

Case ID Number:

DEPRIVATION OF LIBERTY SAFEGUARDS FORM 3

AGE, MENTAL CAPACITY, NO REFUSALS, BEST INTERESTS ASSESSMENTS AND SELECTION OF REPRESENTATIVE

This combined form contains 4 separate assessments and includes selection of representative. If any assessment is negative there is no need to complete the others unless specifically commissioned to do so by the Supervisory Body.

Please indicate which assessments have been completed

(*Supervisory Bodies will vary in practice as to who completes the Mental Capacity Assessment)

Age

Mental Capacity*

No Refusals

Best Interests

This form is being completed in relation to a request for a Standard Authorisation

This form is being completed in relation to a review of an existing Standard Authorisation under Part 8 of Schedule A1 to the Mental Capacity Act 2005.

Full name of the person being assessed

Date of birth
(or estimated age if unknown)

Est. Age

This also constitutes the Age Assessment. If there is any uncertainty regarding the person's age, please provide additional information at the end of the form.

Name and address of the care home or hospital in which the person is, or may become, deprived of liberty

Name of the Assessor

Address of the Assessor

Profession of the Assessor

Name of the Supervisory Body

The present address of the person if different from the care home or hospital stated above.

In carrying out this assessment I have met or consulted with the following people		
NAME	ADDRESS	CONNECTION TO PERSON BEING ASSESSED
The following interested persons have not been consulted for the following reasons		
NAME	REASON	CONNECTION TO THE PERSON BEING ASSESSED
I have considered the following documents <i>(e.g. current care plan, medical notes, daily record sheets, risk assessments)</i>		
DOCUMENT NAME	DATED	

MENTAL CAPACITY ASSESSMENT	
The following practicable steps have been taken to enable and support the person to participate in the decision making process:	
In my opinion the person LACKS capacity to decide whether or not they should be accommodated in this hospital or care home for the purpose of being given the proposed care and/or treatment, and the person is unable to make this decision because of an impairment of, or a disturbance in the functioning of, the mind or brain.	
In my opinion the person HAS capacity to decide whether or not they should be accommodated in this hospital or care home for the purpose of being given the proposed care and/or treatment	
Stage One: What is the impairment of, or disturbance in the functioning of the mind or brain?	
Stage Two: Functional test	
a. The person is unable to understand the information relevant to the decision <i>Record how you have tested whether the person can understand the information, the questions used, how you presented the information and your findings.</i>	
b. The person is unable to retain the information relevant to the decision <i>Record how you tested whether the person could retain the information and your findings. Note that a person's ability to retain the information for only a short period does not prevent them from being able to make the decision.</i>	
c. The person is unable to use or weigh that information as part of the process of making the decision <i>Record how you tested whether the person could use and weigh the information and your findings.</i>	
d. The person is unable to communicate their decision (whether by talking, using sign language or any other means) <i>Record your findings about whether the person can communicate the decision.</i>	
Stage Three: Explain why the person is unable to make the specific decision because of the impairment of, or disturbance in the functioning of, the mind or brain.	

BEST INTERESTS ASSESSMENT	
MATTERS THAT I HAVE CONSIDERED AND TAKEN INTO ACCOUNT	
I have considered and taken into account the views of the relevant person	
I have considered what I believe to be all of the relevant circumstances and, in particular, the matters referred to in section 4 of the Mental Capacity Act 2005	
I have taken into account the conclusions of the mental health assessor as to how the person's mental health is likely to be affected by being deprived of liberty	
I have taken into account any assessments of the person's needs in connection with accommodating the person in the hospital or care home	
I have taken into account any care plan that sets out how the person's needs are to be met while the person is accommodated in the hospital or care home	
In carrying out this assessment, I have taken into account any information given to me, or submissions made, by any of the following: <ul style="list-style-type: none"> (a) any relevant person's representative appointed for the person (b) any donee of a Lasting Power of Attorney or Deputy (c) any IMCA instructed for the person in relation to their current or proposed deprivation of liberty 	
BACKGROUND INFORMATION <i>Background and historical information relating to the current or potential deprivation of liberty. For a review look at previous conditions and include comments on previous conditions set.</i>	
VIEWS OF THE RELEVANT PERSON <i>Provide details of their past and present wishes, values, beliefs and matters they would consider if able to do so:</i>	
VIEWS OF OTHERS	

<p>THE PERSON IS DEPRIVED OF THEIR LIBERTY In my opinion the person is, or is to be, kept in the hospital or care home for the purpose of being given the relevant care or treatment in circumstances that deprive them of liberty</p> <p>Note: <i>if the answer is No then the person does not satisfy this requirement</i></p>	<p>YES</p>	
<p>The reasons for my opinion: Note: <i>Consider the concrete situation of the person including type, duration, effects and manner of implementation of the measures in question in order to determine whether they meet the acid test of continuous (or complete) supervision AND control AND are not free to leave.</i></p> <p>Objective: <i>Applying the acid test should provide evidence of confinement in a particular restricted space for more than a negligible period of time. Refer to the descriptors in the DoLS Code of Practice in light of the acid test.</i></p> <p>Subjective: <i>Evidence that the person lacks capacity to consent to being kept in the hospital or care home for the purpose of being given the relevant care or treatment.</i></p> <p>The placement is imputable to the State because:</p>	<p>NO</p>	
<p>It is necessary to deprive the person of their liberty in this way in order to prevent harm to the person. The reasons for my opinion are:</p>	<p>YES</p>	
<p>Describe the risks of harm to the person that could arise which make the deprivation of liberty necessary. Support this with examples and dates where possible. Include severity of any actual harm and the likelihood of this happening again.</p>	<p>NO</p>	
<p>Depriving the person of their liberty in this way is a proportionate response to the likelihood that the person will otherwise suffer harm and to the seriousness of that harm. The reasons for my opinion are:</p>	<p>YES</p>	
<p>With reference to the risks of harm described above explain why deprivation of liberty is justified. Detail how likely it is that harm will arise (i.e. is the level of risk sufficient to justify a step as serious as depriving a person of liberty?). Why is there no less restrictive option? What else has been explored? Why is depriving the person of liberty a proportionate response to the risks of harm described above?</p>	<p>NO</p>	

