Thompson, Ben Troke and Tom Wood.

The Context

A decision about accepting or refusing to have CPR may be made at any time by a person with the capacity to do so. This information should be documented and known to GPs or medical teams. It should result in a GP or medical team **recording a DNACPR recommendation** and **completing a DNACPR form**. The latter should be clearly visible in a person's records and shared with all teams that are likely to be involved in a person's care.

A **Health and Welfare Attorney** is legally entrusted to make decisions on the behalf of a person who does not have the capacity to make care and treatment decisions - bearing in mind that an attorney cannot insist on CPR being given.

The existence of a documented, **Advance Decision to Refuse Treatment** lets a GP or medical team know that a person wishes to refuse a clearly specified treatment in the future. This legally binding instruction may cite CPR, for example. It should be readily accessible in the documentation concerning DNACPR.

As palliative care consultant Mark Taubert observes: *Many people are not accustomed with what happens in ordinary dying and may feel CPR is part of their or others' civic duty. An education initiative on CPR in terminal illness may help to achieve a better understanding of what really matters in end of life care and this may include popular TV and other media…especially if written by medics such as Adam Kay, who has approached this topic with realism and humanity.*[50] *Not many people know that for some people with palliative illness, the chance of CPR actually working is between 0-2%. Of those few who do survive it,*[51] *a significant percentage can have some form of permanent damage, especially to the brain.*

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[50] Adam Kay's (2024) book Undoctored: The story of a medic who ran out of patients, describes CPR from the perspective of a medical student. "A nurse was pushing hard down onto her naked chest – grunting through the effort, his sweat dripping onto her unperfused skin, spittle flying as he counted his compressions…The cubicle smelled overpoweringly of urine – whether hers or a previous occupants. The lights were bright and oppressive; I felt like I was intruding on a private moment. Her chest wall was bending beyond the rules of physics – perhaps her ribs were snapping. I wouldn't have been able to hear beyond the A&E kerfuffle. Her eyes were rolled back into her head, her mouth was slack, her lips greyed out and thin. An arm jolted with every compression, its hand flopping in response. I saw a wedding ring eroded by years of rubbing for good luck or taking on and off to do the washing up. A life was both materializing and draining away right before my eyes. I don't know how her story ended…I'm not sure what I felt more sick about – the brutal indignity of CPR or the fact I couldn't even watch it. Great doctor I'll be!" (p60)

[51] Approximately 12-18% will survive and leave hospital

Elements of a Proposed Consensus Statement

1. Cardiopulmonary Resuscitation (CPR) is an emergency intervention that involves chest compressions of 5-6cms, artificial ventilation, the application of an electric current and injected medications. It is intended to restart a heart that has stopped due to a potentially reversible clinical problem. It is *not* intended to restart a heart that has stopped at the natural end-point of the dying process.

2. Even if it takes place in an acute hospital, CPR to restore breathing and circulation has a very low success rate.

3. TV hospital dramas can be unrealistic in depicting the success rate of CPR by overestimating the benefits and underestimating the harms.

4. Significant physical damage can result when CPR is applied e.g. internal and external bleeding, organ damage, burned skin from using a defibrillator, a broken breast bone and fractured ribs, aspiration pneumonia, as well as brain damage from oxygen deprivation. Of the few who survive CPR, a significant number die soon after or will require nursing home care.

5. A DNACPR recommendation is intended to prevent CPR being applied when it is determined that is not clinically appropriate; not in a person’s best interests; or when a person with capacity states that they do not want future CPR attempts.

6. Administering CPR may violate a person’s rights if there is no possibility of it being effective, especially if the person with capacity does not wish it. It could give rise to the offence of ill-treatment.

7. Decisions about (i) Cardiopulmonary Resuscitation (CPR) and (ii) Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) recommendations are not trumped by organisations’ policies stating, for example, that CPR should *always* be applied.

8. DNACPR is not a “do not treat at all” or a “don’t do anything” recommendation. It does not deny a person other forms of life saving treatment and care. Many people who have DNACPR recommendations receive intense treatments for reversible conditions.

9. A DNACPR recommendation is often an appropriate element of “end of life” care planning – but it is not the only consideration.

10. A DNACPR recommendation may be disregarded if the reasons for doing CPR are not related to the reasons stated on a DNACPR form. For example, a form stating, “Medical background: advance lung cancer with spread to liver and bones” does not prevent a first responder from offering CPR for choking on food. Also, CPR may be given if a person is undergoing surgery or a heart procedure, even if a DNACPR recommendation has been in place for their background condition.

11. The consent of a patient or another person with legal authority is not required for a DNACPR recommendation – but the need for consultation and openness is paramount. There is a duty to consult.

12. A compassionate and respectful consultation about end of life care is essential. At best, the clinician guides the patient and the patient guides the clinician about what would contribute to a better – and worse – experience. A conversation about what would matter most to the individual and those close to them at the end of life has an edge over one that is focused solely on DNACPR. The consultation should allow the person receiving treatment to ask questions. The conversation should be documented. If there is any disagreement or a mismatch, a second opinion should be sought.

Reflections

> Our staff were shocked to find a "Do Not Attempt Cardio Pulmonary Resuscitation" note in the luggage of a man [with a learning disability] returning home from hospital. He was unsure what it meant and asked for it to be explained. There had been no discussion with him or the staff and manager who had supported him for many years. They were distressed when the man reflected, "I suppose that I'm not worth saving."
>
> My daughter was given CPR at the roadside by a passer-by who had received CPR training…She survived and I am glad.
>
> I worry that DNACPR is all that people focus on.

I have learned that majoritarian devices do not help manage complexity! The proposed consensus statement is unlikely to satisfy all readers, let alone the knowledgeable content experts/ contributors whose many different perspectives brought illumination and shading to the task. However, there are a few, clear-as-a-bell imperatives:

- A DNACPR is a recommendation. It is a proposal as to the best course of action
- A DNACPR is not an order that must be followed in all circumstances
- CPR will not prevent the death of someone who is dying
- Consultation and openness are essential
- Organizations' policies concerning DNACPR and CPR merit attention since they set the parameters for professionals' decision-making
- There is no legal obligation to prolong life.

There are different impacts to be considered for the person:

- who has capacity to make the decision on an anticipated need for CPR
- who has made an advance decision to refuse treatment

- who has a health and welfare Lasting Power of Attorney
- for whom none of the above apply.

It is up to clinicians, healthcare workers, support staff and, if feasible, each of us as potential recipients of CPR - or as the relatives of potential recipients to know:

- whether a person has the capacity to agree to or to refuse future CPR
- whether there is a Lasting Power of Attorney: health and welfare in place
- the different effects of an Advance Decision to Refuse Treatment and a DNACPR recommendation
- how legally compliant decisions may be made with a person who is without relatives, accredited interpreters or support staff.

It is possible that organisations' policies reflect the dilemmas, uncertainties and complexities captured in this draft consensus statement and adapt them according to the decision-maker and/ or different audiences. It is offered as an impetus to greater interest in the topic, respectful and kind communications and improved understanding.

It is possible that the real legacy will be the persistence of sustained and thoughtful debate which bring to the fore examples of reflective practice. For example, the Resuscitation Council UK promotes ReSPECT – a Recommended Summary Plan for Emergency Care and Treatment.[52] The ReSPECT process creates recommendations for a person's care and treatment in the event of a future emergency in which they may be unable to make or express their wishes.

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[52] https://www.resus.org.uk/respect

Partnerships and Networks

By Margaret Flynn

The National Mental Capacity Forum provides a host of learning opportunities for its members. It typically takes an interdisciplinary approach to topics and study opportunities. Forum members' membership of professional and other affiliations expand its network connections.

An example includes working with the Mental Capacity Group of Anheddau, a charity principally supporting adults with learning disabilities. The Group is made up of house managers and support staff. Although it is in its infancy, we began by "thinking back" to the implementation of the Mental Capacity Act and answering the question: "What would have been useful then?" The answers included, "Getting it right for the people we support…knowing people's stories...[and] learning about people's decision-making skills." It has launched us onto familiar training seas – albeit piloting and navigating our own ship at a pace that suits each of us. Broadly, its work hinges on building the confidence of staff in their skills to achieve the larger goals of supporting people's decision-making effectively. The Group considers the scenarios they are dealing with and discusses possible courses of action. Key developments include: establishing the legal authority of certain decisions made on behalf of the people they support; and enthusiasm for responding to a consultation concerning people's experience of hospitalisation. This is a topic explored by Claire Webster at the Social Care Institute for Excellence (SCIE) and funded by the Department of Health and Social Care. *Get me to hospital: When and how to use the Mental Capacity Act to take a person to hospital for physical health treatment. A guide for people, their families and health and social care practitioners.*[53] This work similarly bears the fingerprints of several Forum members.

Turning Point and Learning Disability Today have produced a guide concerning Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) recommendations. It resulted from the alarming rise in DNACPR recommendations citing people's learning disabilities during the pandemic. The Forum's work concerning a Consensus Statement, and that of the Essex Autonomy Project,[54] complemented that of Turning Point and Learning Disability Today and, necessarily, Forum members plus members of other organisations contributed to the guide's development. Taking the view that it is important to continue this work, the Forum has undertaken to work with the Resuscitation Council UK's efforts to support best practice in the use of CPR by providing a comprehensive review of the ReSPECT guidance.

The "Five Nations" initiative brings together safeguarding leads and practitioners across the UK's four nations and the Republic of Ireland. Practitioners' understanding of the Mental Capacity Act is a recognised "poor practice theme" in safeguarding reviews across

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[53] https://www.scie.org.uk/app/uploads/2025/05/Get-me-to-hospital_Final.pdf

[54] https://autonomy.essex.ac.uk/

England and Wales. The Five Nations plan online seminars concerning adult protection and addresses people's decision-making capacity. Forum members' continuing involvement in writing Safeguarding Adult Reviews and attending to the actions arising from these ensures that the Forum remains open to learning from safeguarding practice.

NHS England's Mental Capacity Act Strategic Leadership Forum brings together regional clinicians, safeguarding, policy and MCA leads to share progress concerning workstreams and embedding effective MCA practice.

Links with law lecturers at Keele and Manchester Universities led to contributions to seminars about (i) the far-reaching topic of mental capacity law and sexual relationships and (ii) inquests. This led directly to the scrutiny of the Prevention of Future Deaths' Reports which features in this report. The former resulted in the publication of an important and humane book55 edited by Beverley Clough and Laura Pritchard-Jones which includes contributions from several Forum members. It deals with topics treated as gingerly as possible for too long and sets out the origins of families and professionals' attitudinal and organisational barriers to ensure childlessness and/ or celibacy. It invites readers to ask: Is decision-specificity the new battleground? and even, Has the MCA helped at all? Spoiler alerts: the Mental Capacity Act reinforces the power of professionals in which fears concerning liability prevail; and the MCA does not empower the victims of sexual assaults. However, the Editors note that the Mental Capacity Act's focus on single decisions may be recast as part of a broader assessment concerning contact with another person.

In a quest to understand how practitioners might make the best of where we are in terms of the Deprivation of Liberty, I accepted an invitation to review Ben Troke's (2024) *A Practical Guide to the Law of Deprivation of Liberty.*[56] In the Preface he writes:

> This is the legal framework that protects us when other people, however well intentioned, start making decisions about where and how we live, often through to the end of our lives. I cannot think of anything more fundamental to our identity or our autonomy than that...But we have managed to develop an overly complex, and poorly understood system that leaves tens of thousands of people without any meaningful safeguards, deprived of their liberty unlawfully; organisations exposed to potential liabilities; and huge amounts of time and money spent on a process that too often appears to yield little real benefit to those it is supposed to protect.

Ben Troke acknowledges the contributions of several Forum members. Just three of his memorable proposals merit consideration: rename the MCA: "Making *This* Decision Act;" the role of the Deprivation of Liberty Safeguards (DoLS) is not to impose or enable restrictions but to recognise that where there are restrictions, they warrant independent scrutiny; and DoLS is a spotlight, not a padlock.

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55 Mental Capacity Law, Sexual Relationships, and Intimacy Bristol: Bristol University Press, 2024

56 Somerset: Law Brief Publishing

Most memorably, Ben Troke states:

> "…even without revision, reform or resources, it is in our hands to keep doing better with the resources we have."

I am contributing to the SPIN-D Network Plus (Sustainable Prevention, Innovation and Involvement Network for Dementia)57 as a researcher for TIDE (Together in Dementia Everyday).58 SPIN-D is a UK wide Network that aims to reduce the risk of dementia and improve people's experience of living with the condition by supporting new projects and engaging with communities. Since the work involves the exchange, sharing and co-development of products and services it aligns with one of the Forum's Terms of Reference: to give recognition to the ideas, interests and concerns of people whose lives are affected by the MCA.

The National Institute for Health and Care Research is funding a study[59] concerning the implementation of the Mental Capacity Act in care homes supporting older residents with compromised capacity. It identifies Capability, Opportunity and Motivation related barriers and facilitators.[60] One of the researchers' conclusions is the *"…lack of understanding of what best practice MCA training currently looks like in care homes…"*

The Essex Autonomy Project (EAP) is a research and public policy initiative based in the School of Philosophical, Historical and Interdisciplinary Studies at the University of Essex. It has hosted fabulous Summer Schools led by Professor Wayne Martin who also co-hosts the Forum's webinar series. In collaboration with SCIE, EAP gives the Forum space on its website to promote ideas and discussion.

