DRAFT ILLUSTRATIVE CODE OF PRACTICE

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Policy	Estates
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Clinical	Partnership Working

Document Purpose	For Information	
ROCR Ref:		**Gateway Ref: 7581**
Title	The Bournewood safeguards : Draft illustrative guidance	
Author	DH	
Publication Date	December 2006	
Target Audience	MPs, Peers, media, wide range of stakeholders, public	
Circulation List		
Description	This illustrative draft guidance is intended to provide stakeholders and other interested parties with information about how the Bournewood safeguards that it is intended to introduce into the Mental Capacity Act 2005 through the Mental Health Bill should operate in practice.	
Cross Ref		
Superseded Docs	N/A	
Action Required	N/A	
Timing	**N/A**	
Contact Details	Mike Preston Department of Health Area 223 Wellington House 133-155 Waterloo Road London SE1 8UG 020 7972 3963 www.dh.gov.uk	
For Recipient's Use		

THE BOURNEWOOD SAFEGUARDS: DRAFT ILLUSTRATIVE GUIDANCE (WHEN FINALISED, TO BE INCLUDED IN THE MENTAL CAPACITY ACT 2005 CODE OF PRACTICE)

Background

1. On 5 October 2004, the European Court of Human Rights (ECtHR) gave judgment in the case of HL v the United Kingdom (commonly referred to as the "Bournewood" judgment). The ECtHR held that HL, an autistic man who lacked the capacity to consent to, or to refuse, admission to hospital for treatment, was deprived of his liberty when he was admitted informally to Bournewood Hospital. The ECtHR further held that:-

   - the manner in which HL was deprived of liberty was not in accordance with "a procedure prescribed by law" and was, therefore, in breach of Article 5(1) of the European Convention on Human Rights (ECHR); and

   - Because HL was not able to have the lawfulness of his detention decided speedily by a court, there had been a contravention of Article 5(4) of the ECHR.

2. In order to prevent further breaches of the ECHR, the Mental Capacity Act 2005 will provide additional procedural safeguards for people who lack mental capacity and whose care or treatment involves a deprivation of liberty within the meaning of Article 5 of the ECHR, but who either are not, or cannot be, detained under the Mental Health Act 1983.

3. The ECtHR judgment did not define what was meant by "deprivation of liberty", though it confirmed that it was different from mere restriction of liberty. The difference between deprivation and restriction was said to be one of degree or intensity. The judgment concluded that the health care professionals exercised complete and effective control over HL's assessment, care, treatment, contacts, movement and residence. He was under constant supervision and control, and was not free to leave. This amounted to a deprivation of liberty requiring safeguards satisfying ECHR Article 5(1) and 5(4), which would not have been required had there been only a restriction of liberty.

Overview and purpose

4. The Mental Capacity Act 2005 provides the framework for acting and making decisions on behalf of individuals who lack mental capacity to do these acts or make these decisions for themselves. For this reason, the safeguards put in place in response to the Bournewood judgment (for ease of reference called the "Bournewood safeguards" in this guidance) are contained within the Mental Capacity Act 2005. The safeguards apply to people who are, or are likely to be, deprived of their liberty for the purpose of being given care or treatment in hospitals or care homes. The safeguards will not apply to those people who are more appropriately made subject to the provisions of the Mental Health Act 1983, and who will

instead be entitled to the safeguards provided under that Act. (Chapter 12 of the Mental Capacity Act 2005 Code of Practice contains guidance on the relationship between the Mental Capacity Act 2005 and the Mental Health Act 1983.) **Note: Where there are cross-references to the Mental Capacity Act 2005 Code of Practice in this guidance, they are to the version of the Code issued for consultation on 9 March 2006.**

5. The principles of the Mental Capacity Act 2005, for example supporting the person concerned to exercise capacity to make a decision, acting in the best interests of the person concerned and in the least restrictive manner will all apply to any actions taken under the Bournewood provisions. Chapters 2 (Statutory Principles), 3 (Capacity to make a decision) and 4 (Best Interests) of the Mental Capacity Act 2005 Code of Practice provide more detail on these aspects. Part 2 of Chapter 4 includes guidance on the statutory checklist for determining best interests. It is important that the Mental Capacity Act 2005 and its accompanying Code of Practice guidance are adhered to whenever capacity and best interests issues are being considered in the Bournewood context.

6. The Bournewood safeguards make it clear that a person may only be deprived of their liberty in their own best interests and when there is no less restrictive alternative. They exist only to provide a proper legal process and suitable safeguards in those circumstances where deprivation of liberty is an unavoidable necessity in a person's own best interests. Every effort should be made to prevent deprivation of liberty becoming unavoidable.

7. Depriving someone who is vulnerable, and who lacks capacity, of their liberty is a serious matter, and the decision to do so should not be taken lightly. It is intended that a deprivation of liberty in Article 5 ECHR terms should be avoided if at all possible. The Bournewood safeguards apply specifically to deprivation of liberty and so, for example, it is not necessary or appropriate to apply for a Bournewood authorisation for all admissions to hospitals and care homes simply because the person concerned lacks capacity to decide whether to be admitted.

8. Those involved in the provision of residential accommodation potentially coming within the scope of the Bournewood provisions should, to the greatest possible extent that safety considerations will allow, seek to operate care regimes that promote a person's control over their daily living and maximise their autonomy. This will both reduce the likelihood of deprivation of liberty arising, and enhance their quality of life.

9. It is important that the principles of person centred planning - finding ways of listening to people to find out what is most important to them, what they want from their lives, and helping them to get those things – should be applied to all people who lack mental capacity, whether or not they come within the scope of the Bournewood safeguards.

