Mental Capacity Act

Scenarios

Department of
Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

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Introduction

The Mental Capacity Act (Northern Ireland) 2016 ("the Act") provides a statutory framework for people who lack capacity to make a decision for themselves and for those who now have capacity but wish to make preparations for a time in the future when they lack capacity.

The first phase commencement of the Act provides a statutory framework for deprivation of liberty (DoL) and makes provisions for offences, money and valuables and research.

When the Act is fully commenced the Mental Health (Northern Ireland) Order 1986 ("the 1986 Order") will be repealed for anyone over the age of 16. To manage the commencement of the Act, the 1986 Order will initially be kept for all and a dual system will exist with both the 1986 Order and the Act providing statutory frameworks for DoL. During this period if the 1986 Order can be used it must be used.

The legal framework provided by the Act is supported by two Codes of Practice which provide practical information for how the Act works.

In addition a number of scenarios have been provided in this scenario booklet. The scenarios are based on real life examples and aim to provide practical support to those working with people who lack capacity where deprivation of liberty is considered.

The scenarios must be read in conjunction to the Codes of Practice and the Act.

Unlike the Codes of Practice the scenario booklet does not have a statutory status and should be considered as Departmental guidance.

It is intended that the scenario booklet is a live document, meaning that updates will be provided if and when new scenarios and examples are provided and when difficult situations have been identified.

For the latest version of the scenario booklet please visit Department of Health's Deprivation of Liberty Safeguards web portal at www.health-ni.gov.uk/mca.

Scenario booklet version: 1

Updated on: 16 August 2019

Deprivation of liberty – general scenarios

Deprivation of liberty in nursing home

A person who moves to a nursing home from the family home and will be prevented from leaving at the nursing home is deprived of liberty and the safeguards and additional safeguards of the Mental Capacity Act are required.

Keywords: trust panel, nursing home

Bob is a 78 year old man with dementia living in East Belfast. He has been living in his family home with his wife as his main carer. Due to the dementia Bob has very limited understanding about most things and needs help with all aspects of life.

Bob is prone to wandering, however, he has previously not put himself in immediate danger and the wandering has been managed successfully. As Bob's dementia has deteriorated he is showing an increasing lack in understanding of dangers and has very recently, on a number of occasions, walked out in the road without awareness of cars and other vehicles. Bob's wife and others around Bob have become increasingly worried that he may get hurt as he does not appear to understand normal dangers any more.

Bob's wife's health has now deteriorated to a point where she cannot care for Bob. Bob's health has also deteriorated lately and an assessment of Bob's functionality and health has identified that he would be best suited for a nursing home. A nursing home is identified in Newtownards, which is liked by Bob's wife and their children. It is also considered that as Bob is no longer aware of dangers it would be best for him to be deprived of liberty.

The district nurse who has been involved in Bob's care over the last number of years, and knows Bob and his wife well through this engagement, carries out a capacity assessment in relation to the care arrangements that would amount to a deprivation of liberty. It is quickly determined that Bob lacks capacity in relation to the care arrangements.

The district nurse speaks to Bob's wife, as his nominated person, and Bob's children. She also involves other health and social care workers that have been involved in Bob's care. The district nurse concludes that Bob has made no previous comments on deprivations of liberty and that he is in general happy to receive care and treatment as appropriate. The district nurse therefore considers that care arrangements that would amount to a deprivation of liberty is in Bob's best interests.

During the best interests consideration the district nurse also considers the prevention of serious harm condition. As Bob lacks awareness of normal dangers, such as vehicles, and is prone to wander (and may therefore walk out in front of cars when he is wandering) there is a risk of serious harm to Bob. The district nurse also considers that a detention amounting to a deprivation of liberty in the nursing home is proportionate to the seriousness and likelihood of the harm.

The district nurse contacts the Belfast Trust's single point of contact for deprivation of liberty to ensure a medical examination and report is done, as Bob currently resides in

Belfast Trust. Belfast Trust arranges for one of the doctors that have been assigned as a doctor who can carry out medical reports to visit Bob and examine him. The doctor reads the statement of incapacity and best interests statement and after speaking to Bob and Bob's wife considers that he is satisfied that they are correct and that the criteria for authorisation are met. The doctor therefore fills out the medical report and signs it.

The district nurse then completes an application for trust panel authorisation including all annexes. When completing the Form she considers whether Bob has capacity to decide whether an application should be made to the Review Tribunal in respect of an authorisation that may be granted by the trust panel. The district nurse considers this to be a different capacity threshold than capacity in relation to the care arrangement that amounts to a deprivation of liberty. The district nurse considers if Bob is able to understand:

- that the care arrangements mean that someone will always be checking on him;
- that he cannot leave when he wishes to leave; and
- that a meeting can take place to decide whether or not that should be allowed.

The district nurse considers that Bob can understand this and therefore does not include Form 7 in the application to the trust for trust panel authorisation. The district nurse then sends the application, and all annexes, by email to the single point of contact in the South Eastern Trust as this is the trust where the nursing home where the deprivation of liberty will occur is located.

Whilst waiting for a trust panel authorisation arrangements are made for Bob to move. Bob is moved before the authorisation has been received and the care arrangements that amount to a deprivation of liberty are put in place by using the emergency provisions of the Mental Capacity Act (as it is determined to be an unacceptable risk of harm to Bob to wait with the deprivation of liberty whilst the application for authorisation is considered).

Four working days after the application is received by the South Eastern Trust, the trust panel has made a decision to grant the authorisation. Bob, Bob's wife as the nominated person and the managing authority of the nursing home are notified of the trust panel decision on Form 18. The Form is put in Bob's care plan.

Short-term detention in hospital for examination or examination followed by treatment or care

If a person is deprived of liberty in a hospital and there is no prior trust panel authorisation a short-term detention authorisation is required.

Keywords: shot-term detention, hospital

Victoria is a 69 year old lady who lives in a residential care home. There are normally no concerns about her mental capacity but she requires some help with normal day to day activities due to physical limitations.

Staff in the home have found Victoria in a very confused state. The GP responsible for her normal care has visited the home and diagnosed a urinary tract infection which has caused delirium. It is the GP's opinion that Victoria needs IV antibiotics and should therefore be taken to the Emergency Department (ED) at the local hospital.

The residential care home staff accompany Victoria to ED. Other staff are trying to contact Victoria's relatives, but are unsuccessful.

When arriving at the hospital Victoria is even more confused and tries to leave. ED staff are very concerned over her health and agree with the GP diagnosis and the need for IV antibiotics. They are of the opinion that with IV antibiotics Victoria will recover fairly quickly but without the medication she is at risk of serious harm due to the untreated illness. Staff consider that the criteria for short-term detention in hospital for examination or examination followed by treatment or care are met:

- Victoria suffers from an illness and requires treatment or care in hospital;
- Victoria is unable to understand information due to the delirium which means she lacks mental capacity in relation to the deprivation of liberty;
- It is in Victoria's best interests to be deprived of liberty as this will allow her to receive treatment and regain capacity. If she is not deprived of liberty, she will not receive treatment and may therefore decline further; and
- If Victoria is not deprived, and therefore does not receive treatment and is allowed to leave, there is serious risk that she will come to serious harm, both due to her confusion and lack of awareness and due to a deterioration in the illness. The deprivation of liberty therefore meets the prevention of serious harm condition threshold.

Staff are of the opinion that she needs to be deprived of liberty immediately and this takes place without any of the additional safeguards that can be delayed in the case of an emergency. Victoria is quickly moved to a ward and IV antibiotics are started.

The ward sister is aware of the requirements for a short-term authorisation and it is agreed that the treating doctor will carry out a formal assessment of capacity, best interests statement and the medical report. The doctor does this on the relevant Forms.

The ward sister then tries to contact an approved social worker (ASW) as it is intended that where possible an ASW should make the report authorising the short term detention. No ASW is available at the time and may not be available until the next day. The ward sister, who is suitably qualified and designated by the hospital to make authorisation reports, then makes the short-term detention authorisation on Form 8. As Victoria lacks capacity whether to make an application to the Review Tribunal a Form 7 is completed and the relevant information is sent to the Attorney General's office.

Two days later Victoria's condition has improved and she has regained capacity in relation to the care arrangements. As she no longer meets the criteria for detention amounting to a deprivation of liberty she is discharged from detention and agrees to stay as a voluntary patient to receive further treatment. A Form 21 is provided to Victoria noting the discharge from detention.

As Victoria is no longer deprived of liberty the Attorney General takes no further action.

Detention in hospital when detained in the normal place of residence

If a person is deprived of liberty in a hospital and there is a prior trust panel authorisation a short-term detention authorisation is not required the first seven days.

Keywords: shot-term detention, hospital, trust panel

Victoria is a 69 year old lady who lives in a residential care home. Her mental capacity is limited and she is subject to a deprivation of liberty in the care home.

Staff in the home have found Victoria in a very confused state. The GP responsible for her normal care has visited the home and diagnosed a urinary tract infection which has cause delirium. It is the GP's opinion that Victoria needs IV antibiotics and should therefore be taken to the Emergency Department (ED) at the local hospital.

The residential care home staff accompany Victoria to ED. Other staff are trying to contact Victoria's relatives, but are unsuccessful.

When arriving at the hospital Victoria is even more confused and tries to leave. ED staff are very concerned over her health and agree with the GP diagnosis and the need for IV antibiotics. They are of the opinion that with IV antibiotics Victoria will recover fairly quickly but without the medication she is at risk of serious harm due to the untreated illness. Staff considers that the criteria for short-term detention in hospital for examination or examination followed by treatment or care are met:

- Victoria suffers from an illness and requires treatment or care in hospital;
- Victoria is unable to understand information due to the delirium which means she lacks mental capacity in relation to the deprivation of liberty;
- It is in Victoria's best interests to be deprived of liberty as this will allow her to receive treatment and regain capacity. If she is not deprived of liberty, she will not receive treatment and may therefore decline further; and
- If Victoria is not deprived, and therefore does not receive treatment and is allowed to leave, there is serious risk that she will come to serious harm, both due to her confusion and lack of awareness and due to a deterioration in the illness. The deprivation of liberty therefore meets the prevention of serious harm condition threshold.