BEST INTERESTS REQUIREMENT IS NOT MET

This section must be completed if you decided that the best interests requirement is not met.

For the reasons given above, it appears to me that the person **IS, OR IS LIKELY TO BE,** deprived of liberty but this is not in their best interests.

In my view, the deprivation of liberty under the Mental Capacity Act 2005 is not appropriate. Consequently, unless the deprivation of liberty is authorised by the Court of Protection or under another statute, the person is, or is likely to be, subject to an unauthorised deprivation of liberty.

A Safeguarding Adult enquiry must be considered for any unauthorised deprivation of liberty. Please place a cross in the box if a referral has been made.

Date of Referral:

Please offer any suggestions that may be beneficial to the Safeguarding Adult process, commissioners and / or providers of services in deciding on their future actions or any others involved in the resolution process.

BEST INTERESTS REQUIREMENT IS MET

The maximum authorisation period must not exceed one year

In my opinion, the maximum period it is appropriate for the person to be deprived of liberty under this Standard Authorisation is:

The reasons for choosing this period of time are: *Please explain your reason(s)*

DATE WHEN THE STANDARD AUTHORISATION SHOULD COME INTO FORCE

I recommend that the Standard Authorisation should come into force on:

RECOMMENDATIONS AS TO CONDITIONS (Not applicable for review)	
Choose ONE option only	
I have no recommendations to make as to the conditions to which any Standard Authorisation should or should not be subject (proceed to the Any Other Relevant information section of this form).	
I recommend that any Standard Authorisation should be subject to the following conditions	
1	
2	
3	
4	
RECOMMENDATIONS AS TO VARYING ANY CONDITIONS (Review only)	
Choose ONE option only	
The existing conditions are appropriate and should not be varied	
The existing conditions should be varied in the following way:	
1	
2	
3	
4	
SHOULD ANY RECOMMENDED CONDITIONS NOT BE IMPOSED:	
I would like to be consulted again, since this may affect some of the other conclusions that I have reached in my assessment.	
I do not need to be consulted again, since I do not think that the other conclusions reached in this assessment will be affected.	
ANY OTHER RELEVANT INFORMATION	
<i>Please use the space below to record any other relevant information, including any additional conditions that should or should not be imposed and any other interested persons consulted by you.</i>	
RECOMMENDATIONS, ACTIONS AND / OR OBSERVATIONS FOR CARE MANAGER / SOCIAL WORKER / COMMISSIONER / HEALTH PROFESSIONAL	

SELECTION OF REPRESENTATIVE– place a cross in one box			
<i>(Note that the Best Interests Assessor must confirm below whether the proposed representative is eligible before recommending them)</i>			
The relevant person has capacity to select a representative and wishes to do so.			
Name of person selected:			
The relevant person who lacks capacity to select a representative but has a Lasting Power of Attorney, or Deputy, for Health and Welfare, this decision is within the scope of their authority and they have selected the following person			
Name of person selected:			
Neither the relevant person nor their Donee or Deputy wish to, or have the authority to, select a representative and therefore the Best Interests Assessor will select and recommend a representative.			
RECOMMENDATION OF REPRESENTATIVE – place a cross in one box			
I recommend that the Supervisory Body appoints the representative selected by the relevant person above and confirm that they are eligible and would in my opinion maintain contact with the person, represent and support them in matters relating to or connected with the Standard Authorisation if appointed. <i>(Read guidance notes for clarification of eligibility)</i>			
I have selected and recommend that the Supervisory Body appoints the representative identified below. In so doing I confirm that: <ul style="list-style-type: none"> the person this assessment is about (who may have capacity but does not wish to select a representative) and / or their Donee or Deputy does not object to my recommendation; the proposed representative agrees to act as such, is eligible, and would in my opinion maintain contact with the person, represent and support them in matters relating to or connected with the Standard Authorisation if appointed. <i>(Read guidance notes for clarification of eligibility)</i>. 			
Please tick this box if this section is being completed because an existing representative's appointment has been terminated before it was due to expire and it is necessary for the Supervisory Body to appoint a replacement			
Full name of recommended representative			
Their address			
Telephone number(s)			
Relationship to the relevant person			
Reason for selection			
If you are not able to name a representative please place a cross in the box and record your reason below			
PLEASE NOW SIGN AND DATE THIS FORM			
Signed		Date	
Print Name		Time	