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57 https://spindementianet.org/

58 https://www.tide.uk.net/

59 By Stokes, L., Madden, M., Williams, N., Jacob, N., Shepherd, V., Scott, S., Prout, H., Gates, C., Jones, L., Smith, G., Ingel, M., Bethell, L., Hewkin, P., Hill, R. and Wyn Griffiths, A. Barriers and Facilitators to Implementation of the Mental Capacity Act in Care Homes: A Mixed Methods Systematic Review

52 https://pmc.ncbi.nlm.nih.gov/articles/PMC10360346/

Back to the Basics of Schedule A1’s Requirements

By Lorraine Currie

In work for the West Midlands Association of Directors of Adult Social Services (WMADASS), I had a principal role in streamlining the forms used by local authorities and developing guidance. Since custom and practice has built on the scrutiny that is required, I advise “back to the basics.” This means that the managing authority, the supervisory body, the Best Interests Assessor and the Mental Health Assessor do what is essential in relation to the Deprivation of Liberty Safeguards (see Appendix 1).[61] I considered what must be done, taking note of things that are not even mentioned in the Schedule. The Regulations state who can carry out which assessments and reference the outdated Code of Practice of 2008.

Managing Authorities – Care Homes and Hospitals must:

- Request authorisation when the necessary conditions are met, keep a record of each request and ensure the person is told about authorisation and understands its effects and their rights. Also, they must keep a record of authorisations which are granted and those which are not granted.
- Issue an urgent authorisation if the criteria are met while simultaneously requesting a standard authorisation. The urgent authorisation must be for up to 7 days in writing. Records must be maintained and interested parties informed.
- Give the Best Interests Assessor a copy of needs assessments/care plan.
- Notify the Supervisory Body if there is a change in place of detention.
- Inform the Supervisory Body if the person no longer meets the eligibility criteria.
- Ensure compliance with any conditions stated in the authorisation.
- Respond to third-party requests by supplying all the details they would provide had they initiated the authorisation.

What do **Local Authorities** have to do **as the Supervisory Body** for Deprivation of Liberty Safeguards in England? (In Wales, the supervisory bodies are local authorities for care homes and Local Health Boards for hospitals.)

- Keep a record of all authorisation requests.
- Ensure assessments are carried out by eligible professionals and provide Best Interests Assessors with copies of relevant needs assessments and care plans.
- Grant authorisation if the assessments confirm eligibility, determining the duration and any conditions in line with the Best Interests Assessor’s recommendations. The

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[61] Appendix 1 is reproduced from Ben Troke’s (2024) A Practical Guide to the Law of Deprivation of Liberty Minehead: Law Brief Publishing

Authorisation must be in writing and copies must be distributed. The Act does not specify how this process should be done or reference an Authorizer or signatory.
- Issue notices if an authorisation is suspended or ceases.
- Carry out reviews and third-party assessments if requested.
- Reuse assessments that are less than 12 months old and still relevant and, in the case of a Best Interests' Assessment, representations from the Relevant Persons Representative or Independent Mental Capacity Advocate must be considered.
- Appoint a representative for the person.

Overall, aside from specific areas such as suspension, which have been given significant attention, the statutory requirements remain relatively straightforward.

Best Interests Assessors must:

- Have regard to the Mental Health Assessor's conclusions.
- Consult the Managing Authority
- Review needs assessments and care plans.
- Record the names of all interested parties consulted. While consultation is expected, the Act does not explicitly require it.
- State the maximum authorisation period and whether an unauthorised deprivation of liberty is occurring.
- Consider whether conditions should be reviewed or varied.
- Maintain written records of the assessment and give them to the Supervisory Body.
- Take into account any information provided by Relevant Person's Representative or the Independent Mental Capacity Advocate.

Mental Health Assessors must:

- Consider how the person's mental health will be affected by their status as a 'detained resident' and notify the Best Interests Assessor.
- Keep written copies of the assessments and give them to Supervisory Body.
- Take into account any information provided by Relevant Person's Representative or the Independent Mental Capacity Advocate.

Once a request for authorisation is received it is expected to be accompanied by the care home or hospital's care and treatment plan. Two assessors will be appointed and provided with the necessary information.

Typically, the doctor will visit and assess the person, confirm the diagnosis, determine eligibility and consider how the care arrangements in place will impact the person's mental health. The doctor may also carry out a mental capacity assessment. Meanwhile, the Best Interests Assessor reviews the care and support plan which serves as their primary source of information, except in cases of self-funders.

The Best Interests Assessor consults the care home or hospital and any other relevant parties based on their review of the care and support plan or needs assessment. The Act does not explicitly require visits to the person or consultations beyond the care home or hospital as part of the DoLS process. There are, of course, relevant provisions in s4 MCA. The Act does not specify the nature or length of assessments.

This approach appears to align with the Liberty Protection Safeguards. It focuses primarily on the scrutiny of care plans with necessary consultation. The sticking point remains the requirement for a mental capacity assessment. If assessments carried out by social workers in their usual practice could be used, the process could be streamlined. This suggests that at least one assessor must meet the person to complete a mental capacity assessment.

Once completed, the assessment documents are returned to the Supervisory Body which must issue an authorisation if all criteria are met. The Act specifies the required content of the authorisation.

How then did we get such a convoluted process? What is the rationale for both assessors visiting the person or for lengthy consultation? A return to fundamental principles of the legislation may be required. However, this does not mean diminishing the significance of the Best Interests Assessor role, which is professionally fulfilling and valuable in protecting a person’s rights. Nevertheless, with 41,000 individuals dying without appropriate safeguards and at least 125,000 awaiting assessment during 2023, the current system is no longer sustainable in its existing form.

Questioning Education and Learning

By Wayne Martin

In cooperation with the Essex Autonomy Project, the National Mental Capacity Forum ran a third series of seminars in the Spring and Summer of 2024. Professor Wayne Martin writes:

The series as a whole comprised five webinars:

1. Thursday, 11 April 2024 - Living without the Liberty Protection Safeguards
2. Friday, 3 May 2024 - The MCA and Hospital Discharge
3. Thursday, 23 May 2024 - Decision-Making with 16-18 Year Olds
4. Thursday, 13 June 2024 - Fluctuating Capacity
5. Friday, 5 July 2024 - Deputyships and their Limits

Each webinar was one hour in duration. They were chaired by Margaret Flynn, with technical production handled by the Essex Autonomy Project. Recordings of all five webinars, together with supplementary materials, are available for viewing on the SCIE and Autonomy Project websites.[62]

Interest in the NMCF webinars continues to be robust. Registration figures for the five webinars were as follows:

1. Living without the Liberty Protection Safeguards: 1219
2. The MCA and Hospital Discharge: 1250
3. Decision-Making with 16-18 Year Olds: 1213
4. Fluctuating Capacity: 1172
5. Deputyships and their Limits: 631

Actual attendance at the webinars consistently ran at between 60% and 70% of registration.

The one outlier in the registration data was the reduced numbers of registrants for the webinar on Deputies. This may reflect the interest and professional profile of NMCF

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[62] https://www.scie.org.uk/mca/national-mental-capacity-forum/

“regulars”; it may also reflect the fact that many of our dissemination channels are through NHS and social care channels.

Participation in the webinars was free, but participants were required to register in advance. At the point of registration, registrants were encouraged (but not required) to respond to a series of registration questions. Appendix 2 presents data gathered from this process.

Concluding Thoughts and Next Steps

By Margaret Flynn

> “Every life contains many millions of decisions. Some big, some small. But every time one decision is taken over another, the outcomes differ. An irreversible variation occurs, which in turn leads to further variations.”
>
> (p31)[63]
>
> “The reality is, despite all the shortcomings of the current system, and the obvious pressures for reform, the tools we have now are all we are going to have for the foreseeable future, and we will just have to get on with it as best we can.”
>
> (p440)[64]

Professional practice is being shaped by foreseeable pressure points and setbacks. To families in-the-know, MCA scholars, practitioners and front line activists, it appears that at so many levels there is a culture of belated attention, late questioning and intervention.

As Lucy Series states, the postponed implementation of the Liberty Protection Safeguards and updating Codes of Practice are very pressing matters. In addition, reforms to the Mental Health Act will impact on the MCA, requiring decisions about the future of the Deprivation of Liberty Safeguards and Liberty Protection Safeguards.

This Report reveals the Forum’s range of ties and connections that generate new alliances and resources.

The Case Studies and the Prevention of Future Deaths reports in a 12-month period keenly reflect the limited embeddedness of the MCA in professional practice. It is remarkable that there is no monitoring of institutional responses to PFD reports. Unrelenting efforts are required that underline the necessity of

- calling out narrow and incorrect interpretations of the MCA
- beefing up oversight mechanisms, and
- making people’s care plans relevant.

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[63] Matt Haig (2020) Midnight Library London: Cannongate

[64] Ben Troke (2024) A Practical Guide to the Law of Deprivation of Liberty Minehead: Law Brief Publishing

During 2024-2025, the Forum will continue to gather and provide commentaries on real case studies. They draw attention to care planning as a vehicle to give people more agency and enhance their ability to influence and contribute to decision-making.

What the Forum undertakes and is able to do is emblematic of what is happening. This was exemplified during the pandemic's alarming disruptions. The feedback concerning its responsive and frequent online webinars confirmed that they were highly valued by professionals wanting to learn and by organisations seeking to deal with the threat to their essential functions. The Forum's webinars continue to reach many more people than conferences, for example, and will continue. Of necessity, they are likely to include live and recorded presentations and to reflect the Forum's investment in partnerships and networks.

Another example of engaging with recent events concerns assisted dying. The single reference to capacity in the Assisted Dying Bill [HL] ("capacity" shall be construed in accordance with the Mental Capacity Act 2005; s.12) will provide scope for the Forum to ensure that the open-minded and consultative approach required by the MCA is promoted. During 2025-26, "myth busting" concerning this topic will herald the start of the webinar series. It prompts the question: Why wait until a highly consequential decision is required before establishing a person's mental capacity to make a particular decision?

The advocacy of individuals, their relatives and individual practitioners provide an incredibly hopeful starting point. Although it reveals the sometimes limited and fragmentary ways in which the MCA is percolating into people's care plans and local practice, it also demonstrates people's interpretive knowledge, skills and creativity.[65] During 2025-26, the Forum will seek to understand and give coverage to people's experience as they engage with professionals.

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[65] See, for example, https://gracecurrie.art/journal/grace-currie-a-work-in-progress-2024

Appendix 1: What Schedule A1 requires of each partner

By Lorraine Currie

Managing Authority	Supervisory Body	General	Best Interests Assessor	Mental Health Assessor
Must request an authorisation if conditions are met	Must ensure all assessments are carried out by someone suitable and eligible. No definition of 'assessment' but regulations state who can carry out assessments	What a request for a Standard Authorisation (SA) must include	Best Interests Assessor must consult the Managing Authority (MA)	Must consider how person's mental health will be affected and must notify BIA
Must keep a record of each request	Must keep a record of all requests	Regulations set time periods within which assessments must be carried out (21 days)	Must record the name of every interested person they have consulted	Must keep written copies of the assessment and give to Supervisory Body (SB)
Must give the BIA a copy of any assessments/ care plans	Must give the BIA copies of their needs assessment/ care plan		Must have regard to Mental Health Assessor's (MHA) conclusions	Must take account of any information provided by Relevant Person's Representative (RPR) and Independent Mental Capacity Advocate (IMCA)
Must notify Supervisory Body if there is a change in place of detention	Can use equivalent assessments if less than 12 months old and there is no reason it is not still accurate. But if using equivalent assessment, Best Interests must take		Must have regard to needs assessment and care plans	

	into account information by RPR and IMCA			
Must ensure the person is told about the authorisation and understands effects and rights	Must give authorisation if all assessments are positive and must not give authorisation if any are not positive. No instructions as to how this is carried out i.e. no concept of an Authoriser/ signatory – only that the Supervisory Body must give authorisation. If any assessments are negative they must tell any other assessor to cease their assessment		Must state maximum authorisation period	
Must keep record of granted and not granted authorisation	Must decide the period - no more than Best Interests Assessor recommends		Must state if there is an unauthorised Deprivation of Liberty	
Must give an urgent authorisation if requirements are met and request a standard authorisation at the same time	Must be in writing and the Schedule states what must be included		Must consider if it is appropriate by review to vary conditions	
If given an urgent authorisation, it must be up to 7 days and be in writing	Must give copies as soon as practicable		Must keep written copies of the assessment and give to SB	
Must keep written record and inform interested persons	Must have regard to BIA recommendation before setting conditions		Must take account of any information provided by	