10. A Bournewood authorisation relates solely to the issue of deprivation of liberty. It does not give authority to treat people, nor to do anything else that would normally require their consent. The arrangements for providing treatment to people in respect of whom a Bournewood authorisation is in force are subject to the wider provisions of the Mental Capacity Act 2005. This involves the need to confirm that the person lacks capacity to make the decision concerned and to establish whether the treatment will be in their best interests. Also, the treatment must not conflict with a decision made by a donee of a lasting power of attorney (an "attorney") or a deputy appointed by the court. The provisions of Sections 24 to 26 of the Mental Capacity Act 2005 regarding advance decisions are also relevant. But life-sustaining treatment, or treatment to prevent a serious deterioration in the person's condition, may be provided while a decision as respects any relevant issue is sought from the Court of Protection. The need to act in the best interests of the person concerned will continue to apply in the meantime.

Best practice to avoid deprivation of liberty

11. Much can be done by providers and commissioners of care through best practice to reduce the risk of deprivation of liberty by minimising restrictions and ensuring that decisions are taken involving the person concerned and their carers. Elements of good practice that are likely to assist in this, and in avoiding the risk of legal challenge, include:-

    - Ensuring that decisions are taken (and reviewed) in a structured way and that reasons for decisions are recorded. Protocols for decision-making should include safeguards against arbitrary deprivation of liberty.

    - Effective, documented care planning (including the Care Programme Approach, Single Assessment Process, Person Centred Planning, and Unified Assessment as relevant) for such people, including appropriate and documented involvement of family, friends, carers (both paid and unpaid) and others interested in their welfare.

    - Proper assessment of whether the patient lacks capacity to decide whether or not to accept the care proposed. In accordance with the principles of the Mental Capacity Act 2005, and Chapter 3 of the related Code of Practice, a person should not be taken to lack capacity to make a decision unless they have been given support to make the decision in question. If the person has capacity to do so, they should be supported to make decisions about their own care. It is also important to identify if a person's condition has deteriorated and they no longer have capacity to consent, and to ensure that decision-making complies with the Mental Capacity Act 2005, including consideration of whether they are deprived of liberty.

    - Ensuring, as required by the fifth principle of the Mental Capacity Act 2005, that alternatives to admission to hospital or residential care are

considered and that any restrictions placed on the person while in hospital or residential care are kept to the minimum necessary in all the circumstances of the case. Accordingly, before an authorisation is sought for deprivation of liberty, attempts must always be made to identify ways to meet the person's needs in a less restrictive way. An authorisation for deprivation of liberty is not an alternative to the proper application of the rest of the Mental Capacity Act 2005.

- Ensuring appropriate information is given to the person themselves and to family, friends and carers. This would include information about the purpose and reasons for the admission, proposals to review the care plan and the outcome of such reviews, and the way in which they can challenge decisions (eg through the relevant complaints procedure). The involvement of local advocacy services where these are available should be encouraged to support patients and their families, friends and carers.

- Taking proper steps to help the person retain contact with family, friends and carers. If, exceptionally, there are good reasons why maintaining contact is not in the person's best interests, those reasons should be properly documented and explained to the people they affect. It should be made clear how long the restrictions will be maintained and how the decision can be challenged.

- Ensuring both the assessment of capacity and the care plan are kept under review. It may well be helpful to include an independent element in the review. Such a second opinion will be particularly important where family members, carers or friends do not agree with the authority's decisions. But even where there is no dispute, all involved must ensure their decision-making stands up to scrutiny and complies with the principles of the Mental Capacity Act 2005.

12. Care homes and hospitals that follow best practice in this way will be well placed to implement the Bournewood safeguards, and will have minimised the risk of legal challenge to their actions.

Considerations of ethnicity, race and culture

13. The Bournewood provisions should not impact in any different way on different racial or ethnic groups. Care should be taken to ensure that the provisions are not operated in a manner that discriminates against particular racial or ethnic groups, and managing authorities of hospitals or care homes, and supervisory bodies, should ensure that all involved have the competence to operate the provisions equitably.

14. Account will need to be taken of cultural issues when carrying out the required Bournewood assessments, and assessors should have an understanding of how to take account of the cultural background of the relevant person. Interpretation should be available where necessary for

the assessors to communicate not only with the relevant person but also with people with an interest in their care and treatment. Information should be made available in other languages where necessary. Decisions about the appointment of Independent Mental Capacity Advocates (IMCAs) or relevant person's representatives in accordance with the Bournewood provisions, should take cognisance of the cultural, racial and ethnic background of the relevant person.

Key points for care homes and hospitals (managing authorities)

15. In implementing the Bournewood provisions, managing authorities should be particularly aware of:-

- The need to incorporate into their arrangements for care planning consideration of whether a person has capacity to consent to the services which are to be provided and whether their actions are likely to result in a deprivation of liberty.

- A managing authority must not, except in an emergency, deprive a person of liberty unless a standard authorisation relating to the person's residence in that hospital or care home has been given by the "supervisory body", and remains in force.

- Such authorisation must be requested, and the outcome implemented, by the managing authority.

- Authorisation is to be obtained from the supervisory body in advance of the deprivation of liberty except in circumstances where it is considered to be urgent that the deprivation of liberty begins immediately. In such cases, authorisation must be obtained within seven days of the start of the deprivation of liberty (see paragraphs 112 to 122 regarding urgent authorisations).

- A managing authority must ensure that any conditions attached to the authorisation are complied with.