Staff are of the opinion that she needs to be deprived of liberty immediately. As Victoria is deprived of liberty in the residential care home where she normally resides staff understand that the trust panel authorisation for that deprivation of liberty allows deprivation of liberty in a place other than specified in the authorisation for the first seven days. This is noted on Victoria's care plan and no further action in relation to authorisation is made.

Two days later Victoria's condition has improved and she is ready to be discharged. She is discharged back to the residential care home where she continues to reside as before.

Short-term detention in hospital for examination or examination followed by treatment or care

If a person is deprived of liberty in a hospital and there is a prior trust panel authorisation a short-term detention authorisation is not required the first seven days. If the deprivation continues after seven days a short-term detention authorisation is required.

Keywords: shot-term detention, hospital, trust panel

Victoria is a 69 year old lady who lives in a residential care home. Her mental capacity is limited and she is subject to a deprivation of liberty in the care home.

Staff in the home have found Victoria in a very confused state. The GP responsible for her normal care has visited the home and diagnosed a urinary tract infection which has cause delirium. It is the GP's opinion that Victoria needs IV antibiotics and should therefore be taken to the Emergency Department (ED) at the local hospital.

The residential care home staff accompany Victoria to ED. Other staff are trying to contact Victoria's relatives, but are unsuccessful.

When arriving at the hospital Victoria is even more confused and tries to leave. ED staff are very concerned over her health and agree with the GP diagnosis and the need for IV antibiotics. They are of the opinion that with IV antibiotics Victoria will recover fairly quickly but without the medication she is at risk of serious harm due to the untreated illness. Staff considers that the criteria for short-term detention in hospital for examination or examination followed by treatment or care are met:

- Victoria suffers from an illness and requires treatment or care in hospital;
- Victoria is unable to understand information due to the delirium which means she lacks mental capacity in relation to the deprivation of liberty;
- It is in Victoria's best interests to be deprived of liberty as this will allow her to receive treatment and regain capacity. If she is not deprived of liberty, she will not receive treatment and may therefore decline further; and
- If Victoria is not deprived, and therefore does not receive treatment and is allowed to leave, there is serious risk that she will come to serious harm, both due to her confusion and lack of awareness and due to a deterioration in the illness. The deprivation of liberty therefore meets the prevention of serious harm condition threshold.

Staff are of the opinion that she needs to be deprived of liberty immediately. As Victoria is deprived of liberty in the residential care home where she normally resides staff understand that the trust panel authorisation for that deprivation of liberty allows deprivation of liberty in a place other than specified in the authorisation for the first seven days. This is noted on Victoria's care plan and no further action in relation to authorisation are made.

Victoria is quickly moved to a ward and IV antibiotics are started and it is expected that her treatment will be finished quickly. However, after six days it becomes apparent that Victoria will need further treatment and will remain an in-patient for longer than seven days. As the

trust panel authorisation will no longer be valid after the seven days a short-term authorisation is required.

The ward sister is aware of the requirements for a short-term authorisation and it is agreed that the treating doctor will carry out a formal assessment of capacity, best interests statement and the medical report. The doctor does this on the relevant Forms.

The ward sister then tries to contact an approved social worker (ASW) as it is intended that where possible an ASW should make the report authorising the short term detention. An ASW is available, comes and makes the appropriate examinations and then makes the short-term detention authorisation on Form 8. When considering if Victoria lacks capacity whether an application should be made to the Review Tribunal the ASW is of the opinion that he has capacity in relation to this and Form 7 is not completed.

Nine days later Victoria's condition has improved and is ready for discharge back to the care home. A Form 21, discharge from detention, is provided to Victoria as she is no longer subject to a short-term detention authorisation.

As Victoria's trust panel authorisation was never revoked and as the conditions for detention have been met continuously the trust panel authorisation which authorised the deprivation of liberty in the residential care home is still valid and in force. No further work in relation to authorisations are therefore needed when she is discharged from the hospital back to the home.

Deprivation of liberty in hospital with extension and later trust panel authorisation
A person can be deprived of liberty in hospital using the short-term authorisation report for up to 28 days. When the person is being moved from the hospital a short-term authorisation report is no longer valid and a trust panel authorisation is required.

Keywords: short-term detention in hospital, examination followed by treatment, short-term authorisation report, trust panel, emergency, deprivation of liberty conditions no longer met, formal assessment of capacity

Norman was diagnosed with dementia a number of years ago. He lives alone, with carer support four times every day. Today his daughter finds him much more confused than usual with visual hallucinations. She calls the GP who advises hospital admission.

Norman is diagnosed with delirium, but without any underlying cause, and admission to hospital is discussed. Staff believe that Norman currently lacks the capacity to make the decision about his hospital admission and the requirement to stay in hospital for treatment because of his delirium. A bed in an acute medical admissions ward is available. It is considered to be in Norman's best interests to be admitted and deprived of liberty using a short-term detention authorisation for examination followed by treatment. Norman's daughter, as nominated person, does not object to her father being admitted to hospital for examination and treatment even though this would mean a deprivation of liberty.

A short-term authorisation report requires a number of annexed forms, including a medical report. However, to delay admission until all of the required safeguards are in place would create an unacceptable risk of harm to Norman as it is determined that he needs admitted immediately. The emergency provisions of the Mental Capacity Act are used to admit Norman to hospital.

Norman is admitted to the hospital ward and a medical report and short term detention authorisation are completed later that day. The medical practitioner and the approved social worker believe that Norman lacks the capacity to make the decision about staying in hospital for examination and treatment, has an a illness that requires hospital admission for examination and treatment, that the prevention of serious harm condition is met, and that hospital admission for examination and treatment is in Norman's best interests.

The short term detention authorisation authorises detention in hospital for an initial 14 day period. Norman is examined on admission and an admission report is completed by the responsible medical practitioner. The admission report confirms that:

- Failure to detain Norman in hospital would create a risk of serious harm to Norman (as his delirium would remain un-investigated and untreated, potentially leading to his death);

- The detention for examination and treatment is a proportionate response to the likelihood and seriousness of that potential harm;
- Norman lacks capacity to make the decision to be admitted and stay in hospital for examination and treatment; and
- It is in Norman's best interests to be detained for examination and treatment for his delirium.

Norman still requires to stay in hospital after the initial 14 day period, as his delirium has not resolved and he stills lacks capacity to make decisions about his hospital admission. A further report is required. Norman's daughter is consulted as nominated person and does not have an objection to the extension of the short-term detention. A further report is completed by the alternative medical practitioner. This report confirms that:

- Failure to detain Norman in hospital would create a risk of serious harm to Norman (as his delirium still requires treatment, and failure to treat could potentially lead to his death);
- The detention for treatment is a proportionate response to the likelihood and seriousness of that potential harm;
- Norman lacks capacity to make the decision to stay in hospital for treatment; and
- It is in Norman's best interests to be detained for treatment for his delirium.

The short term detention is authorised for a further 14 days.

When Norman has been in hospital for 21 days, the medical team agree that soon he will no longer need to be treated in an acute hospital ward, but will require on-going treatment after his discharge from hospital. It is agreed that due to Norman's ongoing confusion caused by his delirium, this care and treatment should be delivered by nursing staff in a nursing home. Staff maintain their reasonable belief that Norman lacks capacity to make the decision about where his care and treatment should be provided. Staff are aware that the short term detention authorisation will expire in seven days and that it will not be valid outside the hospital. Staff therefore start the process of authorisation for deprivation of liberty in a nursing home.

A registered nurse with the required training undertakes a formal assessment of capacity. This assessment concludes that Norman lacks the capacity to make the decision about how his care and treatment should be delivered to allow him to recover as fully as possible from his delirium. Norman is unable to understand or retain the information to allow him to make a decision, despite his daughter being involved in helping to provide the information to her father. The registered nurse notes that this is most likely due to the diagnosis of delirium (rather than dementia in this case). A formal statement of incapacity is made.

Norman's daughter has been involved in all of the discussions around what care and treatment is to be provided in her father's best interests. She is hesitant about her father going to a nursing home, anxious that he may never be able to return to his own home. She is reassured however that when her father regains capacity to make decisions on this matter independently, the deprivation of liberty authorisation must be removed. Norman's daughter therefore raises no objection to the planned deprivation of liberty.

The required application form and annexed forms are completed and forwarded to the trust panel based in the Trust area where the care home is situated. The panel consider the application and authorise deprivation of liberty for Norman in a named nursing home for continuing treatment for his delirium for a period of six months. At that point the authorisation for deprivation of liberty must be reviewed.

Norman moves to a nursing home where he is deprived of his liberty. He is subject to continuous supervision by staff, and the exit doors of the care home are locked, preventing him from leaving.

Norman receives continuing care and treatment for his delirium. He progresses over the course of the next three months and his daughter believes that he has regained the capacity to make decisions about where he should live and how he should receive any care and treatment.

An assessment of capacity is undertaken by a registered nurse with the relevant training. Norman is able to understand and retain the information provided to him about staying in the nursing home to receive appropriate care and treatment. He therefore is considered to have the capacity to make the decision independently. The condition of a lack of capacity for authorisation of a deprivation of liberty no longer exists. Norman can no longer be required to stay in the nursing home or be prevented from leaving the nursing home and is discharged from detention.