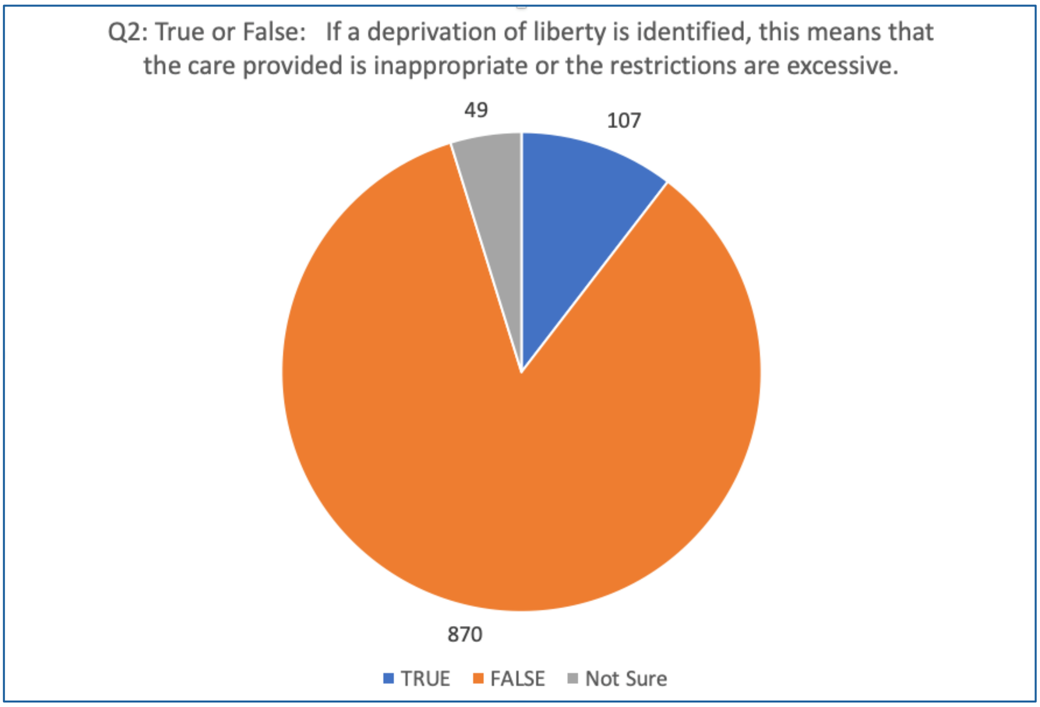
			RPR and/ or IMCA	
Must explain the effect and keep a record	Must give notice to the following that an authorisation has ceased: (a) the Managing Authority (b) the relevant person; (c) the RPR (d) every interested person consulted by the Best Interests Assessor			
Must tell SB if person ceases to meet eligibility	Must select assessors in response to third party requests, but not if they frivolous or vexatious, or the issue has already been decided and the circumstances have not changed			
Must ensure any conditions on the authorisation are complied with	Must keep record of third party requests and copies must be given to (a) the eligible person who made the request (b) the person to whom the request relates (c) the managing authority (d) any section 39A IMCA			
Third party request to MA must supply all the details they have	Must give notice of urgent authorisation ceasing to be in force to (a) the relevant person (b) any section 39A IMCA			

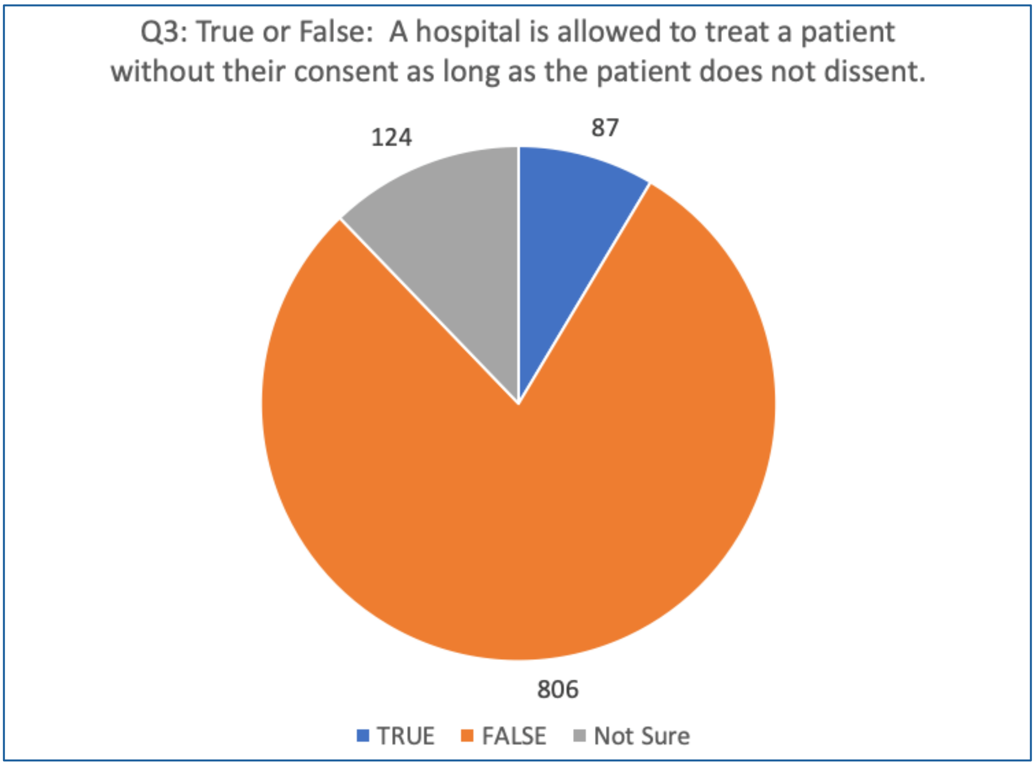
	Must suspend and give notice to (a)the relevant person; (b)the relevant person's representative; (c)the managing authority And again when no longer suspended			
	Must vary or terminate following review and give notice/ written record			
	Must not select an assessor unless suitable and eligible – the Regulations set out assessor eligibility. This must not be the same person for best interests and mental health			
	Before deciding to use an equivalent best interests assessment, any recommendations from RPR and/ or IMCA must be considered			
	Must appoint a representative as soon as practicable after authorisation and if a vacancy occurs during authorisation			
	The Representative must not be appointed unless they can maintain contact with the person and represent and support them in relation to Deprivation of Liberty Safeguards			

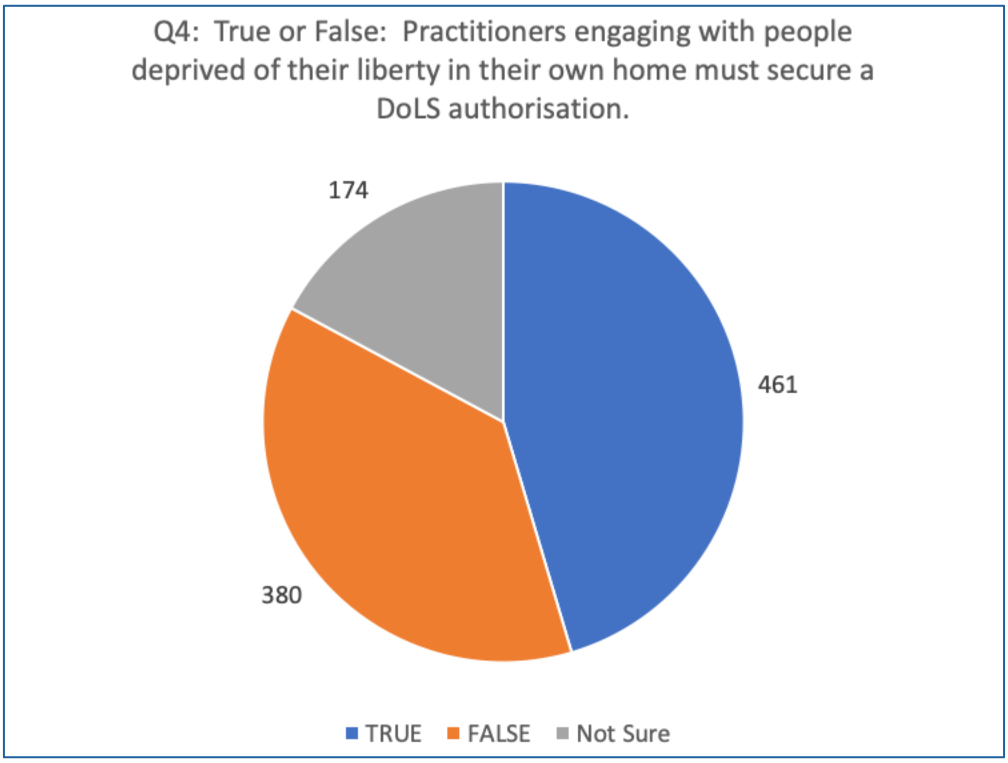
Appendix 2

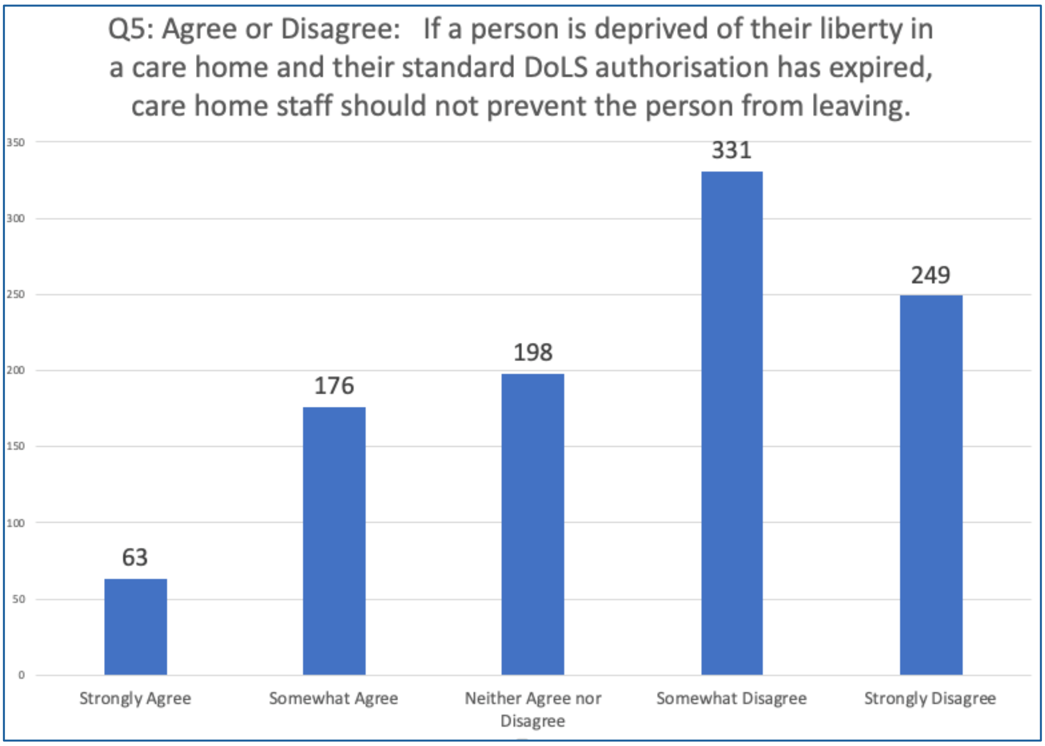
This Appendix presents data captured in the Webinars' registration questions. The data presents a snapshot of key legal knowledge and training needs in the workforce.