Key points for local authorities and PCTs (supervisory bodies)

16. In implementing the Bournewood provisions, supervisory bodies should be aware that:-

- They will receive applications from managing authorities for standard authorisations of deprivation of liberty.

- Before an authorisation for deprivation of liberty may be given, the supervisory body must have obtained written assessments of the

relevant person in order to ensure that they meet the required criteria (including that the deprivation of liberty is necessary to protect them from harm and will be in their best interests).

- Authorisation may not be given unless the assessors recommend it.

- In giving authorisation, the supervisory body must specify its duration, which may not exceed twelve months and may not be for longer than recommended by the best interests' assessor.

- The supervisory body may attach conditions to the authorisation if it considers it appropriate to do so having regard to any recommendations made by the best interests' assessor.

- The supervisory body must give notice in writing to specified people and notify specified people of its decision.

- The supervisory body must, for every person in respect of whom they give a standard authorisation for deprivation of liberty, including those who have no relatives or friends taking an interest in their well-being, appoint a "relevant person's representative" to represent the person's interests.

- At any time when an authorisation is in force, the relevant person, the relevant person's representative or any IMCA representing the individual, has a right to require the authorisation to be reviewed by the supervisory body.

Key points for both managing authorities and supervisory bodies

17. In addition to the above, both managing authorities and supervisory bodies should be aware that:-

- An authorisation may last for a maximum period of 12 months. Prior to the expiry of the current period of authorisation, the managing authority may seek a fresh authorisation for up to another twelve months provided it is established on the basis of further assessment that the relevant criteria continue to be met.

- The authorisation should be reviewed, and if appropriate revoked before it would otherwise expire, where there has been a significant change in the person's circumstances. To this end, the managing authority will be required to ensure that the continued deprivation of liberty of a person remains necessary and appropriate.

- A decision to deprive a person of liberty may be challenged by the relevant person, or by the relevant person's representative, by

means of an application to the Court of Protection. However, managing authorities and supervisory bodies should always be prepared to try to resolve disputes locally and informally. No one should be forced to apply to the Court because of failure or unwillingness on the part of a managing authority or supervisory body to engage in constructive discussion.

- In a case where there is a question about whether or not a managing authority is authorised to deprive a person of their liberty, the deprivation will be lawful where it is necessary for the purpose of giving the person life-sustaining treatment, or to prevent a serious deterioration in their condition, while a decision as respects any relevant issue is sought from the court.

- The complete process of assessing and authorising deprivation of liberty should be clearly recorded, and regularly monitored and audited, as part of an organisation's governance structure.

18. The following flowchart gives an overview of how the Bournewood proposals should operate:-

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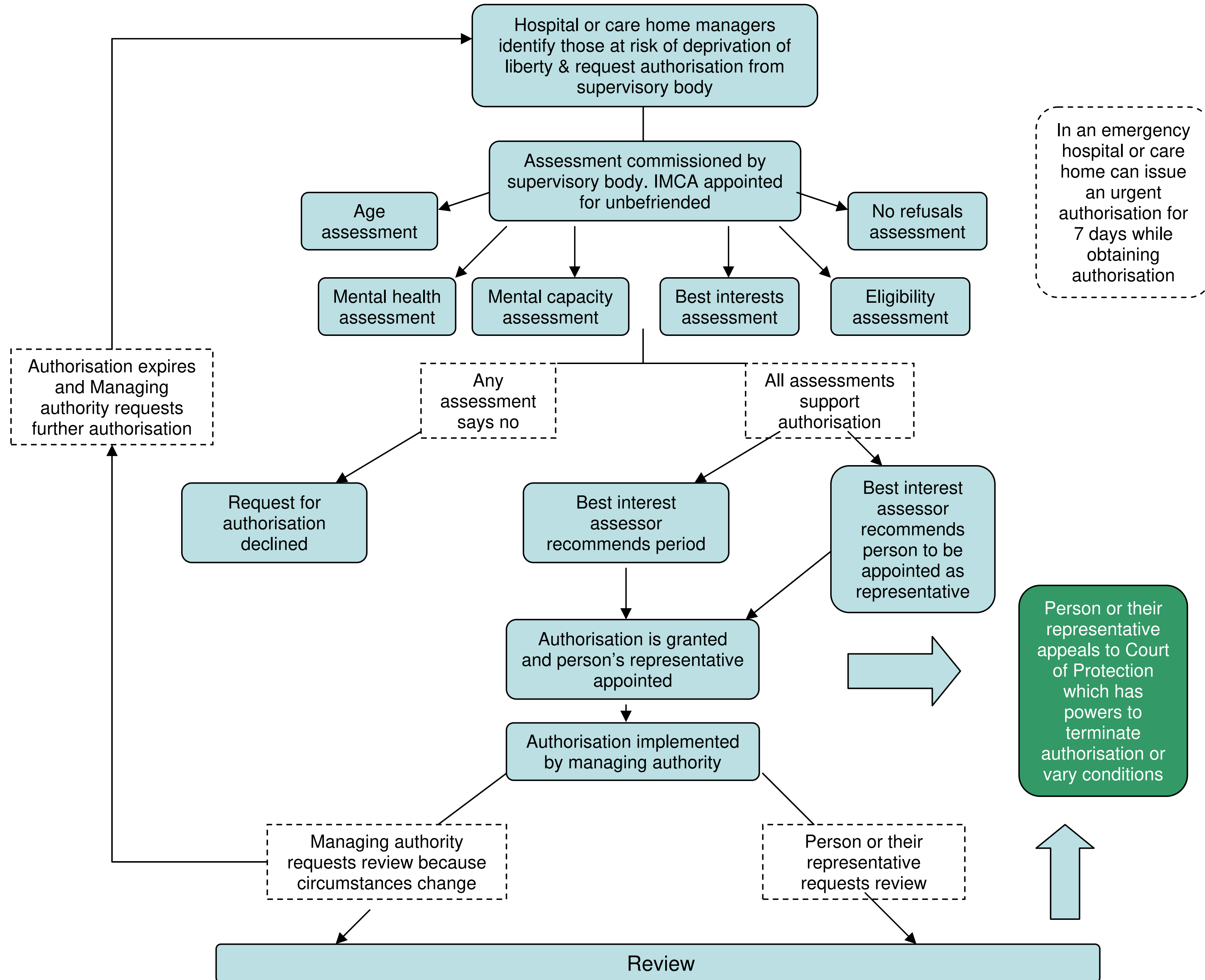