Norman agrees to stay in the nursing home as a voluntary patient for another two weeks to complete his planned treatment and to ensure that appropriate home care arrangements are in place to facilitate his return home. Norman is not prevented from leaving the nursing home when he wishes to do so in that two week period.

Care planning, deprivation of liberty and restraint

Care planning that includes restraint, deprivation of liberty and seclusion to protect the safety of the person.

Keywords: restraint, seclusion, care plan, trust panel authorisation, application for trust panel authorisation, trust panel, emergency, authorisation

Steve is a 35 year old man with severe learning disability. He is non-verbal and does not respond to speech. He is unable to indicate any understanding to questions and cannot express emotions which causes him to be physically aggressive. His aggression has caused himself serious physical harm as he has thrown himself against walls, banged his head against hard objects and put his fists through windows on a number of occasions. His aggression has also caused serious physical harm to others when he has hit his carers.

Steve has recently been assessed by the Behaviour Support Service who have developed a Behaviour Support Plan. The plan includes environmental changes, such as reducing unpredictable noises and using daily schedules, teaching him new skills to help him cope with his emotions and de-escalation strategies for the purpose of risk management.

The support plan is being incorporated in a new care plan which includes Steve being taken to a bedroom or quiet space if he shows signs of heightened agitation, physical restraint as a method to get him to his room and seclusion in the form of having the door closed on the bedroom if he becomes more agitated to protect both him and the staff, with staff standing outside the door monitoring Steve at all time. The care plan also includes provisions for day care facility with locked front doors as Steve has no concept of danger, high locks on rooms within the centre to limit movement and 2 to 1 care at all times to manage any incidents that may occur.

Steve's mental capacity is assessed and it is determined that he lacks capacity in relation to the care plan and the care arrangements that amount to a deprivation of liberty that is contained in the care plan. A best interests meeting is convened where his treating consultant, behaviour support team representative, staff from his residential care home and day care centre and nominated person are present. It is agreed that the care plan (and the arrangements that amount to a deprivation of liberty) is in Steve's best interests and that the plan includes a deprivation of liberty, as it includes locked facilities, seclusion and planned restraint. Considering the circumstances it is agreed that the prevention of serious harm condition is met.

A nurse from the residential care home where he resides completes Form 5 – application for trust panel authorisation. In the application she includes:

- a statement of incapacity on Form 1;

- a best interests determination statement on Form 2;
- details of the consultation with the nominated person on Form 3;
- a medical report on Form 6;
- Steve's care plan; and
- Form 7; the nurse completing the application form considers if Steve has capacity whether an application should be made about the Tribunal if the panel authorises the detention. As Steve is unable to communicate and is not responding to interaction the nurse considers that he lacks capacity whether an application should be made to the Tribunal and therefore fills in Form 7 and signs the statement.

The nurse signs the application and sends it to the trust in which Steve lives. As the panel has seven working days to make a decision the multi-disciplinary team decides that waiting for the authorisation before the care plan is effectuated would cause an unacceptable risk of harm to Steve so the deprivation of liberty is commenced using the emergency provisions of the Mental Capacity Act.

Six working days later the panel has made a decision and authorises the deprivation of liberty. The authorisation is added to the care plan to ensure that all staff who are working with Steve are aware of it.

Deprivation of liberty in an acute hospital

A person who is deprived of liberty in hospital for a physical ill should be detained using short-term detention authorisation

Keywords: restraint, acute hospital

Colin was admitted to an acute medical ward having sustained a head injury caused by a fall. Colin also developed orthostatic hypotension and subsequently had a number of falls in the ward, causing further injuries.

The registered nurse considers Colin to lack the capacity to understand that he needs to stay in bed until his blood pressure stabilises to avoid further injury, including additional head injuries and that he lacks the capacity whether he should leave.

In an immediate attempt to prevent further collapses and potential injuries one to one nursing is introduced and a care plan outlining that Colin should be prevented from leaving if he tries to do so. This includes monitoring Colin's movements and ensuring that he stays in his bed or chair. If he tries to leave the bed or chair the care plan notes that he should be prevented from leaving. The registered nurse believes that this intervention may need to continue until Colin has regained the capacity to understand the significance of the potential harm he could sustain because of the problems with his blood pressure.

The registered nurse considers that the conditions for a deprivation of liberty are met as Colin is not free to leave and is under continuous control and supervision. As Colin is deprived of liberty a short-term authorisation is sought.

Colin is monitored continuously and the care arrangements are regularly reviewed. After a few days Colin is much better and it is considered that he has regained capacity and that one to one nursing is no longer needed and Colin is discharged from detention. A few days later Colin is discharged home.

Capacity to make decisions, even if unwise, and times when decision cannot be made even if the person lacks capacity

No act can be made on behalf of a person who has capacity to make a decision (unless the person consents to the act). A person must be allowed to make capacitous unwise decisions even if this is against the wishes of others, including family and professionals. Family members cannot demand action and cannot veto actions by others.

Keywords: help and support, capacity, unwise decisions, family disagreement, financial exploitation, personal autonomy, no unjustified assumptions, principles, principles

Eileen is a 55 year old woman who has a severe learning disability and autism. She went to "Special School" and lived with her family until she was 16. At this point Eileen's behaviour became more challenging and the family found it increasingly hard to cope. Eileen presented a risk to herself and others, including her siblings and as a result was admitted to Muckamore Abbey Hospital under the powers of detention in the Mental Health (Northern Ireland) Order 1986.

Eileen spent 10 years in hospital moving from acute admissions to the children's ward and then the long-stay ward. She settled fairly well in hospital and responded well to the routine and her treatment. She also engaged positively in activities and the social scene in the hospital. She was often detained for long periods in hospital under the Mental Health Order. She was described as "Special Care".

After many years Eileen moved into the community and increased the range of community based activities she attended, including going to an "integrated club" where clients from mental health services also attended. She starts to talk a lot about her friends at the club and is keen to spend more time with them and to opt out of other activities she previously enjoyed. Issues that arose which resulted in a series of case discussions and reviews, included:

- Eileen talking about one of the group being her boyfriend. She openly says she loves Jim and he loves her. Jim lives in the local mental health group home and has an extensive forensic history, including acts of physical and sexual violence. The views of Eileen's family and the engaged professionals are that this relationship is not in her best interests given her vulnerability and his history.
- Eileen's compliance with her care plan and engagement with staff reduces significantly. She stays out very late, sometimes overnight and says that she wants to move in with Jim and marry him.
- Eileen subsequently becomes pregnant and gives birth to a daughter. There are pre-birth child protection meetings and her daughter is made the subject of a Care Order. Eileen only has limited contact and her daughter is placed for adoption.

- Eileen becomes pregnant again and is physically assaulted by Jim who is arrested and subsequently jailed for 18 months. This baby, is also taken into care. There is more contact with grandparents and kinship arrangements are considered for the baby.
- Eileen remains friendly with a group of friends from club. She reports to staff that she has no money. When asked further she eventually says that she always buys the other group attendees drinks and cigarettes, as she wants them to be her friends.
- Eileen is assaulted again by Jim when he is released from prison and this time she agrees to seek legal redress and a Non-Molestation Order is issued.
- Following this Eileen's mental health deteriorates and she ends up detained under the Mental Health Order in hospital again. When she leaves hospital, a similar pattern continues.

Eileen's family are very critical of the professionals and agencies involved and for failing to protect Eileen at all stages since she started going to the "integrated club" and met Jim. They insist that Eileen should have been deprived of liberty claiming that:

- they should have stopped her going out to see him and his friends;
- they should have intervened when it was obvious they were having a sexual relationship;
- they should have made other arrangements to protect her from Jim on his release from prison; and
- they failed to prevent her getting financially exploited by her "friends".

The multi-disciplinary team now has a meeting with the family where the family's concerns are discussed. At first the principles of the Mental Capacity Act are explained; that no assumptions can be made in relation to a person's capacity, that the person must be allowed to make unwise decisions, that no assumptions can be made due to age or condition, that support must be provided and that any decision on behalf of the person must be in the person's best interests. The team then go through the four individual complaints.

Firstly they talk about Eileen going seeing Jim and his friends. The team explains that in general no decision can be made on Eileen's behalf if she is competent to make the decision, even if it is unwise. And as she has capacity in relation to care arrangements that amount to a deprivation of liberty she should not be detained. The team also explains that Eileen has been provided support to help her keep safe. However, ultimately Eileen must be allowed to make decisions, even if they are risky and may appear unwise, as she has capacity to do so.

Secondly they talk about the sexual relationship. The team explains that a capacity assessment under common law was done in relation to sexual consent and that it was determined that Eileen did not have capacity to consent to sexual acts. The team also

explains that even though she lacks capacity in relation to this there is not much that can be done to prevent it happening without depriving her of liberty. Various options were considered and it was determined that the only two ways of preventing sex was to either ensure that Eileen did not meet Jim, which could not be done as Eileen has capacity in relation to the care arrangements that would amount to a deprivation of liberty. Eileen does not appear to suffer any harm from the sexual activity, and while she does not have capacity in relation to the act, she expresses wishes and feelings that she wants to have sex with Jim. The prevention of serious harm condition is therefore not met and a deprivation of liberty can therefore not be done, even if she lacked capacity. The team also explains that help and support is provided to Eileen to help her understand sex (so she can become capacitous) and to help her understand what is happening when she is meeting Jim.

Thirdly they discuss the protection of Eileen when Jim was released from prison. The team explains as Eileen has capacity to decide whether to see Jim therefore no acts can be done to stop it happening. This is even though seeing Jim may be considered unwise. Help and support is provided to Eileen with the effect that when she is assaulted again she agrees to stop seeing Jim and a Non-Molestation Order is put in place.

Fourthly they discuss the financial exploitation by her friends. Again the team explains that as Eileen has capacity in relation to care arrangements that would amount to a deprivation of liberty and nothing can be done to prevent her seeing her friends as the only mechanisms to do so would be a deprivation of liberty.