S3E1: Living Without LPS

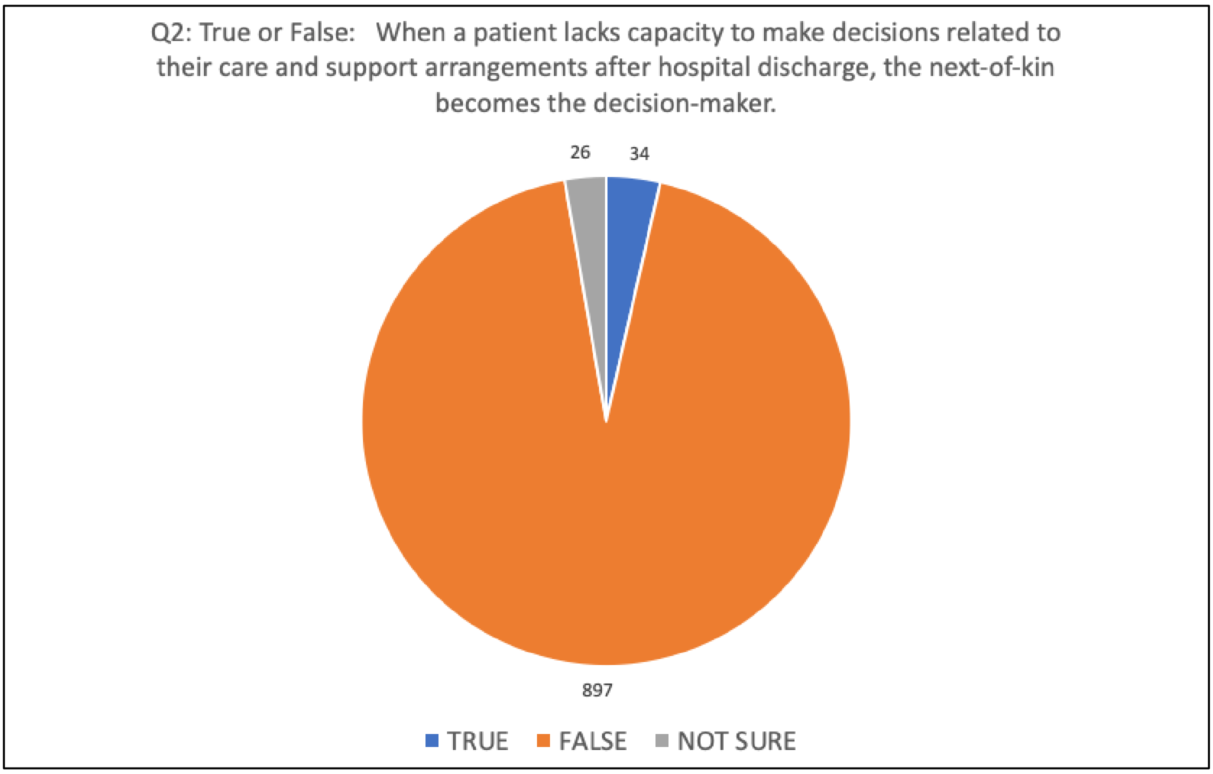


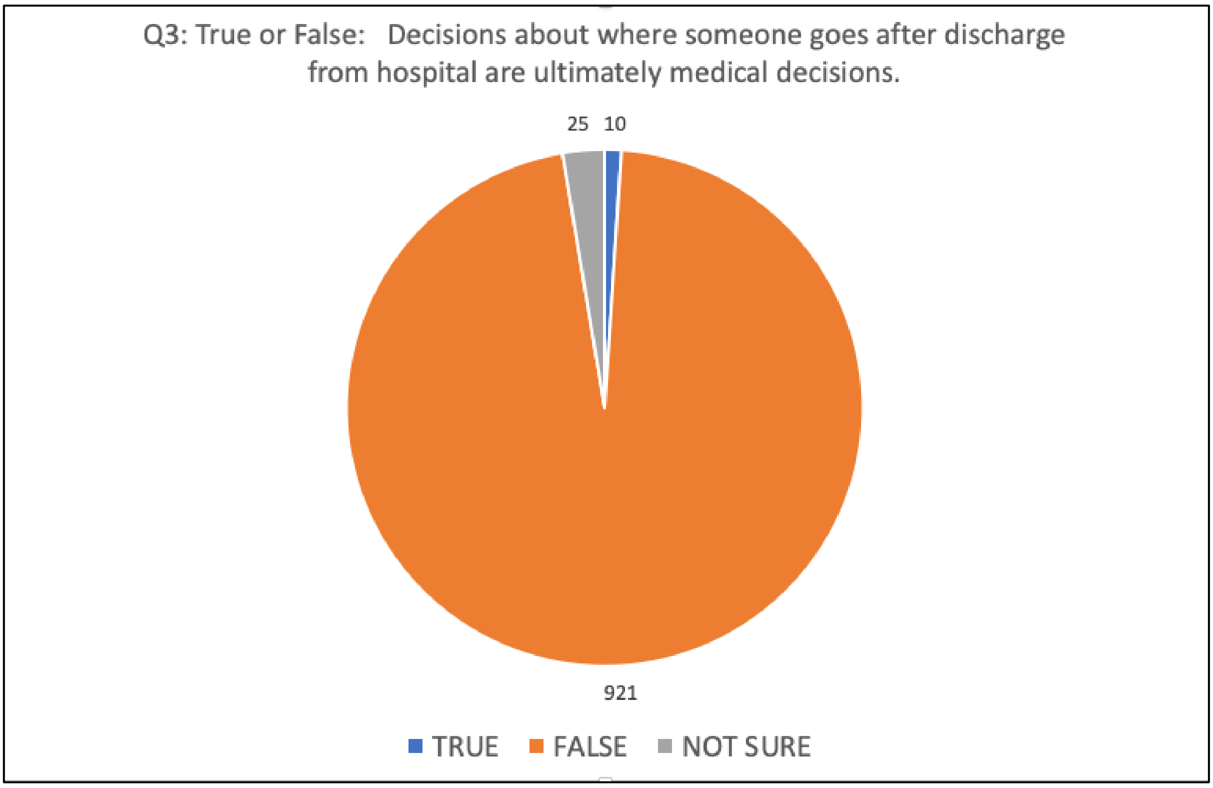

Q3: True or False: A hospital is allowed to treat a patient without their consent as long as the patient does not dissent.
124
87
806
TRUE
FALSE
Not Sure

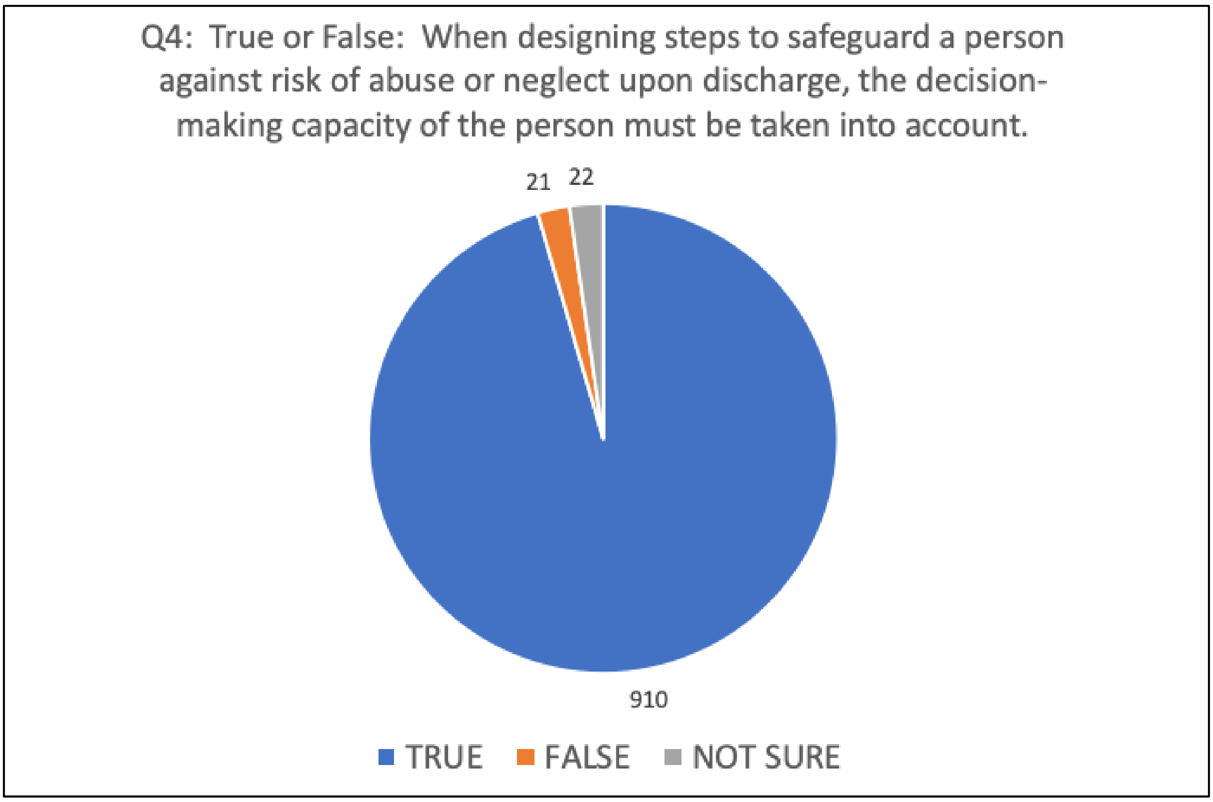

Q4: True or False: Practitioners engaging with people deprived of their liberty in their own home must secure a DoLS authorisation.
174
461
380
TRUE
FALSE
Not Sure


Q5: Agree or Disagree: If a person is deprived of their liberty in a care home and their standard DoLS authorisation has expired, care home staff should not prevent the person from leaving.
350
300
250
200
150
100
50
0
63
176
198
331
249
Strongly Agree
Somewhat Agree
Neither Agree nor Disagree
Somewhat Disagree
Strongly Disagree