Meaning of deprivation of liberty

19. The meaning of deprivation of liberty is a question for the Courts. This guidance seeks to summarise the factors identified as relevant by the ECtHR in cases to date. Professionals using this guidance will need to take account of these factors in assessing whether a person in their care may be deprived of liberty.

20. The ECtHR made clear that the question of whether someone has, in fact, been deprived of liberty depends on the particular circumstances of the case. Specifically, the Court said that: "It is not disputed that in order to determine whether there has been a deprivation of liberty, the starting-point must be the specific situation of the individual concerned and account must be taken of a whole range of factors arising in a particular case such as the type, duration, effects and manner of implementation of the measure in question. The distinction between a deprivation of, and restriction upon, liberty is merely one of degree or intensity and not one of nature or substance."

21. This means that it is not possible to state that a particular measure would or would not constitute a deprivation of liberty in ECHR terms in every case. It is necessary to consider all the factors involved on an individual basis.

Identifying deprivation of liberty

22. Hospitals and care homes, and authorities commissioning care, will need to ensure they have systems in place so that, when making arrangements to provide care to a person who lacks capacity to consent to those arrangements, and a restriction of the liberty of that person is involved, consideration is always given to whether what is proposed amounts in practice to a deprivation of that person's liberty within the meaning of Article 5 of the ECHR. The question of whether the person is deprived of their liberty will need to be kept under review and addressed explicitly whenever a change is made to the care plan. This consideration should be recorded in the person's health and care records.

23. If it is identified that a person may be deprived of their liberty (or at risk of it), consideration should always be given to whether they could safely be cared for with fewer restrictions to avoid deprivation of liberty.

24. In its judgment in HL v UK the ECtHR said that:-

    "the key factor in the present case [is] that the health care professionals treating and managing the applicant exercised complete and effective control over his care and movements" and "the applicant was under continuous supervision and control and was not free to leave".

25. The ECtHR has identified the following as factors contributing to deprivation of liberty in its judgments on cases to date:-

- Restraint was used, including sedation, to admit a person who is resisting;

- Professionals exercised complete and effective control over care and movement for a significant period;

- Professionals exercised control over assessments, treatment, contacts and residence;

- The person would be prevented from leaving if they made a meaningful attempt to do so;

- A request by carers for the person to be discharged to their care was refused;

- The person was unable to maintain social contacts because of restrictions placed on access to other people;

- The person lost autonomy because they were under continuous supervision and control.

26. Deprivation of liberty may result from restrictions placed on a person by actions or omissions of the professionals providing treatment and care. The physical or psychological effects of illness or disability would not in themselves mean that a person is being deprived of their liberty. Deprivation of liberty results from the actions (or omissions) of third parties.

27. The fact that restrictions may be justified because they are necessary for the person's safety does not affect whether or not they constitute a deprivation of liberty in ECHR terms. Indeed, if they are not justified, deprivation of liberty could not be authorised.

28. When assessing whether a person is or, may be, deprived of their liberty it is necessary to consider the combined impact of all restrictions placed upon them. Based on the case law, the following factors may be considered by the courts to be relevant when considering whether or not deprivation of liberty arises:-

- **The person is not allowed to leave the facility**

If a person is, or would be, prevented from leaving the facility at all, whether by distraction, locked doors or restraint, that would be a relevant factor in considering whether or not there is deprivation of liberty. However, restrictions placed for the person's protection would not necessarily amount to deprivation of liberty in the absence of other restrictions, for example if they are only able to leave when accompanied by a friend, family member or carer, or are not allowed to leave in the middle of the night.

A person is not deprived of their liberty simply because they lack the physical ability to leave, or the mental capacity to form a genuine intention to leave. But such a person could still be deprived of their liberty if-

- Family, friends or carers, who might reasonably expect to take decisions under the Mental Capacity Act 2005 in relation to the person, are prevented from moving them to another care setting or from taking them out.
- They are given no (or very limited) opportunity temporarily to go outside of the home or hospital (escorted or otherwise) even though that is physically possible and it seems likely that they would enjoy it, it would reduce their distress or anxiety, or would otherwise be beneficial.

- **The person has no or very limited choice about their life within the care home or hospital**

For example, where they can be within the facility, what they can do, whom they can associate with, when and what to eat. This could equally apply if choices were available but the care given to the person did not enable them to exercise that choice. If a person is not allowed any freedom of movement within the unit they are probably deprived of their liberty. Regular use of medication or seating from which a person cannot get up in order to control a person's behaviour and movement may constitute deprivation of liberty. Restrictions which are unavoidable in a group living situation, and which apply to all residents, would be unlikely in themselves to constitute a deprivation of liberty but this would depend on the context and the extent of other restrictions imposed on the person concerned.