Unauthorised deprivation of liberty

A person cannot be deprived of liberty if he or she has capacity in relation to the deprivation.

Keywords: unauthorised deprivation of liberty, keypad, request access to leave

Molly is 49 years old and has a learning disability. She was admitted to a hospital ward in a hospital for people with learning disability. Although Molly tends to drink a lot of alcohol at home, her alcohol consumption was not the reason for her hospital admission. Her admission was not authorised as a short term detention as Molly had the capacity to consent to the hospital admission for examination and treatment. Molly does not meet the criteria for detention under the Mental Health Order.

Access to and from the ward is controlled by staff, or by the use of a swipe card. Molly requests a swipe card so she can come and go from the ward as she wishes, particularly as she enjoys a daily walk. The request is discussed at the multidisciplinary ward meeting. The request is rejected, as some of the team are concerned that Molly will buy and consume alcohol when she leaves the ward.

The registered nurse at the meeting reminds the rest of the multi-disciplinary team that Molly is neither subject to a short term detention authorisation, nor a deprivation of liberty authorisation and that she is not detainable under the Mental Health Order. To deny Molly the ability to leave the ward when she wishes is an unauthorised deprivation of liberty and unlawful. Those making this decision could be liable to prosecution, as there is no legal basis to deprive Molly of her liberty. The registered nurse states that Molly's reason for being in hospital is not associated with alcohol consumption, and that it isn't usual for Molly to buy alcohol when out walking. Additionally the registered nurse states that any consumption of alcohol is a lifestyle choice which had been discussed previously between Molly and her community nurse, with Molly confirming that she understood the potential consequences of excess alcohol consumption.

The multi-disciplinary team immediately accepts what the registered nurse said and acknowledges Molly's rights. As there are no swipe cards immediately available the staff on the ward are instructed to open the door for Molly when she wants to leave and Molly is informed of these arrangements. As Molly is now free to leave she is not deprived of liberty.

Unauthorised deprivation of liberty – false imprisonment

A person cannot be deprived of liberty if he or she has capacity in relation to the deprivation. If a person is deprived of liberty without authorisation the person preventing the leaving can be held criminally liable.

Keywords: unauthorised deprivation of liberty, keypad, request access to leave, false imprisonment

Molly is 49 years old and has a learning disability. She was admitted to a hospital ward in a hospital for people with learning disability. Although Molly tends to drink a lot of alcohol at home, her alcohol consumption was not the reason for her hospital admission. Her admission was not authorised as a short term detention as Molly had the capacity to consent to the hospital admission for examination and treatment. Molly does not meet the criteria for detention under the Mental Health Order.

Access to and from the ward is controlled by staff, or by the use of a swipe card. Molly requests a swipe card so she can come and go from the ward as she wishes, particularly as she enjoys a daily walk. The request is discussed at the multidisciplinary ward meeting. The request is rejected, as some of the team are concerned that Molly will buy and consume alcohol when she leaves the ward.

The registered nurse at the meeting reminds the rest of the multi-disciplinary team that Molly is neither subject to a short term detention authorisation, nor a deprivation of liberty authorisation and does not meet the criteria under the Mental Health Order. To deny Molly the ability to leave the ward when she wishes is an unauthorised deprivation of liberty and unlawful. Those making this decision could be liable to prosecution, as there is no legal basis to deprive Molly of her liberty. The registered nurse states that Molly's reason for being in hospital is not associated with alcohol consumption, and that it isn't usual for Molly to buy alcohol when out walking. Additionally the registered nurse states that any consumption of alcohol is a lifestyle choice which had been discussed previously between Molly and her community nurse, with Molly confirming that she understood the potential consequences of excess alcohol consumption.

The multi-disciplinary team immediately accepts what the registered nurse said and acknowledges Molly's rights. As there are no swipe cards immediately available the staff on the ward are instructed to open the door for Molly when she wants to leave and Molly is informed of these arrangements.

However, some staff are unhappy with allowing Molly to leave and refuse to open the door when Molly asks. The staff are on a number of occasions reminded of their legal obligations to open the door for Molly but still refuse to do so. Molly is getting increasingly agitated by

the refusal of some staff to let her out and discusses this with her non-statutory independent advocate, with whom she has a good long standing connection. The independent advocate discusses the issue with Molly and they agree to lodge a complaint with the PSNI.

PSNI investigate the complaint and come to the conclusion that Molly has been falsely imprisoned as there was no legal foundation of the deprivation of liberty. They also consider that the staff did so knowingly as they had been reminded a number of times that Molly must be let out when she wants to leave. A report is prepared for the Public Prosecution Service for decision on prosecution.

Unauthorised deprivation of liberty – unlawful detention

If a person who lacks capacity in relation to a deprivation of liberty is deprived of liberty without authorisation the person preventing the leaving can be held criminally liable.

Please note, the offence of unlawful detention is being commenced on 1 October 2020.

Keywords: unauthorised deprivation of liberty, keypad, request access to leave, unlawful detention, criminal offence

Molly is 49 years old and has a learning disability. She was admitted to a hospital ward in a hospital for people with learning disability. Although Molly tends to drink a lot of alcohol at home, her alcohol consumption was not the reason for her hospital admission. Whilst Molly does not have capacity in relation to her hospital stay her admission was not authorised as a short term detention as the prevention of serious harm condition was not met. Molly does not meet the criteria for detention under the Mental Health Order.

Access to and from the ward is controlled by staff, or by the use of a swipe card. Molly requests a swipe card so she can come and go from the ward as she wishes, particularly as she enjoys a daily walk. The request is discussed at the multidisciplinary ward meeting. The request is rejected, as some of the team are concerned that Molly will buy and consume alcohol when she leaves the ward.

The registered nurse at the meeting reminds the rest of the multi-disciplinary team that Molly is neither subject to a short term detention authorisation, nor a deprivation of liberty authorisation and does not meet the criteria under the Mental Health Order. To deny Molly the ability to leave the ward when she wishes is an unauthorised deprivation of liberty and unlawful. Those making this decision could be liable to prosecution, as there is no legal basis to deprive Molly of her liberty. The registered nurse states that Molly's reason for being in hospital is not associated with alcohol consumption, and that it isn't usual for Molly to buy alcohol when out walking. Additionally the registered nurse states that any consumption of alcohol is a lifestyle choice which had been discussed previously between Molly and her community nurse, with Molly confirming that she understood the potential consequences of excess alcohol consumption.

The multi-disciplinary team immediately accepts what the registered nurse said and acknowledges Molly's rights. As there are no swipe cards immediately available the staff on the ward are instructed to open the door for Molly when she wants to leave and Molly is informed of these arrangements.

However, some staff are unhappy with allowing Molly to leave and refuse to open the door when Molly asks. The staff are on a number of occasions reminded of their legal obligations

to open the door for Molly but still refuse to do so. Molly is getting increasingly agitated by the refusal of some staff to let her out and discusses this with her non-statutory independent advocate, with whom she has a good long standing connection. The independent advocate discusses the issue with Molly and they agree to lodge a complaint with the PSNI.

PSNI investigate the complaint and come to the conclusion that Molly has been unlawfully detained in accordance with section 269 of the Act as there was no legal foundation of the deprivation of liberty. They also consider that the staff did so knowingly as they had been reminded a number of times that Molly must be let out when she wants to leave. A report is prepared for the Public Prosecution Service for consideration for prosecution.

As the issue is a systemic issue where the management of the hospital were aware of the unlawful detention but failed to act to prevent the offence taking place further investigation into the conduct of the senior officers were held. As section 273 provides for criminal liability for the corporate entity a file for prosecution was prepared in respect of the hospital manager.

Deprivation of liberty and the Mental Health Order
If the Mental Health Order can be used it must be used.

Keywords: Mental Health Order,

Wendy is 16 and has an eating disorder. Wendy has had a year of community based treatment with limited response. She is underweight and not eating. She has recently lost a further 3kgs in weight and purges daily. Her blood potassium levels are dangerously low which could cause cardiac arrest. The GP and the approved social worker believe that Wendy requires to be hospitalised. They believe that she lacks the capacity to make a decision about eating a healthy diet, has an a illness that requires hospital admission for treatment, that hospital is required to prevent serious harm, and that hospital admission for treatment is in Wendy's best interests.

As Wendy meets the requirements of the Mental Health (Northern Ireland) Order 1986 she is detained for admission for assessment, in line with normal procedures. The Mental Capacity Act cannot be used.

Capacity in relation to the deprivation of liberty

Determining capacity

Applying the functional test.

Keywords: functional test; appreciation, Principles, prevention of serious harm condition

Roberta is an 84 year old lady with early onset dementia. She lives by herself and has done so since her husband died 20 years ago. Her children live far away and while they have regular phone contact they do not often visit Roberta's house.

Roberta has recently had a fall and has been hospitalised for the last week. During the hospital stay the hospital staff became concerned that Roberta was not eating properly at home and that she was very dirty. Her children also expressed surprise at the state Roberta was in as she appeared to have lost a lot of weight since the last time they saw her.

Roberta's medical treatment is now finished and she is due to be discharged from hospital. The hospital staff are querying if she is able to cope at home and want her to move to a residential care home, rather than returning home. Roberta does not want to move to a care home and wants to return to her own home. She also expresses very strong views against anyone coming into her home to help her cope. It is considered that if Roberta is moved to a care home she would be deprived of liberty as she would most likely try to leave and return home.

A multi-disciplinary team meeting is called in the hospital where Roberta's case is discussed. It is agreed at the meeting that Roberta's ability to do normal day-to-day activities is severely reduced and that she is unable to provide food for herself or to keep her personal hygiene at safe levels. All participants at the meeting are of the opinion that it would be best for Roberta to move to a residential care home and that if she doesn't move to a care home she is at risk of serious physical harm to herself. It is agreed that a capacity assessment should be carried out to determine if Roberta has mental capacity to decide about the care arrangements amounting to a deprivation of liberty that will be put in place at the home.