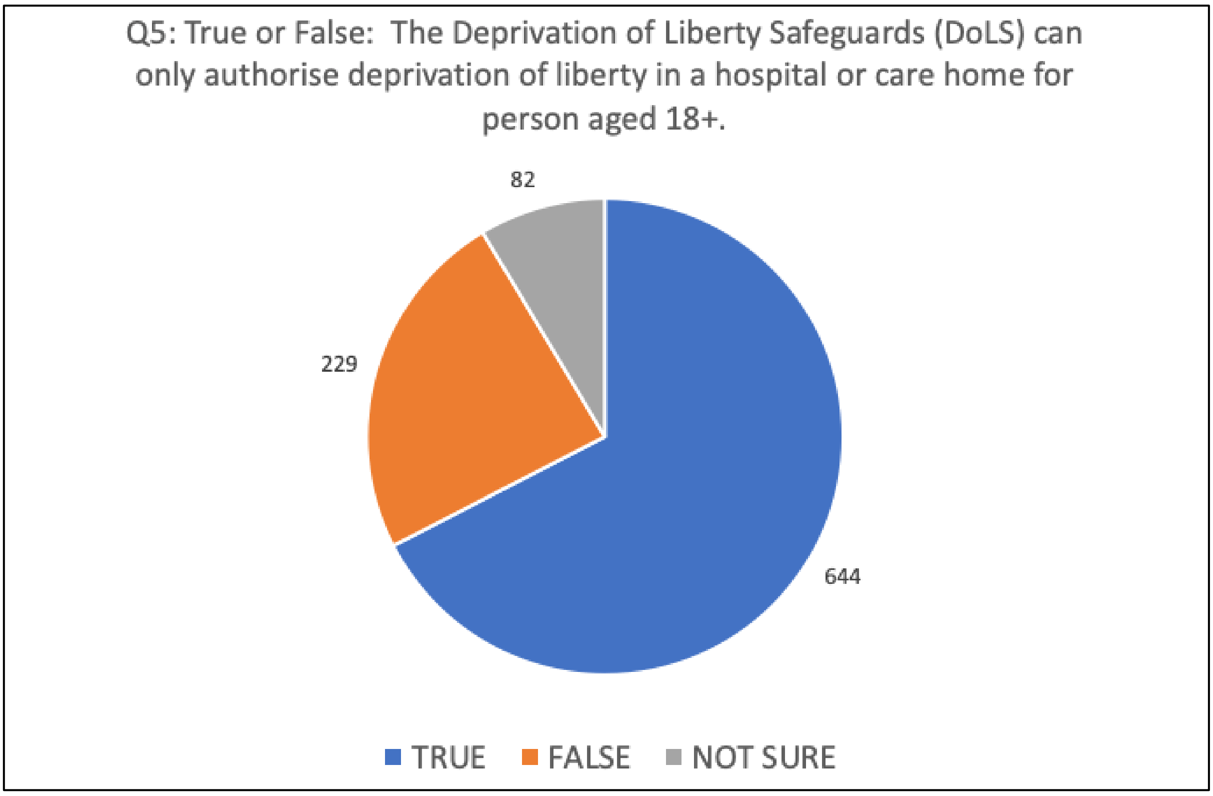
S3E2: MCA and Hospital Discharge



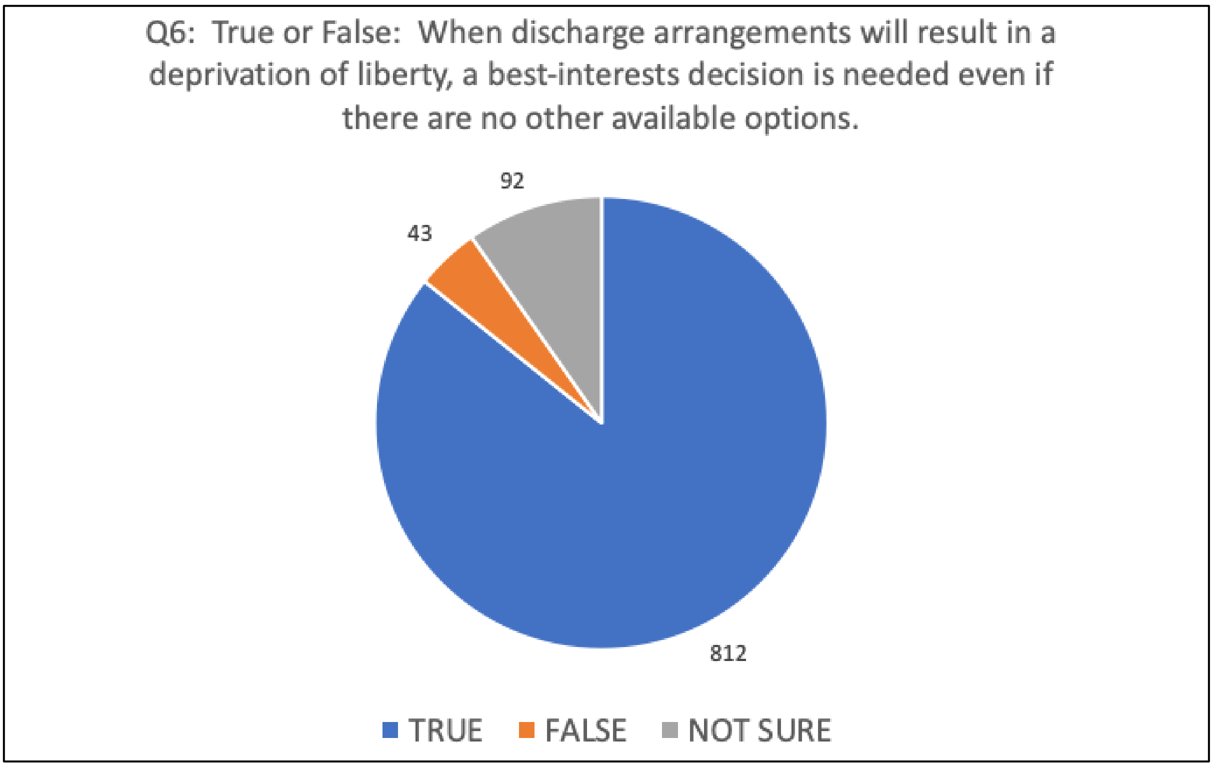


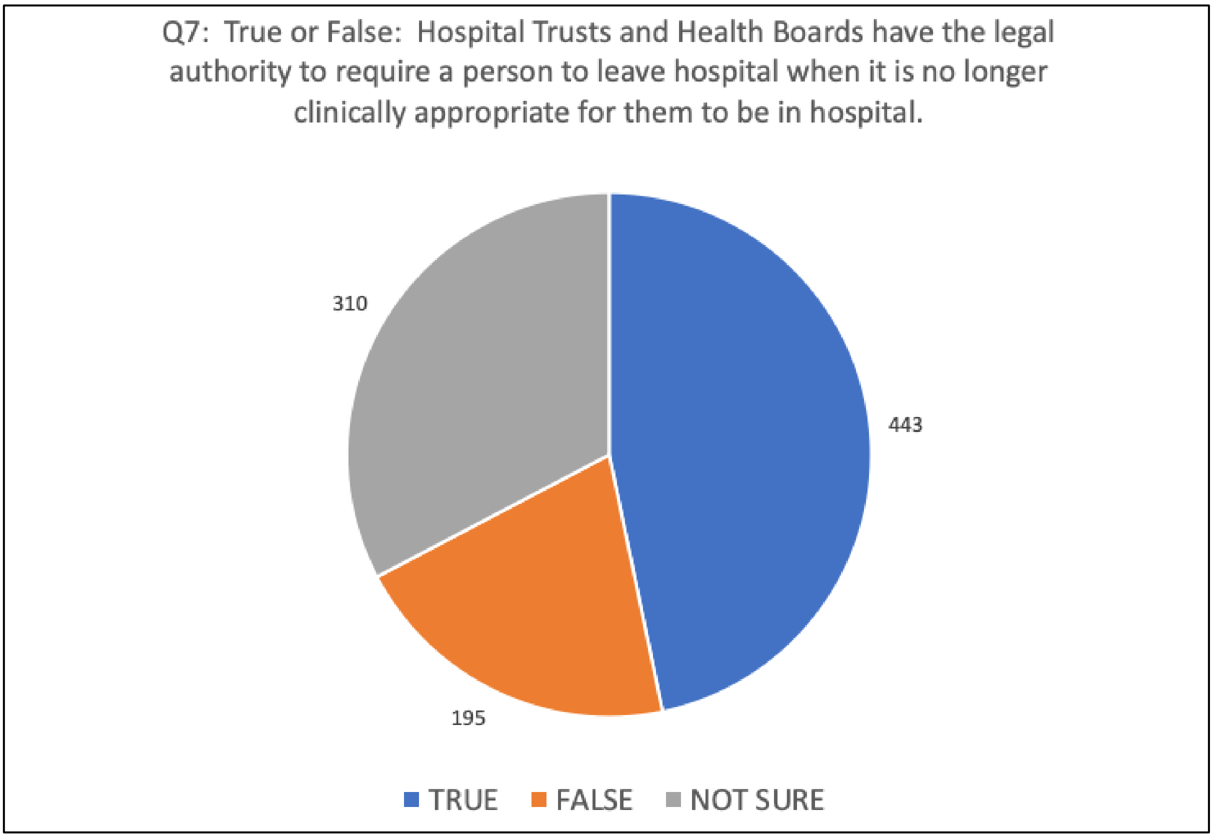


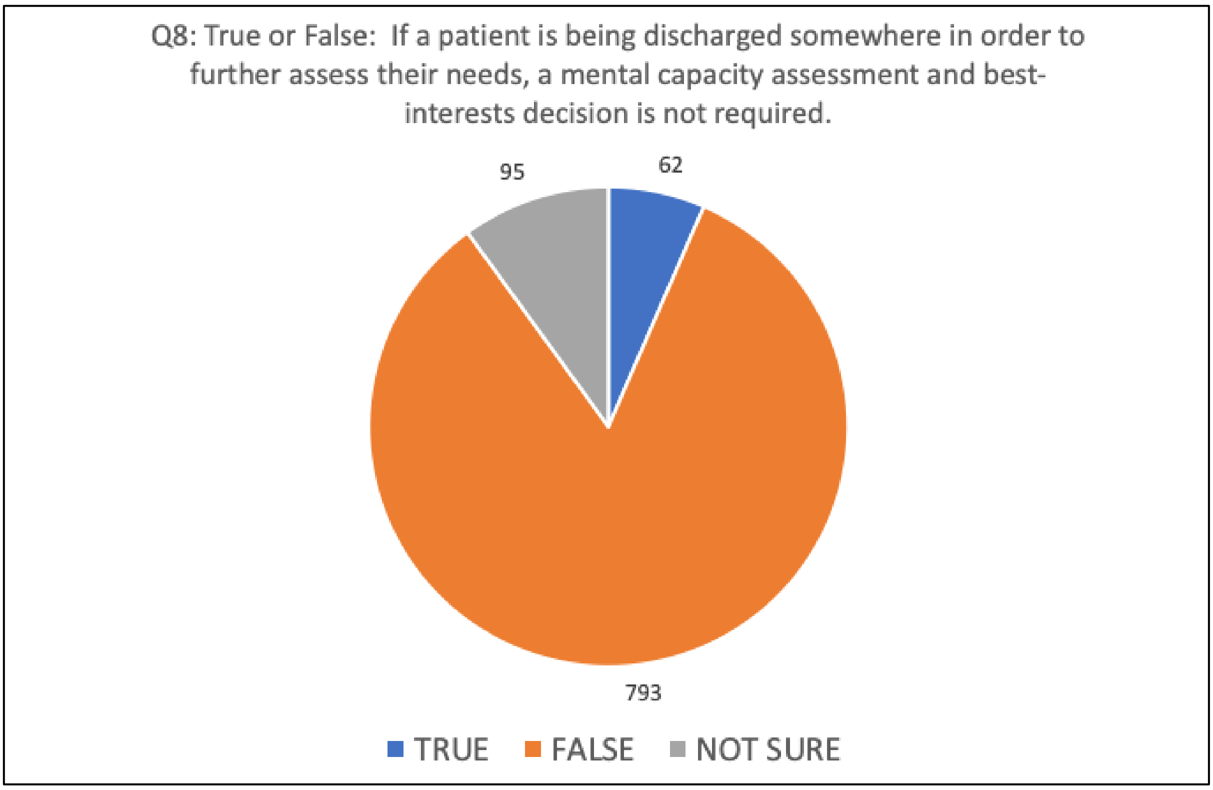
Q4: True or False: When designing steps to safeguard a person against risk of abuse or neglect upon discharge, the decision-making capacity of the person must be taken into account.



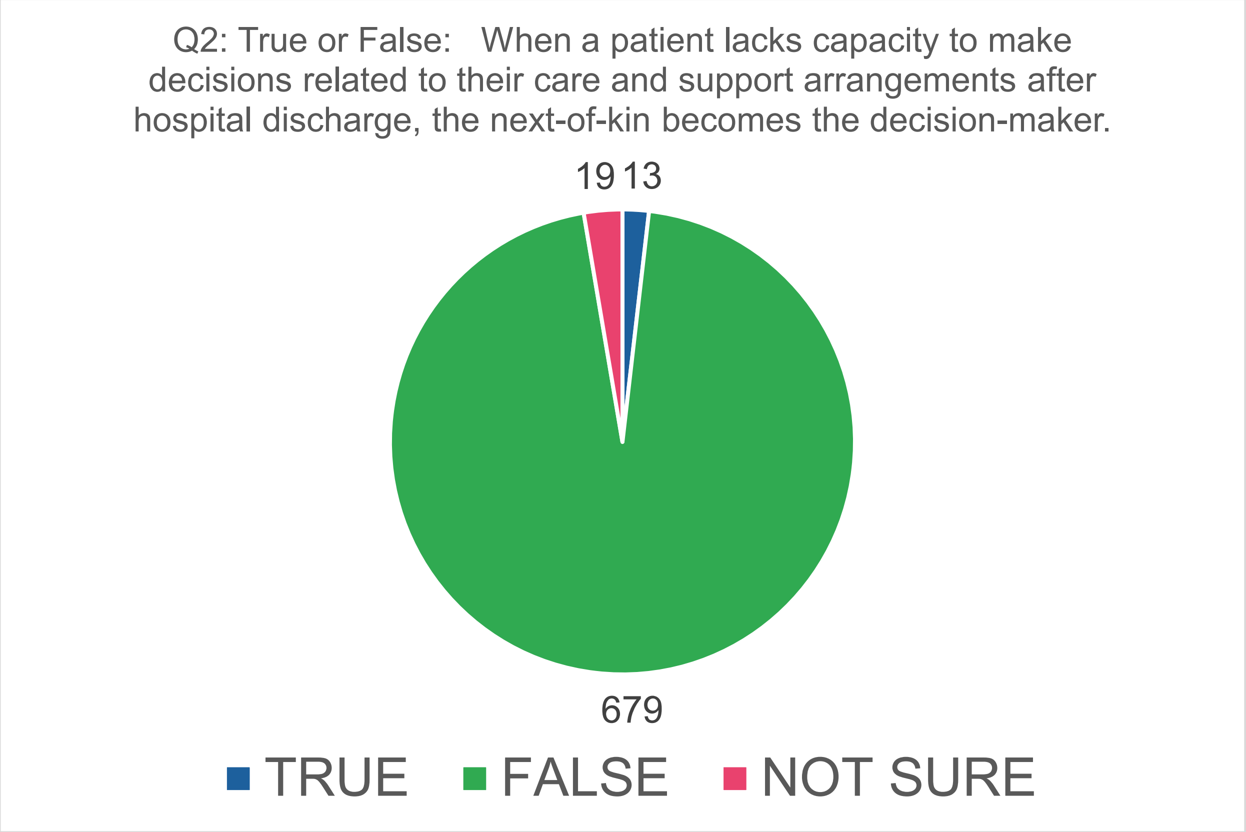
Q5: True or False: The Deprivation of Liberty Safeguards (DoLS) can only authorise deprivation of liberty in a hospital or care home for person aged 18+.

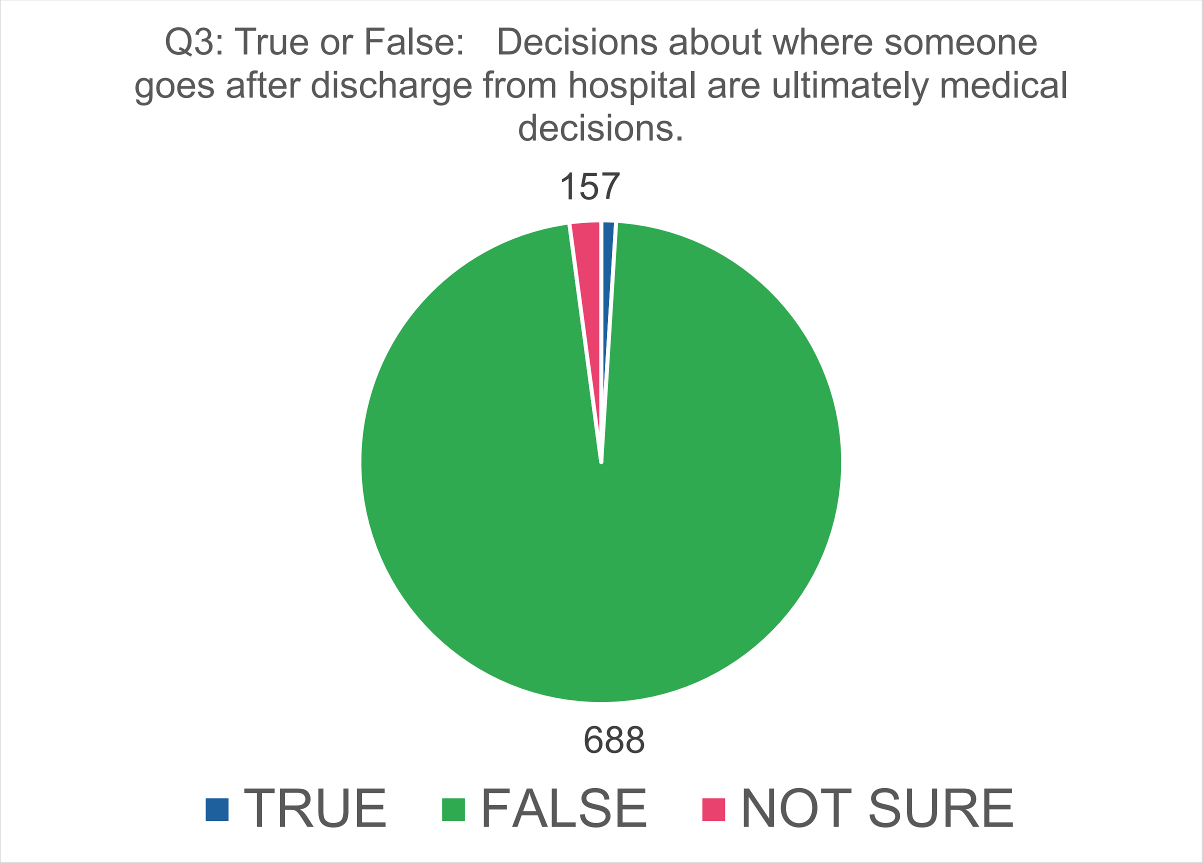

Q6: True or False: When discharge arrangements will result in a deprivation of liberty, a best-interests decision is needed even if there are no other available options.
92
43
812
TRUE
FALSE
NOT SURE