- **The person is unable to maintain contact with the world outside the care home or hospital**

For example if restrictions are placed on who may visit them, use of the telephone etc. Restrictions for the benefit of the running of the unit and the other patients/residents, for example, general restrictions on early morning or late evening visits, or on numbers of visitors at any one time would not in themselves be likely to constitute deprivation of liberty unless the effect on the particular individual would be to cut them off from people with whom they would otherwise keep in contact, for example if family or friends are realistically only able to visit late in the evening.

- **Restraint is/was used on admission and the person is not realistically subsequently able to leave**

The person may be unable to leave because they lack the physical or mental capacity to arrange their removal. Although use of restraint to administer treatment or care would not necessarily constitute a deprivation of liberty in the absence of any other restrictions, it should be seen as an indicator that a person's wishes may be being over-ridden and careful consideration given to whether they are deprived of their liberty**.** In the case of a person detained in hospital for mental health treatment, the need for restraint is likely to indicate that they are objecting to treatment or to being in hospital, which would make them ineligible for an authorisation under the Bournewood safeguards.

The fact that a person who lacks capacity is living in a hospital or care home does not necessarily mean that the person is deprived of liberty even if the unit is locked or staff would not allow the person to leave unescorted for their own protection. However, the fact of a locked door, or other similar devices such as confusion handles or security key pads, would make it necessary to consider whether a person is deprived of their liberty.

A court may be less likely to consider that a person has been deprived of their liberty if there are firm plans for the restrictions to be temporary, for example a short period of respite care after which the person will return home.

People coming within the scope of the Bournewood provisions

29. The provisions relate to people aged 18 and over who meet the relevant criteria, and apply across England and Wales. Where people come from other countries into England or Wales, the Bournewood safeguards will apply to them if they meet the relevant criteria while in England or Wales.

30. Although the Bournewood judgment was specifically about a hospital patient lacking capacity to consent to admission, who was subsequently detained under the Mental Health Act 1983, the judgment had wider implications that extend to a larger group of people who might be deprived of their liberty in settings other than hospitals.

31. The Bournewood safeguards cover those who lack capacity to consent to the arrangements made for their care and for whom receiving care or treatment in circumstances that amount to a deprivation of liberty will protect them from harm and be in their best interests. Such people are largely those with significant learning disabilities, or elderly people suffering from dementia or some similar disability, but may also include a minority of others who have suffered physical injury, for example brain injury. The safeguards will apply where a process of assessment has

identified a need for them to be cared for in hospital or care home regimes that deprive them of their liberty within the meaning of Article 5 of the ECHR.

People admitted as a result of physical illnesses or injuries

32. There will be occasions in which people who lack capacity to consent to admission are taken to hospital for treatment of physical illnesses or injuries and may be cared for in circumstances that amount to a deprivation of liberty. For the purposes of Article 5 of the ECHR, there is no distinction in principle between depriving a person who has a mental disorder of liberty for the purpose of treating them for a physical condition rather than for treatment of their mental disorder.

33. However, it may be that admission for the purposes of treating a physical condition is more likely to be of a short duration and less likely to entail close supervision and control of the person, and so less likely to involve deprivation of the person's liberty. The Bournewood safeguards do though; cover admission to hospital for physical treatment where deprivation of liberty arises.

Short-term/temporary stays in hospitals or care homes

34. There is no minimum period of deprivation of liberty for the purposes of the Bournewood provisions. A decision as to whether or not deprivation of liberty arises will depend on all the circumstances of the case, but the fact that a stay was short-term/temporary, perhaps for a brief period of respite care for example, may lead a court to conclude that there was no deprivation of liberty if there was a clear plan in place for the person to return home.

Private Placements

35. The requirement to act in accordance with the ECHR applies only to public authorities. But the ECHR case of Storck v. Germany (2005) shows that there is nevertheless an obligation on States to secure Convention rights for all its citizens, and that this obligation cannot be delegated to private institutions.

36. The Mental Capacity Act 2005 applies in general to acts and decisions taken in the best interests of a person who lacks capacity. If, as a result of a private arrangement, deprivation of liberty arises without an authorisation as provided for in the Bournewood provisions, or without the deprivation being a consequence of giving effect to an order of the Court of Protection in relation to a matter concerning the person's personal welfare, the deprivation will not be given a lawful basis by the Mental Capacity Act 2005. The Bournewood safeguards therefore apply to both publicly and privately arranged placements.

Deprivation of liberty in other settings

37. It is envisaged that the Bournewood provisions will cover the vast majority of people who are affected by the Bournewood judgment. Deprivation of the liberty of a person who lacks capacity would not be lawful under the Mental Capacity Act 2005 in a setting other than a hospital or care home, for example in a person's own home or a day centre, unless it is a consequence of giving effect to an order of the Court of Protection in relation to a matter concerning the person's personal welfare.

The deprivation of liberty authorisation process

Standard authorisations

38. The managing authority has responsibility for requesting authorisation of deprivation of liberty. In the case of an NHS hospital, the managing authority for the purpose of the deprivation of liberty provisions will be the NHS body responsible for the running of the hospital in which a person potentially coming within the scope of the Bournewood provisions is, or is to be, a resident. In the case of a private hospital or care home, the managing authority will be the person registered, or required to be registered, under Part 2 of the Care Standards Act 2000 in respect of the hospital or care home.

39. Managing authorities should have a policy/protocol in place that identifies what steps should be taken to assess whether or not an authorisation should be sought, how such matters should be kept under review, what action should be taken if an authorisation does need to be requested, and who should take the necessary action.

