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| **DEPRIVATION OF LIBERTY SAFEGUARDS FORM 3**  **AGE, NO REFUSALS, BEST INTERESTS ASSESSMENTS**  **AND A SELECTION OF REPRESENTATIVE** | | | |
| This combined form contains 3 assessments and the selection of a representative. Should the requirements of any assessment not be met, the remaining assessments need not be completed unless they have been specifically commissioned by the Supervisory Body. | | | |
| 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 deprived of liberty |  | | |
| Date of birth (or estimated age if unknown-)  This also constitutes the **AGE ASSESSMENT**  If any uncertainty please provide additional information at the end of the form. | |  | |
| Contact details of the Supervisory Body | | | |
| Name |  | | |
| Address (including ward if appropriate) |  | | |
| Telephone Number |  | | |
| Email |  | | |
| Usual address of the person liable to be deprived of their liberty (if different to above) |  | | |
| Name and address of Managing Authority |  | | |
| Details of Care Co-ordinator/ Care Manager |  | | |
| Communication Needs and any relevant medical history |  | | |

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| **In carrying out the assessments contained within this form I have met or consulted with the following people** | | | |
| **NAME** | **ADDRESS** | **CONNECTION TO PERSON BEING ASSESSED** | |
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| **The following interested persons have not been consulted for the following reasons** | | | |
| **NAME** | **REASON** | **CONNECTION TO THE PERSON BEING ASSESSED** | |
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| **I have considered the following documents** *(e.g. current care plan, medical notes, daily record sheets, risk assessments)* | | | |
| **DOCUMENT NAME** | | | **DATE OF DOCUMENT** |
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| **NO REFUSALS ASSESSMENT** | |
| 1. There is not a valid Advance Decision, Lasting Power of Attorney or Deputy for Health   and Welfare in place. |  |
| 1. To the best of my knowledge and belief the requested standard authorisation **would not** conflict with an Advance Decision to refuse medical treatment or a decision by a Lasting Power of Attorney or Deputy for Health and Welfare. |  |
| 1. To the best of my knowledge and belief the requested standard authorisation **would** conflict with an Advance Decision to refuse medical treatment or a decision by a Lasting Power of Attorney or Deputy forHealth and Welfare. |  |
| *Please describe further:* |  |

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| **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 |  |
| I have, so far as is practical and possible, sought the views of :   * anyone the person has previously named as someone they want to be consulted * anyone involved in caring for the person * anyone interested in the person’s welfare (for example, family carers, other close relatives, or an advocate already working with the person), and * any donee or deputy who represents the person |  |
| **BACKGROUND INFORMATION**  Relevant 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. | |
| **VIEWS OF THE RELEVANT PERSON**  Provide details of their past and present wishes, values, beliefs and matters they would consider if able to do so. | |
| **VIEWS OF OTHERS** (the interested persons who have been consulted in carrying out the assessment should provide their views in relation to best interests). | |

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| **OUTCOME OF ASSESSMENT**  **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 care or treatment in circumstances that amount to depriving them of liberty. | | **YES** |  | |
| **NO** |  | |
| Consider the 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 supervision AND control AND not free to leave**. Refer to the descriptors in the Code of Practice in the light of the acid test.  **Objective Reasons*:*** *For example, applying the acid test should provide evidence of confinement in a particular restricted space over a not negligible period of time.*  **Subjective Reasons**: *A lack of valid consent to be confined in the hospital or care home to receive care and / or treatment.*  **The placement is imputable to the State because**: | | | | |
| **This deprivation is necessary in order to prevent harm to the person.** | | **YES** |  | |
| **NO** |  | |
| **The reasons for my opinion are**:Support this with examples and dates where possible. Include severity of any actual harm and the likelihood of this happening again.  **LEAST RESTRICTIVE OPTIONS**  After giving your reasons above you should now carry out analysis of the benefits and risks of each option identified**.**  **Option 1:**   |  |  | | --- | --- | | Benefits: | Risks: | |  |  |   **Option 2:**   |  |  | | --- | --- | | Benefits: | Risks: | |  |  |   (Repeat process if there are more options)  **OUTCOME OF ASSESSMENT**    **Concluding reasons**  **This deprivation is in the person’s best interests and is a proportionate response given the likelihood that the person will otherwise suffer harm and the seriousness of that harm.**    **YES**  **NO** | | | | |
| **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 under other statute, the person is, or is likely to be, subject to an unauthorised deprivation of liberty. | | | |  |
| A Safeguarding Adult enquiry must be made for any unauthorised deprivation of liberty.  Please place a cross in the box to confirm that a referral has been made.  Date of Referral: | | | |  |
| Reasons for safeguarding referral | | | | |
| **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)**  **Tick ONE box 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)**  **Tick ONE box only** | | | | |
| The exisiting conditions are appropriate and should not be varied | | | |  |
| The existing conditions should be varied in the following way: | | | |  |
| 1 |  | | | |
| 2 |  | | | |
| 3 |  | | | |
| 4 |  | | | |
| **IF ANY OF THE RECOMMENDED CONDITIONS ARE NOT IMPOSED**:  **Tick ONE box only** | | | | |
| 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**  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. | | | | |
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| **RECOMMENDATIONS, ACTIONS AND / OR OBSERVATIONS FOR CARE MANAGER /CARE CO-ORDINATOR/SOCIAL WORKER / COMMISSIONER / HEALTH PROFESSIONAL** | | | | |
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| **SELECTION OF A REPRESENTATIVE** | | | | | | | |
| **CAPACITY OF THE PERSON TO SELECT THEIR OWN REPRESENTATIVE**  **Tick ONE box only** | | | | | | | |
| 1 | The relevant person has capacity to select a representative. | | | | | |  |
| 2 | The relevant person lacks capacity to select a representative. | | | | | |  |
| 3 | The relevant person who lacks capacity has a Lasting Power of Attorney or Deputy for Health and Welfare and they have selected the following person because: | | | | | | |
| **THE REPRESENTATIVE** | | | | | | | |
| Please enter the details of the person selected to represent the person that this assessment is about and your reasons. In doing so, you are confirming that:   * If you are selecting a representative, then the person and / or their deputy agree with your recommendation. * That the person you are naming is eligible and agrees to be their representative | | | | | | | |
| 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 to appoint a replacement | | | | | | |  |
| Full name of representative selected | | |  | | | | |
| 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 |  | | |