It is agreed that a social worker, who has had previous interactions with Roberta, should carry out the capacity assessment.

The social worker speaks to Roberta at length in the hospital. Roberta expresses a clear wish to return home and to return to an independent life. She does not want to move to a residential care home. She also does not want to be "robbed" of her independence by being unable to leave.

The social worker tests if Roberta is unable to make a decision. Firstly he checks if Roberta can understand what they are discussing and if she can remember the information long enough to make a decision. Roberta is able to repeat what is being said and is demonstrating an understanding of the information.

Secondly the social worker asks Roberta about the consequences of her decision to see if she can appreciate and use and weigh the information. Roberta explains that she understands that poor hygiene and a lack of food may make her unwell and that this can cause her harm and even death. She also understands what the effect of the care arrangements in the home would be in relation to these issues and that these arrangements would amount to a deprivation of liberty; that she would not be free to leave. She says that the risks identified are risks she is willing to take as she has lived a long and happy life which has always been independent, especially as the option is to lose the independence she has always had. The social worker is of the opinion that Roberta can appreciate and use and weigh the information and that she can communicate the decision.

The social worker therefore concludes that as Roberta is able to do the four aspects of the functional test she does not lack capacity in relation to the care arrangements amounting to a deprivation of liberty.

The social worker asks Roberta if she wants to move to a residential care home or receive help to cope in her home. Roberta confirms that all she wants is to go home without any help. As Roberta has capacity and as her medical treatment in hospital is complete she is discharged into her own home without further help imposed on her.

Appreciation and vulnerable adults

Appreciation in long term situations and deprivation of liberty. The requirement to meet the prevention of serious harm condition before a deprivation of liberty can be imposed.

Keywords: vulnerable adult, appreciate, unwise decisions, prevention of serious harm condition, functional test

Mary is a 23 year old woman with brain injury who lives in a supported living facility. The facility is staffed 24 hours a day and provides the residents with regular care. A number of months ago staff at the facility became concerned that Mary has had several incidents where she has become severely distressed that short-term relationships, including one night stands after visiting a local nightclub, have not developed into long term relationships. The staff recognised that Mary is vulnerable and were concerned about what actions should be taken to protect Mary. The staff considers locking the door and preventing Mary leaving to control who she is seeing.

A clinical psychologist was asked to determine Mary's capacity in relation care arrangements amounting to a deprivation of liberty to prevent her visiting nightclubs with the ultimate aim to prevent the one night stands. During the assessment Mary demonstrated that she can describe the risks and benefits of going to nightclubs. She showed clear understanding that she becomes upset when there is no long term relationship as a result of the one night stands originating in the night club. Mary clearly retains the information well and can communicate her thoughts and her decision that she wants to continue going to the nightclub, but that she will resist one night stands as she knows this will only lead to distress.

The psychologist is of the opinion that Mary has capacity to make decisions around the care arrangements that would amount to a deprivation of liberty. As these arrangements are a direct impact on the nightclub visits and the one night stands this forms a substantial part of the discussion, in particular around harm. Ultimately, however, it is the capacity in relation to the arrangements that amount to a deprivation of liberty that is assessed.

The psychologist recommends that Mary should be supported to prevent disappointment when short term relationships, and one night stands, does not develop into long term relationships.

It is now six months later and there have been a further 13 incidents where Mary has become distressed following one night stands originating in the local night club. This affects Mary's emotional and psychological wellbeing, however, Mary is not at immediate risk of serious harm.

The clinical psychologist has returned and is assessing Mary's capacity again. Mary again clearly demonstrates that she understands the effect of care arrangements amounting to a deprivation of liberty by discussing the benefits and risks of going to the nightclub. She also expresses a clear understanding that one night stands will not lead to long term relationships and that this will cause her significant distress. Mary is insisting that she can go to the nightclub without a resulting one night stand.

The clinical psychologist considers that Mary can clearly understand the information, retain it long enough to make a decision and communicate the decision. The psychologist is also considering that Mary can present a reasoned understanding of the effects of the decision. However, taking into account the evidence of her actions, which is contrary to what she is saying, the psychologist considers that Mary is unable to appreciate that going to the nightclub will lead to one night stands which in turn leads to distress. This means that she cannot appreciate that the care arrangements amounting to a deprivation of liberty may have positive effects on Mary. The psychologist therefore determines that Mary is unable to make a decision about the care arrangements amounting to a deprivation of liberty because of her brain injury; Mary therefore lacks capacity in relation to deprivation of liberty to prevent her going to nightclubs.

Before considering if a deprivation of liberty would be in Mary's best interests the prevention of serious harm condition is considered; that failure to detain Mary would create a risk of serious harm to her or serious physical harm to others and the likelihood of harm and the seriousness of the harm is proportionate to the detention. The psychologist weighs up the arguments, including that the detention would be short-term and temporary although regular (as it would only prevent her to leave to go to the night club, in general on Friday and Saturday nights), that detention is a very serious infringement on a person's human rights and the harm it would cause Mary to let her continue going to the night club.

The psychologist considers that, at present, the non-existence of long term relationships after one night stands causes Mary distress. However, the distress abates fairly quickly, within a few days, and is not preventing Mary attending her place of work (day centre placement) or other regular events in the supported living facility. The psychologist therefore considers that while detaining Mary would prevent harm to her, the detention would not prevent serious harm and the detention would not be proportionate to the seriousness of the harm. As the prevention of serious harm condition is therefore not met the psychologist does not consider if a deprivation of liberty is in Mary's best interests.

The psychologist informs the supported living facility that Mary cannot be prevented from leaving. However, to help Mary cope with break ups and to make decisions she is happy with the psychologist suggestion of regular meetings with a counsellor to help Mary. Mary accepts this help and the supported living staff help organise the meetings.

Unwise decisions

Making unwise decisions

A person is allowed to make decisions that to others appear unwise. Unwise decisions cannot be used as evidence of lack of capacity.

Keywords: unwise decisions; vulnerable adult, principles

Mary is a 19 year old lady with a mild learning disability and attachment disorder. She lives in privately rented accommodation and has a social worker that helps her manage her money. Mary and the social worker has a good relationship and Mary is often keen on speaking to the social worker about her private life.

Mary has told her social worker that she is having casual sex with her landlord. Her social worker is concerned that the landlord is sexually exploiting Mary and using his position as her landlord to have sex with her. Mary is also very active online and regularly meets men she has met online for casual sex.

The social worker is concerned that Mary's actions are putting her at risk and wants Mary to move to a 24 hour staffed supported living facility where she would be deprived of liberty as she would otherwise try to leave, in particular to have sex. However, Mary states that she is fine and that she is fully aware of the dangers of the lifestyle she is living, including the risk of getting killed and sexually assaulted. She also repeatedly refuses the request to move into a supported living facility and is very upset at the concept of being deprived of liberty.

The social worker is still concerned and reports the landlord's behaviour to the police and wants it assessed if Mary has common law capacity to consent to sex (as the landlord may otherwise commit sexual offences) and mental capacity in accordance with the Mental Capacity Act in relation to the care arrangements that would amount to a deprivation of liberty at the supported living facility. The social worker discusses this in the multi-disciplinary team involved in Mary's long term care and it is decided that the consultant psychiatrist on the team will assess Mary's mental capacity.

The psychiatrist speaks with Mary, who is very open about her sex life and clearly expresses an understanding of the dangers of casual sex and meeting men online. Mary also expresses a clear understanding on all aspects of sex, including pregnancy, sexually transmitted diseases and contraception. In the discussion about supported living Mary is clear that she wants to reside at her own home and that she understands the risks of having causal sex with her landlord. She refutes that the landlord is exploiting her and states that she has sex with him because she wants to, not because he forces her.

Using the common law assessment of capacity the psychiatrists considers that Mary has an understanding about sex and residence. In the psychiatrists opinion Mary can consent to sex and has mental capacity in relation to care arrangements that would amount to a deprivation of liberty. No actions can therefore be taken to prevent Mary having sex and she cannot be forced to move away from her current residence.

Mary consents that the psychiatrists report is shared with the police. After the police receive the report they stop the investigation of sexual exploitation as the sex was consensual.

It is important to note that although the Mental Capacity Act can never be used if the person has mental capacity there may be other protocols and procedures, such as vulnerable adult protocols, that it may be appropriate to follow.

No assumptions can be made because of an unwise decision

A person cannot be assumed to lack capacity merely because of an unwise decision. A determination of capacity must be based on evidence and the test provided in the Mental Capacity Act. A capacitous person must be allowed to make an unwise decision.

Keywords: unwise decisions, principles, no assumptions because of an unwise decision, no assumptions because of illness or disability

Seamus is 32 years old. He lives in his own apartment within a supported living facility. Seamus has a mild learning disability. He has misused drugs in the past but currently denies any drug misuse when questioned by his support staff. Seamus is responsible for paying his rent and utilities bills, and for buying his own food.

Staff note a change in Seamus's behaviour. He is verbally aggressive towards staff. His fridge and cupboards have little food in them. He tell staff he has no money to pay his rent. Seamus admits to staff that he has used his money to buy drugs. He says that he knows it is illegal and that it is not safe to take drugs but he wants to do it anyway.

Staff assume that Seamus lacks the capacity to understand the consequences of buying and taking illegal drugs, and of spending all of his money on drugs. They believe that if they could prevent Seamus leaving, he would not be able to buy drugs and have sufficient funds to buy food and pay his bills. They therefore want to impose care arrangements that would amount to a deprivation of liberty.