40. The supervisory body is responsible for authorising deprivation of liberty. In a case where the Bournewood provisions are applied to a person in a hospital situated in England, the supervisory body will be:-

- If a PCT commissions the relevant care or treatment, that PCT.
- If the National Assembly for Wales or a Local Health Board in Wales commission the relevant care and treatment in England, the National Assembly for Wales.
- In any other case, the PCT for the area in which the hospital is situated.

41. The supervisory body in a case where the Bournewood provisions are applied to a person in a hospital situated in Wales will be the National Assembly for Wales unless a PCT commissions the relevant care and treatment in Wales, in which case the PCT will be the supervisory body.

42. The supervisory body in a case where the Bournewood provisions are applied to a person in a care home, whether situated in England or

Wales, will be the local authority for the area in which the person is ordinarily resident. However, if the person is not ordinarily resident in the area of a local authority, the supervisory body is the local authority for the area in which the care home is situated.

43. The usual mechanisms under the National Assistance Act 1948 apply for the purposes of determining place of ordinary residence. Any unresolved questions arising as to the ordinary residence of a person is to be determined by the Secretary of State or by the National Assembly for Wales.

[Note: Regulations will specify the arrangements that will apply where a person's place of ordinary residence is not clear.]

44. A managing authority must request a standard authorisation when it appears to the managing authority to be likely that, either currently or at some time during the next 28 days, a present or future resident will be accommodated in their hospital or care home in circumstances that amount to a deprivation of liberty within the meaning of Article 5 of the ECHR. The request must be made to the supervisory body. Wherever possible, the request should be made in advance (but see paragraphs 112 to 122 regarding urgent authorisations).

45. If a person who is subject to a standard authorisation moves to a different hospital or care home, the managing authority of the new hospital or care home must request a standard authorisation. The application should be made before the move takes place. If the move has to take place so urgently that this is impossible, the managing authority of the new hospital or care home would need to issue an urgent authorisation. The only exception is if the care regime in the new facility will not involve deprivation of liberty. These arrangements are not an alternative to applying the provisions of the Mental Capacity Act 2005 regarding change of residence.

46. There is no requirement for a standard authorisation to be applied for where a person is lawfully deprived of liberty as a consequence of giving effect to an order of the Court of Protection in relation to a matter concerning the person's personal welfare. However, it would not be lawful to continue to deprive the person of liberty after expiry of the order of the Court of Protection. In this case, a standard authorisation must be sought. The managing authority may make the application before the order expires, for example if this is necessary to secure continuity of care.

47. When a person is identified as potentially coming within the scope of the Bournewood provisions, the hospital or care home must establish whether there is a suitable independent person to look after their interests. The managing authority must notify the supervisory body if the managing authority concludes that there is nobody, other than a person engaged in providing care and treatment for the relevant person in a

professional capacity or for remuneration, whom it would be appropriate to consult in determining the person's best interests. In such a case, the supervisory body must instruct an IMCA to represent the relevant person (see paragraphs 54 to 57).

48. The request from a managing authority for a standard authorisation must include **[Note : Regulations will be made to cover this]**:-

- The name, age and a brief summary of the circumstances of the person who is the subject of the application, and the reasons why it is considered that deprivation of liberty is an essential element of the care regime for the person concerned.

- Information about the person's ethnicity to enable the supervisory body to consider whether there are any cultural aspects that will need to be taken into account in the assessment process. Guidance on best practice in recording a person's ethnicity should be followed.

- The location for the deprivation of liberty to which the application relates.

- The date from which the authorisation is sought.

- Where relevant, the fact that an urgent authorisation has been issued and the date when it expires.

- Whether the person is subject to guardianship or Supervised Community Treatment, or is conditionally discharged from detention under the Mental Health Act 1983.

- Whether or not it is necessary for the supervisory body to instruct an IMCA to represent the person's interests.

- Details of the care regime and the restrictions placed on the person.

49. The supervisory body should consider whether the request is one that should appropriately be pursued, and should immediately seek any further information that it requires from the managing authority to inform it's consideration. If the supervisory body has any doubts about proceeding with the request, it should seek to resolve them with the managing authority. The request for authorisation must though, be processed in a timely manner unless the managing authority subsequently agrees the authorisation is no longer required and withdraws their request.

50. There may be cases in which the supervisory body considers that an application for an authorisation has been made too far in advance, for example meaning that an assessor might find it impossible to make an assessment of the circumstances as they were likely to be when the authorisation was expected to come into force. In such a case, the

supervisory body may agree with the managing authority that the application should be withdrawn, to be resubmitted at a more appropriate later time.

51. As soon as the validity of a request has been established, the supervisory body must seek the relevant assessments to ascertain whether the qualifying requirements of the Bournewood provisions are met.

52. Regulations **[Note : Yet to be made]** state that all assessments required for a standard authorisation must be completed within 21 days from the date the supervisory body receives a request for such an authorisation from a managing authority. However, if an urgent authorisation is in force, the assessments must be completed before the expiry of that authorisation (urgent authorisations may be given for an initial seven-day period, and may, in exceptional circumstances, be extended by the supervisory body for up to a further seven days). A standard authorisation of deprivation of liberty cannot be given unless all the assessments come to a positive conclusion.

53. Supervisory bodies should have a policy/protocol in place that identifies what action should be taken on receipt of a request for a standard authorisation, by whom and within what timescale.