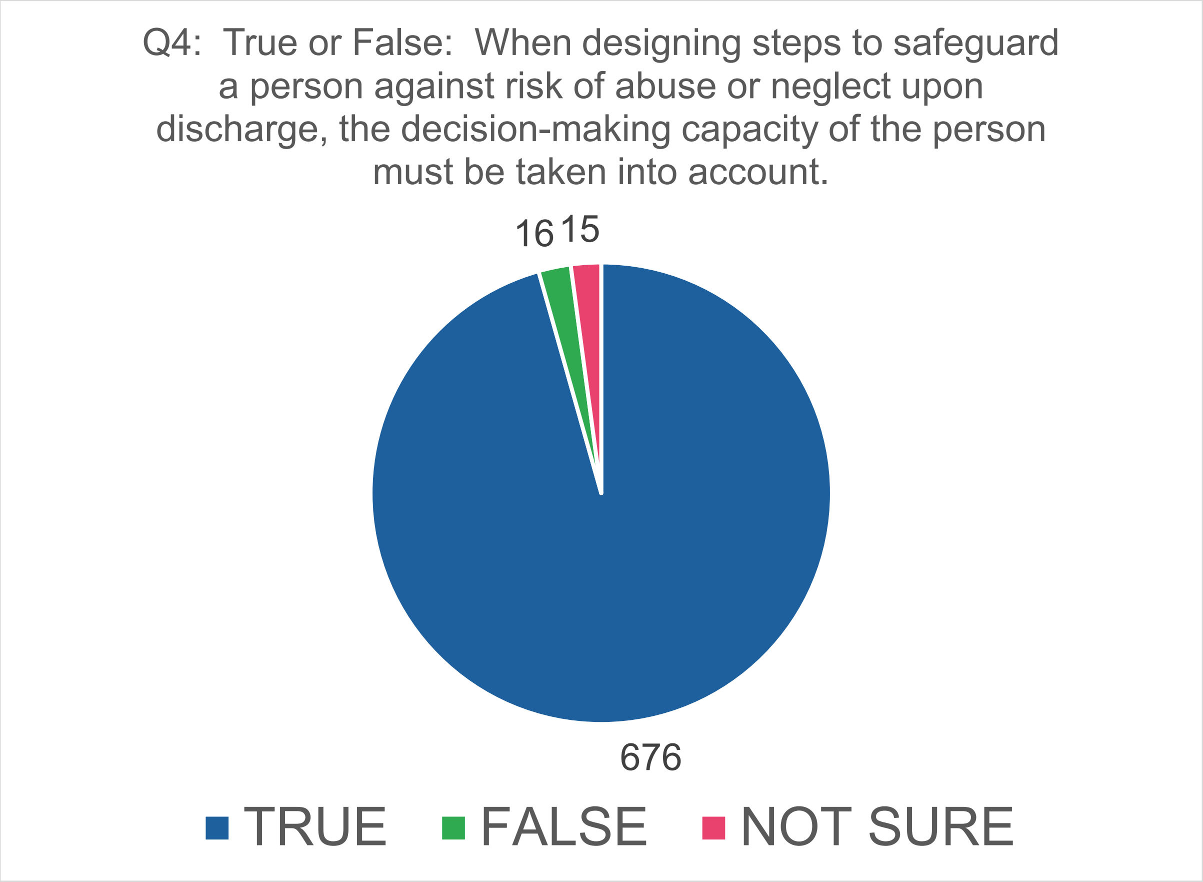

Q7: True or False: Hospital Trusts and Health Boards have the legal authority to require a person to leave hospital when it is no longer clinically appropriate for them to be in hospital.
310
443
195
TRUE
FALSE
NOT SURE


Q8: True or False: If a patient is being discharged somewhere in order to further assess their needs, a mental capacity assessment and best-interests decision is not required.
95
62
793
TRUE
FALSE
NOT SURE

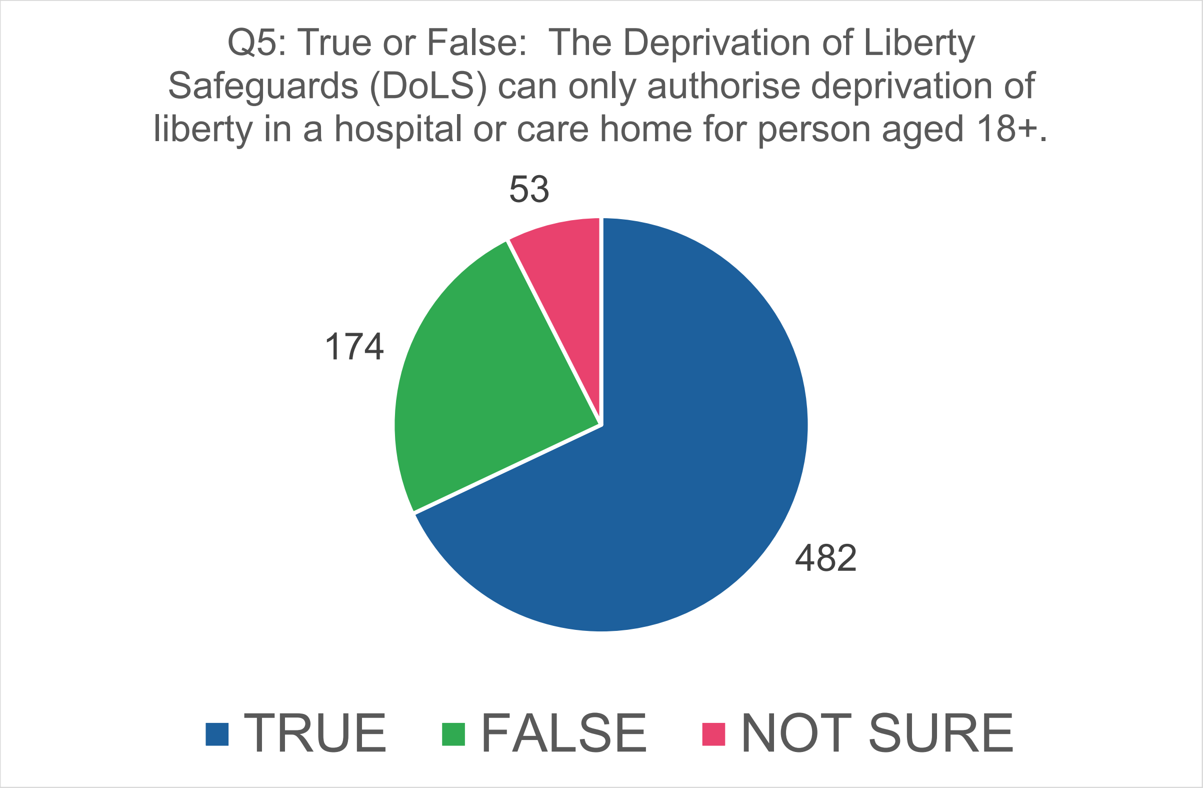
S3E3: Decision-Making with 16-18 Year Olds







Q4: True or False: When designing steps to safeguard a person against risk of abuse or neglect upon discharge, the decision-making capacity of the person must be taken into account.