Seamus's community learning disability nurse ("CNLD") knows Seamus very well. He assesses Seamus's ability to make decisions around the care arrangements that would amount to a deprivation of liberty. As the arrangements would be a direct consequence of the drug use they discuss the legality of the situation and the potential for police and court involvement, and what this could mean for his job and his tenancy. They discuss the health and safety aspects and how even limited use could have an immediate and/or long lasting effect on his health and safety. They discuss the risk to his health if he has no money to buy food and the risk to his tenancy should he not be able to pay his rent.

Seamus's CNLD is satisfied that Seamus's learning disability does not impact on his decision making around buying and taking drugs and that he has full understanding in relation to care arrangements that would amount to a deprivation of liberty. Seamus was able to understand and retain all of the information discussed with his CNLD. He articulated the risks associated with taking drugs, knows that there are risks to his health, safety, tenancy and job and he can outline how the care arrangements would work and how this would provide a perceived advantage to his drug use and general wellbeing. He believes that his

drug use is occasional and that he is willing to take the risks discussed regardless of the potential consequences.

As Seamus has capacity in relation to the care arrangements that amount to a deprivation of liberty no actions to detain Seamus can be done. Seamus continues to receive help and support and the staff are working on helping Seamus overcome his drug use.

Deprivation of liberty and unwise decisions

A capacitous person cannot be deprived of liberty and must be free to leave, even if doing so is considered unwise by others.

Keywords: nursing home, unwise decisions, principles

Deprivation of liberty was authorised for Muriel in a care home for respite care 13 weeks ago to allow her to be treated for a delirium.

Muriel has regained capacity to independently make the decision about her care arrangements. This condition for an authorisation of deprivation of liberty is no longer met and Muriel can therefore no longer be deprived of her liberty.

Muriel wishes to return to her own home. She has limited family support and as yet not all of the required domiciliary care calls have been sourced. Muriel's nearest relative, her nephew who lives in England, wants Muriel to stay in the care home. He believes the risk to Muriel's safety, falling for example, are too much for her to manage living alone.

Muriel wants to return home immediately, regardless of whether the domiciliary care package is in place or not.

The risks are discussed with Muriel, who accepts that they exist. Staff in the care home and Muriel's nephew believe that Muriel is making an unwise decision but, as Muriel has capacity, to prevent her from leaving the care home would be unlawful.

Muriel returns home without all of the required support package in place.

Best interests and prevention of serious harm condition

Best interests

Special regard must be had to wishes, feelings, beliefs and values.

Keywords: best interests; special regard; religious beliefs; wishes and feelings, principles

This case does not relate to deprivation of liberty. However, it provides a real life example of special regard to wishes, feelings, beliefs and values even if this is contrary to the clinically best decision.

Ben is a 73 year old man. He is diabetic and has been a long-term sufferer of a form of bipolar disorder and a long-standing mental illness that has deprived him of the capacity to make most decisions for himself.

Ben is now suffering from peripheral neuropathy, a complication of diabetes resulting in reduced sensation in the feet. This can lead to the patient being unaware that they have damaged their foot, leading to ulceration and subsequent infection. Ben's leg has now become severely infected. Ben's doctor, Dr Shaw is considering whether to amputate the leg or not. If the leg is amputated Ben might live for a few years, if it is not, it is likely that he would die, quite possibly within a few days.

When examining Ben's records Dr Shaw finds that Ben has a particular type of mental illness that causes him to have religious delusions. He has previously described hearing angelic voices that told him whether or not to take his medication. Dr Shaw also finds that Ben has always put a lot of importance to his religious views.

Dr Shaw assesses Ben's mental capacity and finds that he lacks capacity as he cannot appreciate and use and weigh the information to make an informed decision. Dr Shaw also determines that the medically best option would be to have surgery to amputate the leg.

Dr Shaw then considers the best interests of Ben, including consulting with all relevant people and having special regard to his wishes, feelings, beliefs and values. Although Ben lacks capacity Dr Shaw starts by speaking to him to involve him as much as possible in the decision. They discuss Ben's preferred option and what his wishes, feeling, beliefs and values are. During this discussion Mr B says:

> *I don't want an operation.*
> *I'm not afraid of dying, I know where I'm going. The angels have told me I am going to heaven. I have no regrets. It would be a better life than this.*
> *I don't want to go into a nursing home, my wife died there.*

I don't want my leg tampered with. I know the seriousness, I just want them to continue what they're doing.
I don't want it. I'm not afraid of death. I don't want interference. Even if I'm going to die, I don't want the operation.

Dr Shaw then speaks to others, including Ben's nominated person. In these discussions it becomes evident that Ben's religious views are strong and persistent. It also becomes evident that Ben's future life quality would be significantly limited if he has to live in a residential care or nursing home as he has strong negative connotations with them after his wife passed away in one.

Dr Shaw considers that Ben's expressed wishes, whilst not capacitous, did not appear to be showing florid psychiatric symptoms or to be unduly affected by toxic infection; rather they appeared to reflect his religious views. Even if the operation to amputate the foot was a success, the loss the foot would be a continual reminder that his wishes, feelings, beliefs and values had not been respected. Further to that, Ben's religious sentiments will undoubtedly continue and he will believe that the amputation was carried out against the Lord's wishes.

Dr Shaw also considered Ben's life after a successful operation, where he would not be able to return to any sort of independent life. At this point Ben has already been in hospital for 15 months and, given his multiple physical and mental difficulties, a discharge date could not be predicted. Dr Shaw considers that the best that could be hoped for was a discharged to a residential care home or, more likely, a nursing home.

To determine Ben's best interests, Dr Shaw combines all the known factors and after having special regard to wishes, feelings, beliefs and values finds that it would not be in Ben's best interests to take away the little independence and dignity he has in order to replace it with a future for which he does not want and which would be against his strongly held religious beliefs.

Dr Shaw therefore finds that the best interests of Ben is not to have surgery to amputate the leg and that he should be allowed to die in accordance with his religious views.

This is an adaptation of the Court of Protection case of Wye Valley NHS Trust v Mr B [2015] EWCOP 60.

Prevention of serious harm condition

The prevention of serious harm condition must be met for a deprivation of liberty to be lawful.

Keywords: extension report, extension, prevention of serious harm condition, approved social worker, responsible person

Suzanna is a 70 year old lady with schizophrenia. She is currently deprived of liberty in a nursing home and has been so for the last five years.

The current period of detention is nearing its end. The medical practitioner in charge of Suzanna's care has determined that she lacks capacity in relation to the deprivation of liberty and that it would be in her best interests to continue the deprivation of liberty.

The medical practitioner has also spoken to the nominated person who has provided some objections to the deprivation of liberty. However, overall the multi-disciplinary team has concluded that a continued deprivation of liberty would be in Suzanna's best interests.

The medical practitioner is now writing the extension report and is considering if the prevention of serious harm condition is met. She knows that if this condition is not met the deprivation of liberty must stop and an extension report cannot be made.

Suzanna is currently on depot injection and is not compliant with medication or with therapy sessions. Her family reports that she eats from bins when unwell and that she seriously neglects her hygiene. Suzanna has also been prone to wander and not return to her place of residence but rather stay on the streets. However, the medical practitioner also acknowledges that Suzanna has been in detention for five years.

Staff in the nursing home has reported that Suzanna has claimed to be raped in the past. However, no evidence of this, either medical or from the police, can substantiate the claims. The staff has also reported that Suzanna over the last few months on a number of occasions have been trying to self-harm in such a serious way that without intervention she would have suffered serious physical injuries and potentially even death. This appears to be from being unable to control herself when she has not been compliant with medication and therapy.

The medical practitioner therefore considers that the prevention of serious harm condition is met. An approved social worker, acting as the responsible person, provides a responsible person statement. The medical practitioner completes the extension report authorising the deprivation of liberty for a further year. The medical practitioner notes the nominated person's objections and Suzanna's wishes to go home. The medical practitioner ensures the

care plan includes help and support for Suzanna to become compliant and notes that the criteria for detention should be checked frequently to ensure that it is the most appropriate interventions and that other, less intrusive interventions such as attendance requirements, are considered when appropriate.

Deprivation of liberty and finding consensus when there is an objection
If a person is not free to leave and under continuous care and supervision he or she is deprived of liberty. An action can be done even though it is against the wishes and feelings of the person. Conflict resolution is good, but not required to make a decision.

Keywords: reasonable objection, consensus, special regard, wishes and feelings, conflict resolutions, trust panel

Fay is in her late 70s. She has been a widow for six years and lives alone. She has one son who lives 30 miles away. Fay had a brain tumour removed 20 years ago. As a result she experiences left sided weakness, communication, mobility and swallowing difficulties, and cognitive impairment. She requires a hoist for all transfers and sits in a wheelchair during the day. She has an extensive history of falls and fractures; because of her cognitive impairment she sometimes forgets that she cannot walk independently. She is doubly incontinent. She is an insulin dependent diabetic, receiving insulin 3 times every day for poorly controlled blood sugars. The speech and language therapist has prescribed a softened diet, but Fay doesn't always eat her meals. She is unable to prepare any meals for herself. Carers visit four times every day to assist with activities of daily living. They often find that Fay has not eaten the food prepared for her at the previous visit. This means she is at an increased risk of life threatening hyper- and hypoglycaemic episodes, as well as other potentially life changing health related illnesses. Fay has had numerous hospital admissions relating to her unstable blood sugar levels, fractures sustained after falling and head injuries.

The community nurse determines Fay's capacity regarding her diabetes, the requirement for insulin and the requirement to eat a prescribed but balanced diet at regular intervals. The community nurse considers that Fay is unable to make decisions about her diabetes and her meals independently. Fay's short term memory loss means that she cannot retain the relevant information.