Instruction of an IMCA

54. Where a managing authority is applying for a Bournewood authorisation, it will be necessary to establish whom among family friends and informal carers should be consulted during the best interests assessment. If there is nobody appropriate to consult, other than people engaged in providing care or treatment for the relevant person in a professional capacity or for remuneration, the managing authority must notify the supervisory body accordingly. The supervisory body must then instruct an IMCA to represent the person.

55. An IMCA instructed at this initial stage in the Bournewood context has the following rights and role over and above the rights and role of an IMCA instructed under the Mental Capacity Act 2005 more generally (see also paragraphs 152 and 153 about the instruction of an IMCA during gaps in the appointment of a relevant person's representative):-

- To give information or make submissions to assessors, which assessors must take into account in carrying out their assessments.
- To receive from the supervisory body copies of any Bournewood assessments that the supervisory body are given.
- To receive a copy of a standard authorisation, if granted, from the supervisory body.

- To be notified by the supervisory body that the supervisory body are unable to give a standard authorisation because all the Bournewood assessments did not come to a positive conclusion.

- To receive a copy of an urgent authorisation from the managing authority.

- To receive from the supervisory body a copy of a notice declining to extend the duration of an urgent authorisation.

- To receive from the supervisory body a copy of a notice that an urgent authorisation has ceased to be in force.

- To apply to the Court of Protection for permission to take the relevant person's case to the Court in connection with a matter relating to the giving or refusal of a standard or urgent authorisation.

56. An IMCA will need to familiarise themselves with the circumstances of the person to whom the Bournewood provisions are being applied, and to consider what submissions they may wish to make to any of the assessors during the course of the assessment process. They will also need to consider whether they have any concerns about the outcome of the assessment process. Differences of opinion between an IMCA and an assessor should ideally be resolved while the assessment is still in progress. Where there are significant disagreements between an IMCA and one or more of the assessors that cannot be resolved between them, it may be helpful to draw the matter to the attention of the supervisory body prior to the finalisation of the assessment. The supervisory body could then consider what action might be appropriate, including perhaps convening a meeting to discuss the matter. An IMCA will also need to consider whether they have any concerns about the giving of an urgent authorisation. The objective should be, wherever possible, to resolve differences of opinion informally in order to minimise the occasions on which it is necessary for an IMCA to make application to the Court of Protection regarding either a standard or urgent authorisation.

57. Once a relevant person's representative is appointed, the role of the IMCA falls away. However, the IMCA may still apply to the Court of Protection for permission to take the relevant person's case to the Court in connection with the giving of a standard authorisation but, in doing so, the IMCA must take the views of the relevant person's representative on the matter into account.

The assessment process

58. Assessments must be obtained to ascertain whether a person in respect of whom a standard authorisation is requested by the managing authority meets the qualifying requirements for deprivation of liberty under the Bournewood provisions. The assessments are age, mental health, mental capacity, best interests, eligibility and no refusals. Detailed

information about the assessment process is contained in the following paragraphs. **[Note: Where references are made to regulations, the regulations concerned have yet to be made.]**

59. **Age assessment** - The purpose of the age assessment is to establish whether the relevant person has reached age 18. (The legal basis for depriving a person who lacks capacity and is under the age of 18 of their liberty in a Bournewood type scenario is Section 25 of the Children Act 1989, which provides a mechanism for giving safeguards meeting the requirements of Article 5 of the ECHR.)

60. Anybody who appears to the supervisory body to be suitable is permitted to undertake the age assessment, including a person conducting one or more of the other assessments.

61. **Mental health assessment** - The purpose of the mental health assessment is to establish whether the relevant person is suffering from a mental disorder within the meaning of the Mental Health Act 1983, but disregarding the special provision in that Act in relation to persons with a learning disability. This means that a person with a learning disability can receive Bournewood safeguards whether or not the disability is associated with abnormally aggressive or seriously irresponsible conduct.

62. For supervisory bodies in England, the regulations specify that this assessment must be carried out by a doctor and that the assessing doctor either has to be approved under Section 12 of the Mental Health Act 1983, or is a registered medical practitioner who has special experience in the diagnosis and treatment of mental disorder. Where the assessor is Section 12 approved, they must also have undertaken basic Bournewood/Mental Capacity Act 2005 training. Where the doctor is not Section 12 approved, they should have completed Mental Capacity Act 2005 mental health assessor training. Assessing doctors should also possess the published competences for the mental health assessment. **[Note : The Welsh Assembly Government are separately considering what regulations should be prepared on this aspect in relation to Wales.]**

63. Supervisory bodies should consider whether there is a benefit in the assessment being undertaken by a doctor who has previous acquaintance with the person. The benefit would primarily arise if a professional involved in the person's care is considered best placed to carry out a reliable assessment, bringing to bear knowledge of the person over a period of time. It may also help in reducing any distress that might be caused to the person if they are assessed by somebody they do not know.

64. The mental health assessor is required to consider how, if at all, the mental health of the person being assessed is likely to be affected by

being deprived of their liberty, and to report his conclusions to the best interests assessor.

65. **Mental capacity assessment** - The purpose of the mental capacity assessment is to establish whether the relevant person lacks capacity in relation to the decision as to whether or not they should be accommodated in the relevant hospital or care home for the purpose of being given the relevant care or treatment.

66. The Mental Capacity Act 2005 establishes in sections 1 to 3 the basis for determining a person's capacity to make decisions. Chapter 3 of the Mental Capacity Act 2005 Code of Practice (Capacity to make a decision) is also relevant. These apply to the assessment of a person being considered for deprivation of liberty under the Bournewood provisions.