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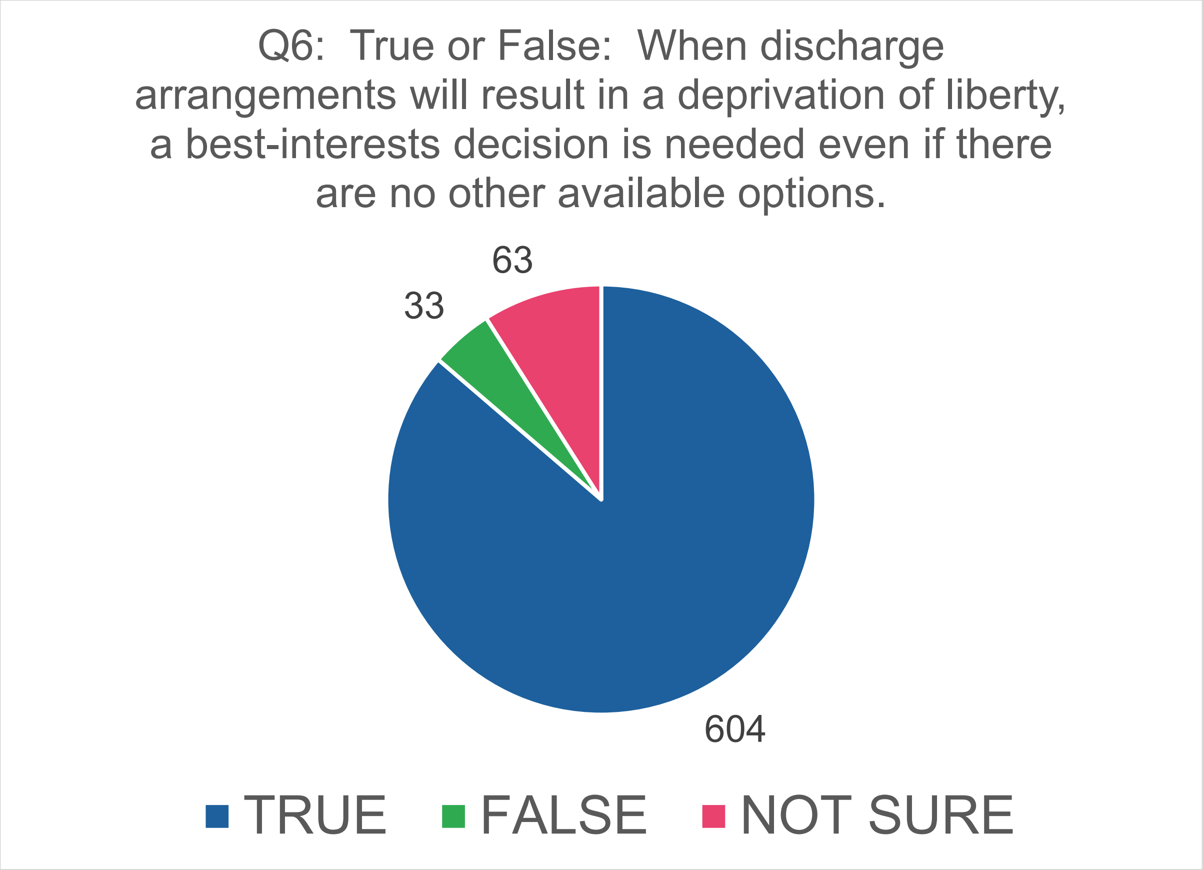
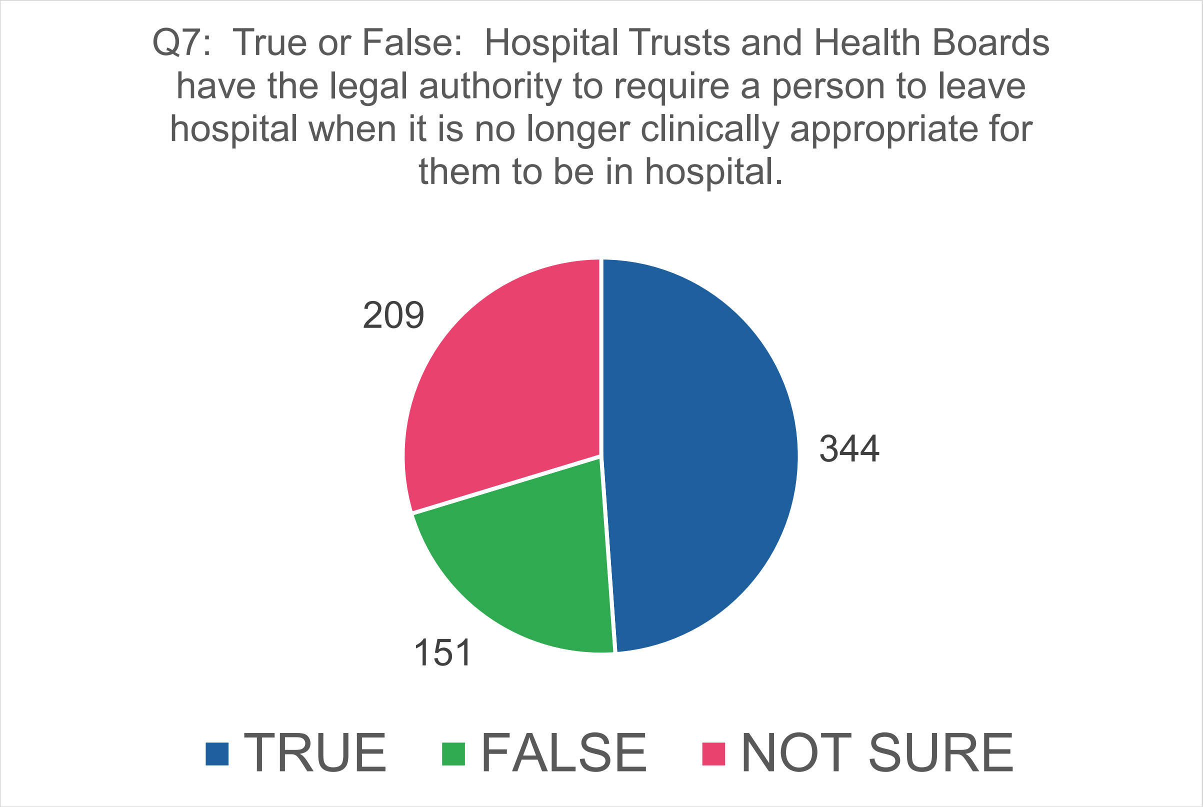
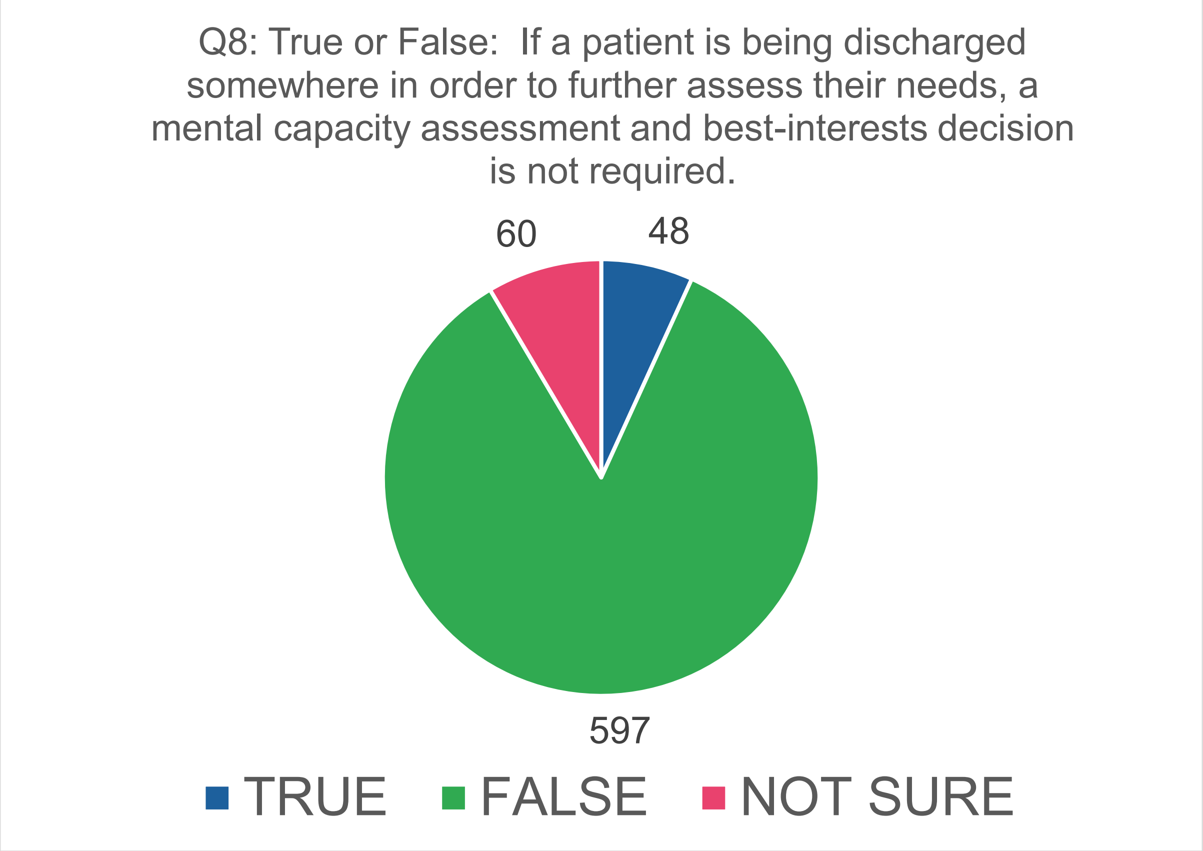
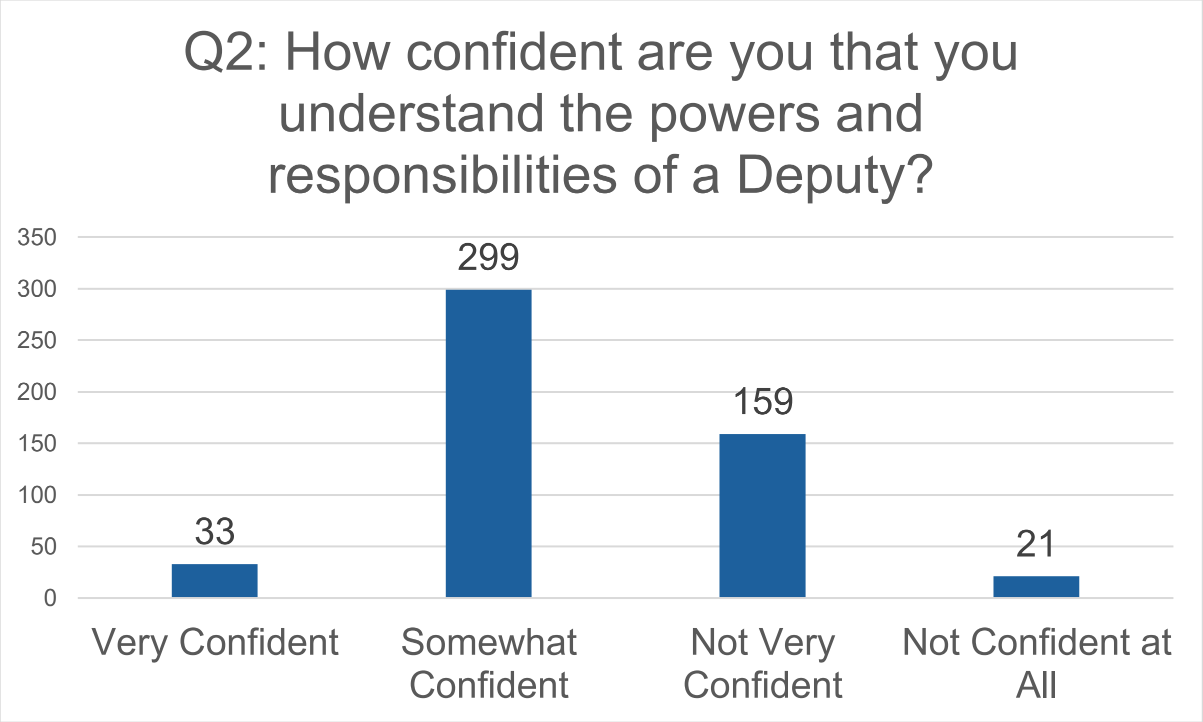
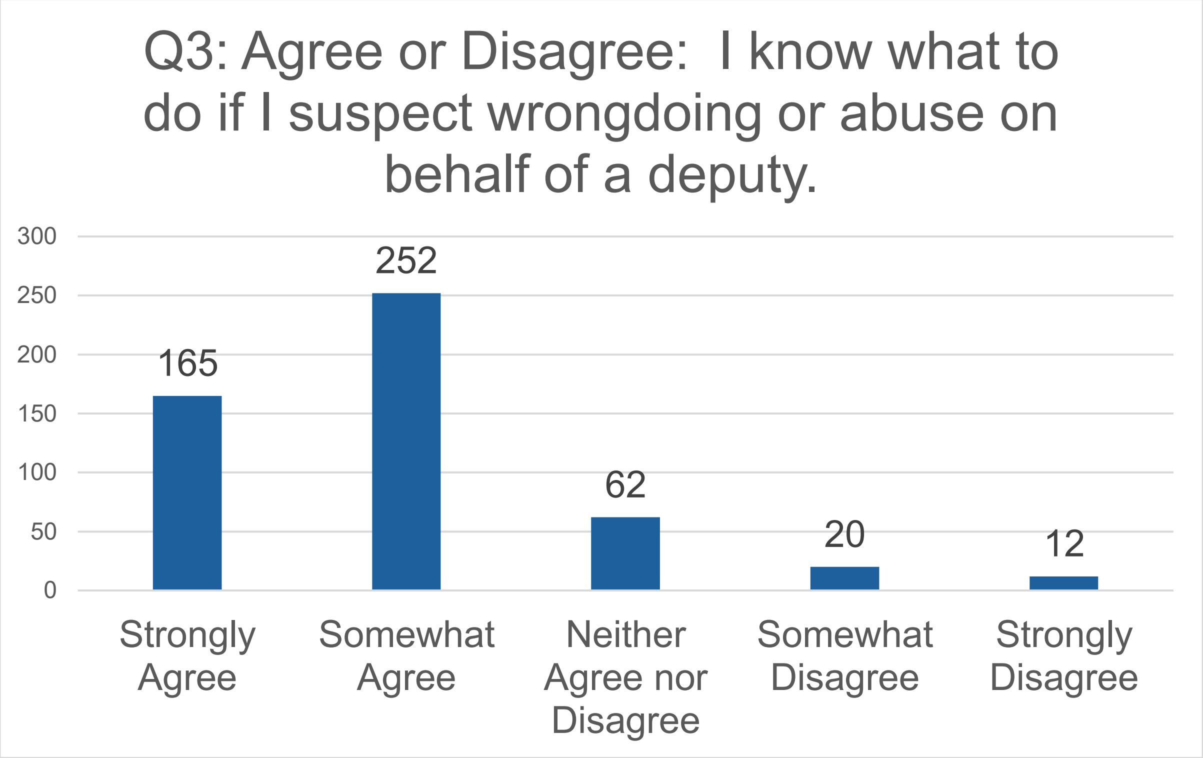

Q6: True or False: When discharge arrangements will result in a deprivation of liberty, a best-interests decision is needed even if there are no other available options.

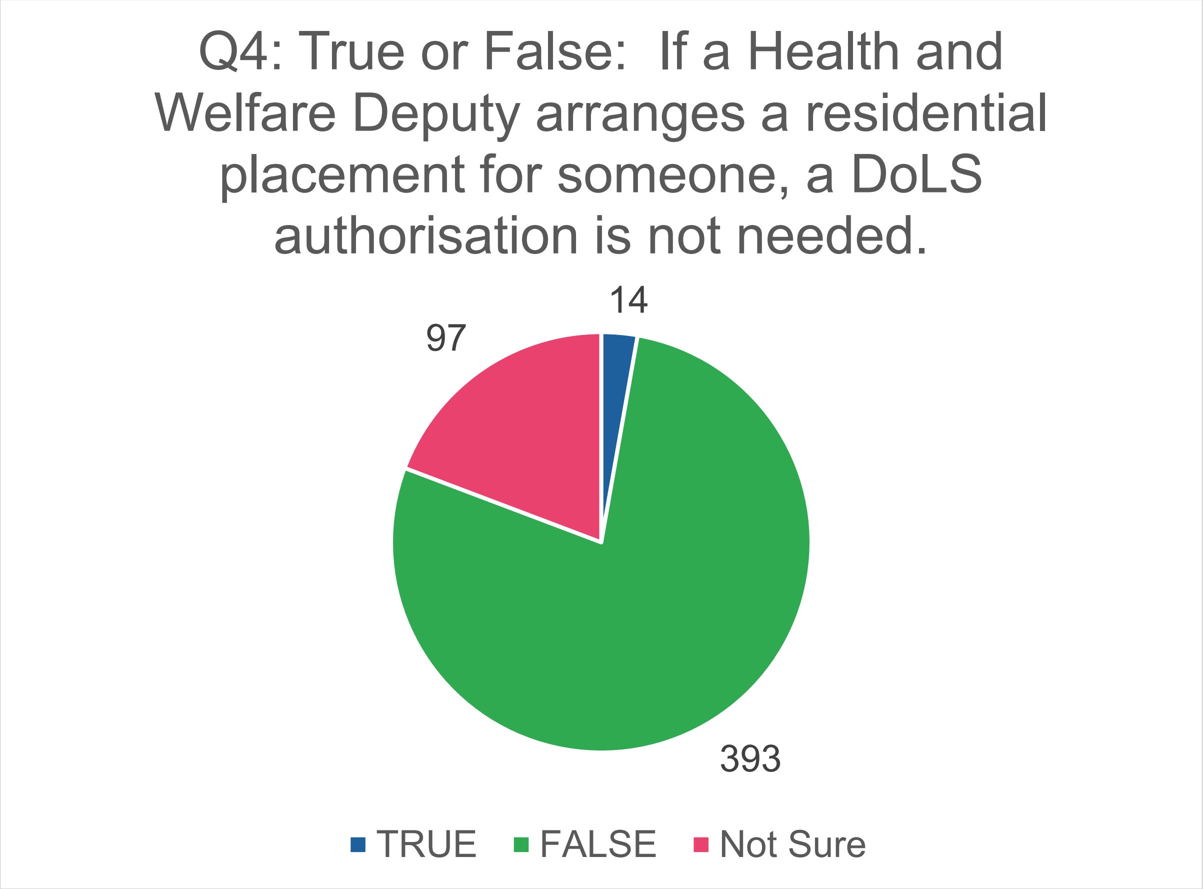

Q7: True or False: Hospital Trusts and Health Boards have the legal authority to require a person to leave hospital when it is no longer clinically appropriate for them to be in hospital.