The community nursing team feel that Fay should be cared for in a nursing home. Her dietary intake would be more closely monitored. Insulin administration would be adjusted promptly by a registered nurse in response to fluctuating blood sugar levels and actual dietary intake. This may improve her overall health, her cognition and reduce the number of hospital admissions. The effect of a controlled diet and regular care may also mean she may regain capacity.

The nursing team, together with a social worker and the nursing home management consider a care plan for Fay. The outcome is that that Fay would be deprived of liberty if admitted into the home. The team also considers that this would be in Fay's best interests.

Fay's son does not want his mother to go into a nursing home. When he was 15, prior to her brain surgery, he promised his mother that she would never have to live in a nursing home. He has previously refused short break care for his mother.

As a result Fay's son is disappointed and angry with the decision. However, an open and honest discussion with the community nurse in charge of his mother's care helps him to realise that this decision has been made in the best interests of his mother. Carers already visit four times every day and he cannot provide any additional help and support that would allow his mother to remain safely at home, as he lives 30 miles away. Fay will likely experience a more comfortable quality of life with less hospital admissions if her unstable diabetes and dietary intake are more closely monitored. Fay's son is reassured that the deprivation of liberty will be reviewed in six months' time, or removed sooner should his mother regain the capacity in relation to the care arrangements amounting to a deprivation of liberty by being able to independently make decisions about management of her diabetes (which would negate the need for a deprivation of liberty). He is also aware of the role of the review tribunal and how to make an application to the tribunal as nominated person.

As an admission to care home would amount to a deprivation of liberty additional safeguards are required, including trust panel authorisation. As part of the application for the authorisation process, all relevant factors are considered, including Fay's son's reasonable objection to any admission to a care home. Special regard is given to the promise that Fay's son made to her 20 years ago, that she would never have to live in a care home.

An authorisation panel consider the following reports and how they meet the criteria for authorisation:

- Medical report;
- Statement of incapacity;
- Best interests statement;
- Care plan detailing what care and treatment Mrs F will receive in the care home regarding her diabetes and dietary intake; and
- The views of the nominated person.

The panel authorises admission to a nursing home that will amount to a deprivation of liberty.

Least restrictive option and alternatives to deprivation of liberty

Less restrictive practices and finding alternatives to deprivation of liberty

A person who is not deprived of liberty must be free to leave when he or she wishes.

Keywords: keypad, less restrictive practices, finding alternative solutions

Minnie is 84 years of age. Her physical health is in decline. She needs assistance with personal care tasks and walks with a Zimmer frame. A distant niece has recently arranged for admission to a local nursing home, but has little other involvement in Minnie's life. Minnie has a diagnosis of dementia but this is not the main reason for admission to the care home. She was able to participate in the decision making around moving to the care home.

The nursing home staff note that Minnie becomes distressed when she cannot get outside for a walk during the day. Staff believe that although Minnie has fluctuating levels of confusion, nevertheless she could go outside for walk and return safely back to the care home. The exit doors of the nursing home can only be opened by keying number code into a keypad. Minnie has been given the exit code but she cannot remember the numbers. Staff have written the code on a piece of paper for Minnie. However, her dementia makes it difficult for her to understand what to do with the information. If Minnie wants to go outside for a walk she needs a member of staff to permit her access in and out of the home.

The home manager considers that Minnie is being deprived of her liberty, although that is not the intention of the staff. The home manager is concerned that staff are acting unlawfully because there is no legal basis to deprive Minnie of her liberty, although in reality this is what is happening; staff are in control of when Minnie can exit the home. The home manager considers that Minnie is able to make decisions about her safety when outside the home. Deprivation of liberty is not appropriate or in Minnie's best interests.

The home manager arranges for a key operated lock on the front door, which will work in tandem with the electronic keypad. Minnie is given a door key. She is able to exit and re-enter the building when she wishes to do so.

Less restrictive practices and finding alternatives to deprivation of liberty
Restrictive practices may be a suitable alternative to deprivation of liberty.

Keywords: less restrictive practices, least restrictive option, restrictive practices, GPS tracker, special regard, best interests

Ivan is an 82 year old man who has lived with his wife in a care home for around five years. He was diagnosed with dementia a number of years ago. Physically he is well. As a younger man he regularly ran marathons, running until he was 70 years old. When he was no longer fit enough to run, Ivan walked around five miles every day. He really enjoys being outside. When he and his wife moved to the care home, Ivan maintained his daily walking routine. He always informed the staff in the care home when he was leaving the home, and gave an approximate return time.

Recently staff have noted a deterioration in Ivan's memory. He has become confused about the time of day, regularly thinking evening time is morning time. He often forgets that he has already been for his daily walk. He has started leaving the care home much more frequently and has stopped informing staff when he leaves. He is walking further away from the care home than he used to. He has gotten lost on a number of occasions recently, and has been returned to the home by the police.

An assessment of capacity indicates that Ivan is unable to independently make decisions about his safety when outside of the care home. The nursing home manager and her team meet with Ivan's family to discuss their concerns. Ivan's eldest son was appointed nominated person when Ivan was first diagnosed with dementia. Ivan is leaving the care home more often the he did before, increasing the risk of harm to himself. Together the staff and Ivan's son discuss how to keep Ivan safe. Three options are discussed:

A. Authorised deprivation of liberty, which would allow staff to keep the exit door locked and Ivan in the building;
B. A GPS tracking system; and
C. 30 minute checks by staff of Ivan's whereabouts.

Option A is not considered to be in Ivan's best interests. Special regard is given to the fact that Ivan has always been an "outdoors" person and to not allow him the option of an independent daily walk would be detrimental to his physical, mental and emotional health.

Option C is not suitable either, as Ivan could leave the building in the time between checks.

Option B appears to be the most suitable, least restrictive option. Ivan's son agrees that a GPS tracking system with a pre-determined perimeter would be appropriate. The system would alert staff and family when Ivan moves outside of the perimeter, allowing someone

to monitor Ivan and direct him back home if he appears lost. This will allow Ivan to continue his daily walking routine, whilst providing some reassurances about his safety. There is some discussion around the ethical use of a tracking device. Ivan's son confirms that he believes his father would not object to the use of the tracking device if it allows him to continue to have the freedom to walk safely around the neighbourhood.

Ivan now wears a keyring on his belt that incorporates a GPS tracker that alerts Ivan's son when he walks outside of the agreed perimeter, allowing his son to quickly locate him or alert the care home of Ivan's whereabouts.

Restrictive practices and least restrictive option

A person cannot be deprived of liberty if there are less restrictive options available. Restrictive practices can often be used to prevent harm meaning a deprivation of liberty is not required.

Keywords: restrictive practices, least restrictive option, proportionality, private home, door alarm, locking door from the outside

David is an 88 year old man with dementia. He lives alone. Carers attend to David three times daily. The last call is around 8pm, when David is helped to get ready for bed. Recently David has started to leave his house after midnight, dressed in only his pyjamas. The police have returned David to his home on three occasions in the last month.

David's daughter has instructed the carers who attend to David to help him get ready for bed to lock the front door of her dad's house with a key from the outside, and to leave the key under the doormat. This will mean that is no key inside the house for David to open the door and leave the house. The carers are concerned about this instruction for a number of reasons:

- David would not be able to leave the house in an emergency, a fire for example;
- Someone could see them place the door key under the mat and use it to gain access to David's house; and
- There is currently no authorisation to deprive David of his liberty and he does not meet the deprivation of liberty criteria (as he would not be under continuous control and supervision).

The registered nurse who manages the integrated care team coordinating David's care meets with David and his daughter. David does not recall that he left his house after midnight on several occasions recently. However, David also does not appreciate the risks involved in being outside in his pyjamas alone and after midnight. The registered nurse concludes that David lacks capacity to make decisions about his safety if leaving the house alone and after midnight.

The registered nurse and David's daughter consider the circumstances around David's usual and current presentations. Leaving the house in the night-time, dressed in pyjamas is an unusual occurrence for David. The registered nurse and David's daughter agree that the GP should be involved to undertake some monitoring of David's current physical health which could be contributing to his increased disorientation. They also agree that the least restrictive intervention that could be used at this time in David's best interests and to keep him safe at night-time will involve the use of assistive technology to track David's movements. An alarm could alert David's daughter that he his opening his front door, allowing her time to react by either calling him on the phone or to drive to his house.

The registered nurse and David's daughter agree that this is a proportionate response that will help to keep David safe whilst investigations into his physical health are underway. Staff will not be required to lock David inside his own home without authorisation. David will still have an escape route in case of emergency and no-one else will have access to his front door key.

In the next month David attempts to leave his house after midnight on four occasions. On three occasions David's daughter telephones her dad when the alarm sounds. The call distracts David and David returns to bed after chatting to his daughter. On the fourth occasion David's daughter has to drive to her dad's house, where she finds him in the street. He tells her that he is going to the shop to get bread. She takes her dad home.

Clinical investigations are satisfactory. David's daughter suspects that her dad is hungry at night and that is why he is leaving the house; he is going to the shop. She arranges for the carers who come to help David get ready for bed to make him some tea and toast before they leave, and to have a snack on his bedside locker. Hopefully these actions will address David's hunger and make him less likely to want to leave the house during the night.

Depriving David of his liberty has been avoided for now and other aspects of his safety uncompromised.

Restraint and exceptions

Restraint

Restraint to enable treatment.

Keywords: restraint

John is a man in his early twenties. He is physically fit and well and lives an active and happy life but has a severe learning disability and does not speak or sign. He does not have capacity to make decisions unless he is physically presented with very simple choices about, for example food or clothing. He lives with his sister and brother-in-law who are his main carers since his parents passed away a few years ago.

Whilst John's care mostly does not present any problems he does not like having his teeth brushed and, in the past, went for periods with no brushing. His diet is very healthy and he has no active decay but he is staring to develop signs of gum disease. His gums are visibly red and bleed very easily and he sometimes has halitosis. However, he does not seem to be in pain.