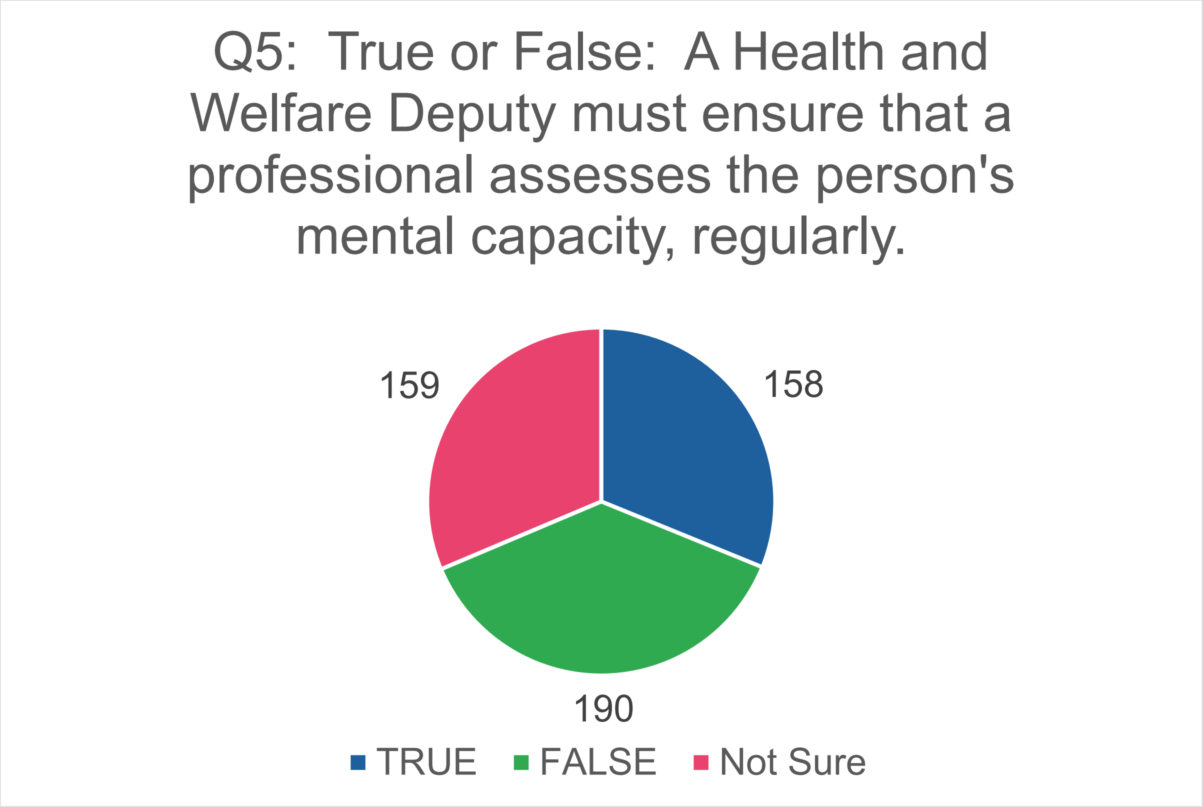


S3E5: Deputyships and their Limits

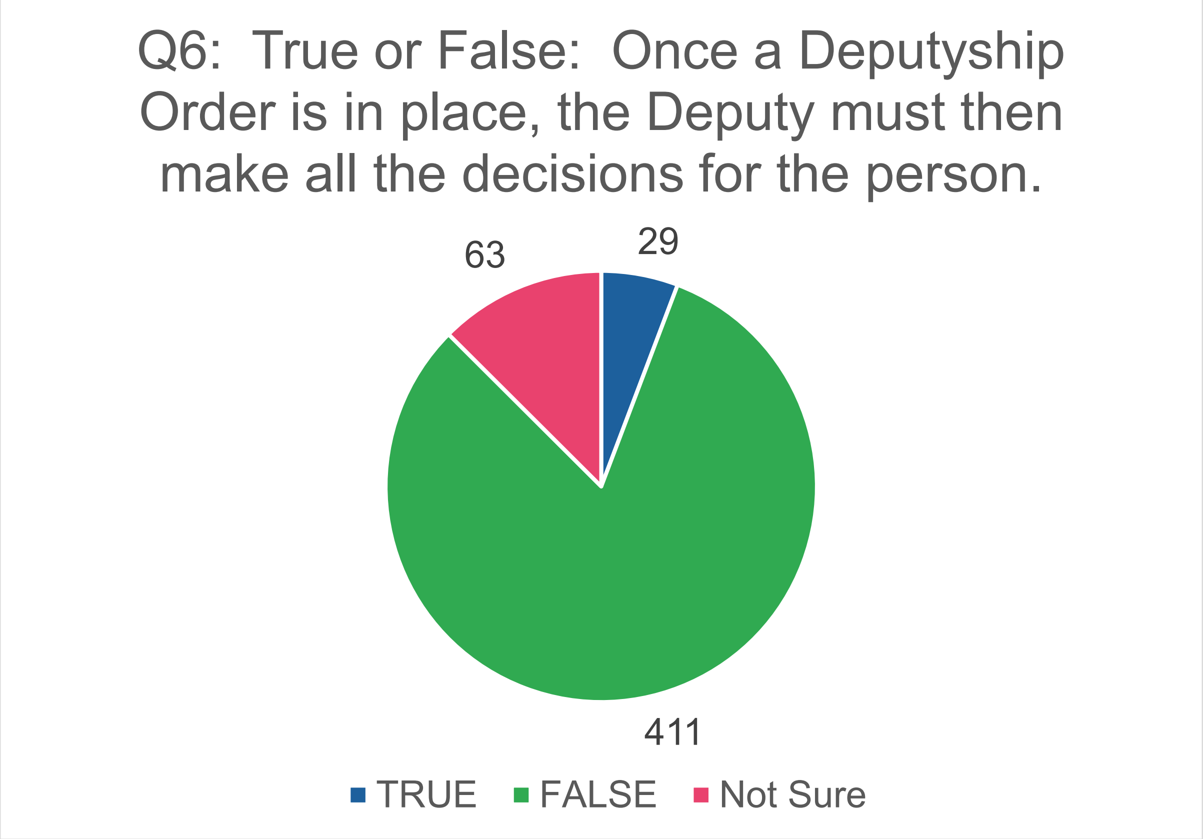



Q3: Agree or Disagree: I know what to do if I suspect wrongdoing or abuse on behalf of a deputy.
300
250
200
150
100
50
0
165
252
62
20
12
Strongly Agree
Somewhat Agree
Neither Agree nor Disagree
Somewhat Disagree
Strongly Disagree

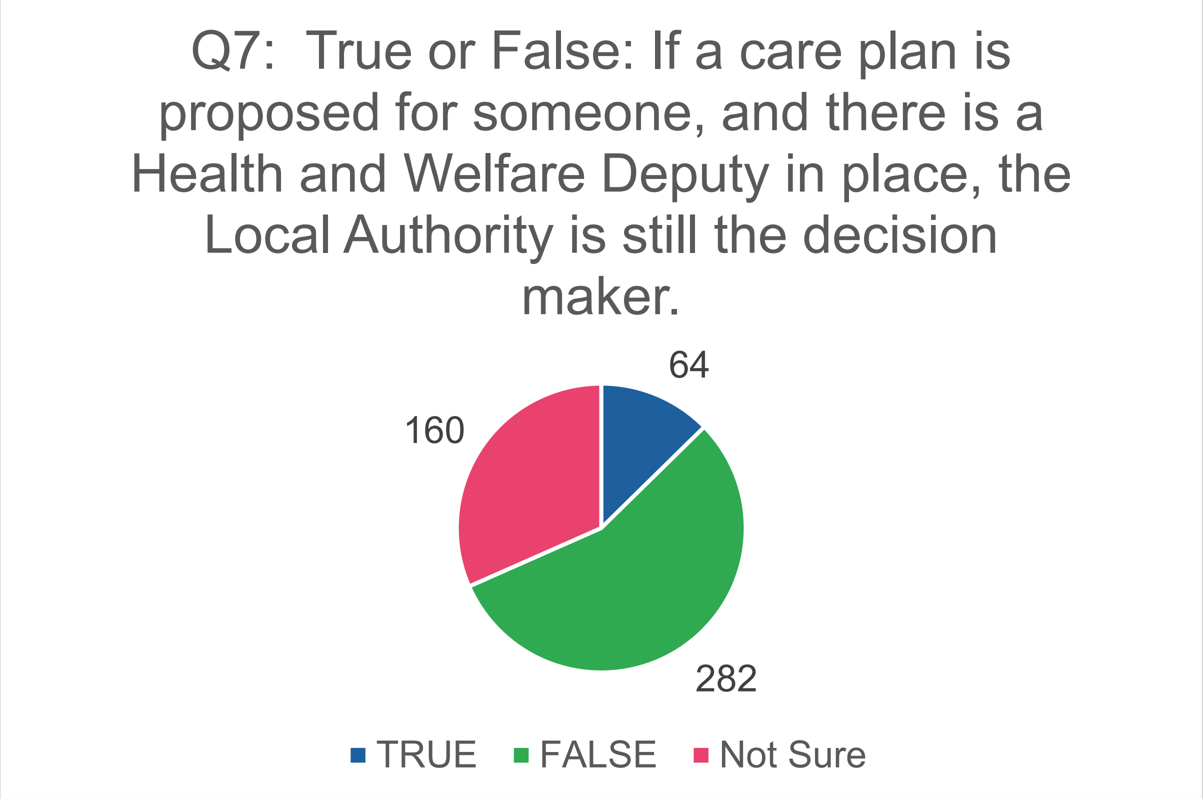

Q4: True or False: If a Health and Welfare Deputy arranges a residential placement for someone, a DoLS authorisation is not needed.
14
97
393
TRUE
FALSE
Not Sure

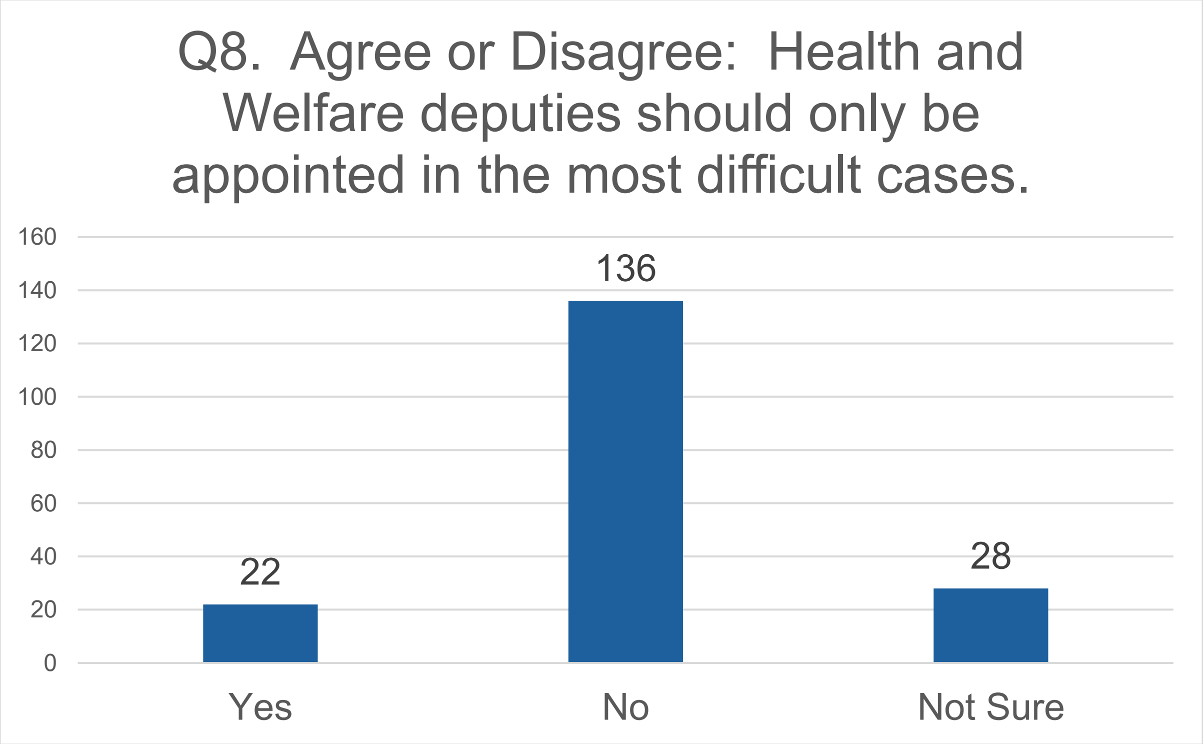


Q5: True or False: A Health and Welfare Deputy must ensure that a professional assesses the person's mental capacity, regularly.



Q6: True or False: Once a Deputyship Order is in place, the Deputy must then make all the decisions for the person.





Additional Question about Pathways of Dissemination of Information about NMCF Webinars