His sister wishes to prevent progressive worsening of his gum disease, especially as there is a family history of the condition. After discussing all options, including a full oral exam using general anaesthesia, it was determined that the best interests would be regular cleaning in surgery with support by his family.

John comes to the dental surgery with his sister and brother-in-law. However, John is unsettled, will not sit still and will not open his mouth. In order to allow examination and simple scaling treatment John would have to be restrained. John's sister and brother-in-law are not trained in clinical holding but they have developed techniques that work for them, as they have to hold John at home for daily tooth brushing and other care that he does not like. The restraint would involve the brother-in-law sitting on the dental chair and holding John while his sister holds his head.

The dentist is concerned that if John does not receive fairly minor treatment now he will require major treatment in the not too distant future, including general anaesthesia. The dentist therefore considers that the restraint is necessary.

The treatment is a struggle for all concerned as John resists strongly. However, it is carried out in short sessions to reduce the distress to John and he seems to recover quickly when it is over. It is not possible to complete ideal treatment in these circumstances and it would not be in John's best interests to subject him to pro-longed restraint or to involve more people in the treatment. It is therefore agreed by the dentist and his family that he will be recalled every two months for short treatments with restraint. It is hoped that his condition

can be somewhat controlled with this approach but it is acknowledged that his condition will deteriorate over time. The dentist decides that regular reviews are required as if John's interests deteriorates his best interests may change rapidly.

The dentist is aware of the conditions for deprivation of liberty and considers if the restraint could be identified as a deprivation of liberty. Even though the restraint is planned, the intention behind the restraint is to provide short-term treatment and is not intended to prevent John leaving. Immediately after the treatment is finished the restraint is stopped and John is free to leave. The dentist therefore considers that the restraint does not amount to a deprivation of liberty.

Restraint in an acute hospital ward

A person can be restrained to prevent harm without it amounting to a deprivation of liberty

Keywords: restraint

Colin was admitted to an acute medical ward, having sustained a head injury caused by a fall. Colin also developed orthostatic hypotension and subsequently had a number of falls in the ward, causing further injuries.

The registered nurse considers Colin to lack the capacity to understand that he needs to stay in bed until his blood pressure stabilises to avoid further injury, including additional head injuries. However, the circumstances of the care does not meet the test for deprivation of liberty as he would be free to leave to ward if he so wished.

In an immediate attempt to prevent further collapses and potential injuries one to one nursing is introduced. This includes monitoring Colin's movements and encouraging him to stay on his bed or chair. If he tries to leave the bed or chair the nurse will support him to ensure he doesn't fall and hurt himself. This may include restraining Colin by holding him to prevent immediate harm.

The registered nurse believes that this intervention may need to continue until Colin has regained the capacity to understand the significance of the potential harm he could sustain because of the problems with his blood pressure. A number of days later Colin is much better and the one to one care can stop. Colin is later discharged home.

Restraint and deprivation of liberty in intensive care

Restraint in intensive care and acts that appear to be deprivation of liberty that is not when life-saving and in intensive care.

Keywords: restraint, intensive care, sedation

Maria is 35 years old and has Down's syndrome and severe learning difficulties. She confined to a wheelchair. Maria is unable to live independently so lives with her parents and adult sister.

Maria's difficulties means that she has limited decision making capacity and whilst Maria is receiving support in her home there are no formal arrangements for her care and there is no deprivation of liberty in place.

Maria's doctor is heavily involved in Maria's care and has a good relationship with both Maria, her parents and her sister. Maria is used to the doctor and is in general cooperative in dealings with him.

Maria is presenting to her doctor with breathing difficulties. After examination the doctor advices that Maria is taken to hospital for further examination and treatment. Maria cooperates with the decision to go to hospital for further examination and it is determined that Maria has capacity to consent to such arrangements. As Maria has been examined in hospital many times it is a scenario she is comfortable with and understands that it needs to happen. Maria's sister drives Maria to the hospital.

At the hospital it is determined that Maria has pneumonia and heart problems. She is admitted to a medical ward where she has not been before. Maria is not comfortable in unfamiliar surroundings and dislikes the medical tests required for the heart problem. The doctor in charge of her examination and treatment determines that Maria lacks capacity in relation to the examination and treatment. The doctor is of the opinion that if Maria was to be settled in the ward she may regain capacity. However, waiting for her to regain capacity would put her at serious risk of harm. Considering all factors he determines that it would be in Maria's best interests to be treated immediately. Consent Form 4 is therefore completed.

Over the course of a few days Maria's condition improves and arrangements are made for her discharge subject to certain checks being completed. Maria understands this and it is determined that Maria has capacity to consent to the checks required before discharge.

In the course of the checks, Maria's condition worsens, she drifts in and out of consciousness and she is admitted to an intensive care unit. In intensive care the staff

considers that Maria needs to be chemically restrained as she is lashing out and is very unsettled and is therefore preventing life-saving treatment.

Firstly, the staff determines that Maria lacks capacity as she is unable to understand the information in relation to the restraint (sedation) communicated to her. Secondly, the staff considers the sedation would be necessary.

Maria is intubated and sedated. She has a mitt placed on one of her hands to prevent removal of the tube.

The staff then considers if Maria is deprived of her liberty. In intensive care Maria is under continuous control and supervision and as she is sedated she is not free to leave. The staff determines that Maria, on first appearance, meet the deprivation of liberty test as set out in *Cheshire West*.

The staff then considers if the deprivation of liberty originates in Maria's lack of capacity or if it originates in the physical illness for which she is being treated. The staff remembers that a person is not deprived of liberty if treated for a life-threatening physical illness in intensive care and the treatment was one which it appeared to all intents would have been administered to a person who did not have her mental impairment.

As Maria is being physically restricted in her movements by her physical condition, and by the sedation, but the root cause of the loss of liberty is her physical condition, not any restrictions imposed by the hospital, the ICU staff correctly determines that Maria is not deprived of her liberty and no further safeguards are required.

As soon as Maria's condition improves the staff recognises that restrained is no longer necessary. Maria is then moved back to the ward where she was originally treated and when the treatment is complete she is discharged back into the care of her family.

Emergencies

Emergency deprivation of liberty

Preventing a person from leaving hospital and moving her to a nursing home where she is deprived of liberty.

Keywords: emergency

Lynn is a 50 year old married woman living at home with her husband and adult son. She has a long history of alcohol abuse. Efforts to treat her addiction have failed and her family has resorted to buying her alcohol to placate her.

Lynn has now developed alcohol related brain damage and liver failure and has been admitted to a medical ward. As her health improves she expresses a strong wish to go home. However, her family say that they cannot manage her and that she is not welcome back in the family home. It is also clear from her care need that she cannot live independently and the family refusing to care for her.

It is decided that Lynn should be moved to a care home due to necessity. The multi-disciplinary team caring for Lynn in hospital has had a best interests meeting where it was determined that she needs regular care, without the care Lynn would be at risk of serious physical harm and that it would be in her best interests to move permanently to a residential care home where she can have regular contact with the family.

Lynn gets very upset when she is told that she is moving to a residential care home. She immediately uses her mobile to phone a taxi and starts packing up her belongings. She tells the staff that she is leaving to go home.

The staff are very concerned for the wellbeing of Lynn and the family. They know that the family has said they will not let her back into the house. The staff considers that Lynn has nowhere to go and that she does not understand this. The staff also know that it has been determined that Lynn lacks capacity in relation to residence and discharge and that she would be at risk of serious physical harm unless she receives the correct care and treatment.

The staff wants to prevent Lynn leaving the ward and considers if the criteria for deprivation of liberty have been met:

- reasonable belief that she lacks capacity in relation to leaving;
- reasonable belief that it would be in her best interests to stay; and
- that she would be at risk of serious harm if she left (and that the deprivation of liberty is proportionate to the seriousness and likelihood of the harm).

The staff are aware that additional safeguards have to be in place before protection from liability applies. However, as Lynn is leaving immediately they consider that waiting for the

safeguards to be in place would create an unacceptable risk of harm to her and that the situation therefore is an emergency.

The staff tell Lynn that she is not allowed to leave and prevent her from leaving.

As the situation is an emergency the staff as soon as practicable ensure that all additional safeguards are put in place.

The next day Lynn is calmer and the staff do not consider that she would be at risk if she was not deprived of liberty. The deprivation is therefore ended. Later that week Lynn moves to the residential care home without any problems.

Nominated person

Nominated person from default list

If there is no nominated person a person should be selected from the default list.

Keywords: nominated person, default list

Pearl is 98 years old and has been living alone at her own home for the last 30 years since her husband died. Pearl has lived an independent lifestyle with only limited help. Domiciliary care workers have been helping her during two short visits per day as Pearl struggles to get dressed and undressed herself.

This morning the domiciliary care worker found Pearl unconscious on the floor next to her bed. An ambulance was called and Pearl was taken to hospital. At the hospital Pearl regains consciousness but is clearly delirious and tries to leave the hospital. Pearl is therefore deprived of liberty.

The doctor in charge consults Pearl's medical records and speaks to the domiciliary care agency to find out if Pearl, when capacitous, has appointed a nominated person. No appointment is found so the surgeon then consults the default list.

Pearl has no carer and no spouse of civil partner. Neither does she have anyone who has lived as spouse or partner. However, Pearl has two children, Lilly, who is 69 years old and Robert, who is 67. Robert has turned up in hospital but Lilly is still at her home.

Even though Robert is in hospital the doctor realises that Lilly, as the oldest child, is the default nominated person. The doctor then contacts Lilly and asks her to come to the hospital to discuss what would be in Pearl's best interests. As Robert is also concerned about Pearl's best interests he is also involved in the discussion.