67. In practice, this assessment is likely to be usually undertaken by a doctor, but regulations allow for other appropriately qualified professionals to perform the role, for example approved mental health professionals or professionals (social workers, nurses, occupational therapists and chartered psychologists) who possess the relevant skills and experience that would enable them to apply for approved mental health professional status if they so wished.

68. As with the mental health assessment, supervisory bodies should consider whether there is a benefit in the assessment being undertaken by a professional who has previous acquaintance with the person being assessed.

69. **Best interests' assessment** – In England, regulations specify that the Bournewood best interests' assessment must be undertaken by an approved mental health professional, or by other professionals (see paragraph 67 above) who possess the relevant skills and experience that would enable them to apply for approved mental health professional status if they so wished. A Bournewood best interests assessor should also have completed basic Bournewood/Mental Capacity Act 2005 training, possess the published competences for Bournewood best interests assessors and have completed specific Bournewood best interests assessor training. **[Note: The Welsh Assembly Government are separately considering what regulations should be prepared on this aspect in relation to Wales.]**

70. Section 4 of the Mental Capacity Act 2005 sets out the general best interests principles that apply for the purpose of that Act. Chapter 4 (Best Interests) of the Mental Capacity Act 2005 Code of Practice is also relevant. Part 2 of Chapter 4 includes guidance on the statutory checklist for determining best interests. These principles and guidance apply equally to the establishment of best interests for the purpose of the Bournewood provisions but there are additional considerations of relevance to the Bournewood best interests assessment. (References to

the best interests assessor or assessment in paragraphs 71 to 81 are to the assessor or assessment for Bournewood purposes.]

71. The purpose of the best interests assessment is to establish whether deprivation of liberty is occurring, or is going to occur, and, if so, whether it is in the best interests of the relevant person to be deprived of liberty, whether it is necessary for them to be deprived of liberty in order to prevent harm to themselves, and whether such detention is a proportionate response to the likelihood of the relevant person suffering harm and the seriousness of that harm.

72. The best interests assessor must consult the managing authority of the relevant hospital or care home, and have regard to any relevant needs assessments and care plans prepared in connection with the relevant person being accommodated in the hospital or care home. The managing authority and supervisory body must provide the best interests assessor with any such needs assessment or care plan that has been undertaken by them, or on their behalf. The best interests assessor must consider whether the proposed care plan would constitute a deprivation of liberty. If it would not, then no Bournewood authorisation would be required for that care plan.

73. The best interests assessor should firstly establish whether there is prima facie evidence that deprivation of liberty is occurring, or is going to occur, since there is no point in the assessment process proceeding further if deprivation of liberty is not at issue. Should the assessor conclude that deprivation of liberty is not occurring, and is not going to occur, they should notify the supervisory body accordingly. In that case, the best interests assessor must inform the supervisory body that deprivation of liberty is not in the person's best interests because there is obviously a less restrictive option available.

74. If the best interests assessor considers that deprivation of liberty is, or will be, occurring, the best interests assessment should proceed as set out in the following paragraphs.

75. The best interests assessment process involves seeking views of friends, family members, carers, and any IMCA who has been instructed, as well as professionals involved in the person's care. As such, the provisions of section 4(7) of the Mental Capacity Act 2005 are relevant to the best interests assessment. The best interests assessor must state in his assessment the name and address of every interested person who he has consulted in carrying out the assessment (paragraph 176 to Schedule A1 of the Mental Capacity Act 2005 sets out who is an interested person for this purpose).

76. In undertaking the assessment, the best interests assessor will also need to consider the conclusions of the mental health assessor about how the person being assessed is likely to be affected by being deprived of their liberty.

77. If the best interests assessment supports deprivation of liberty in the care home or hospital in question, the assessor should state for how long any authorisation should be given, with a maximum period of 12 months. The best interests assessor should take account of the information obtained during the consultation process that he has undertaken and form a judgment on what is the most appropriate period for the authorisation to last. The assessor will need to consider the likelihood of circumstances changing and what can reasonably be predicted about the required period for any authorisation to last.

78. Where possible, the best interests assessor should also make recommendations about who should be appointed as the “relevant person's representative”. The assessor should be well placed, as a result of the consultation process, to identify whether there is anybody who could suitably act as a relevant person’s representative. Whilst the appointment of the relevant person’s representative cannot take place unless and until the authorisation is given, the best interests assessor should consider who should be recommended as the representative while carrying out the assessment rather than waiting for the outcome of all the assessments.

79. The best interests assessor may recommend that conditions should be attached to the authorisation. This might, for example, be used to deal with contact issues, issues relevant to the person’s culture or other major issues related to the deprivation of liberty, without which deprivation of liberty would cease to be in the patient’s best interests. But it is not the best interests assessor’s role to specify conditions that do not directly relate to the issue of deprivation of liberty. Conditions should not be a substitute for a properly constructed care plan and the application of the Care Programme Approach and Care Management. In specifying conditions, best interests assessors should aim to impose the minimum necessary constraints, so that they do not unnecessarily prevent or inhibit the staff of the care home or hospital from responding appropriately to the person’s needs, whether they remain the same or vary over time. It would be good practice for the assessor to discuss any proposed conditions with the relevant personnel at the home or hospital before finalising the assessment.

80. Where the best interests assessor comes to the conclusion that the best interests requirement is not met, but it appears to the assessor that the person being assessed is already being deprived of his liberty, he must include a statement to that effect in the assessment report. The supervisory body will need to liaise with the managing authority in order to ensure that an unauthorised deprivation of liberty is not permitted to continue in these circumstances. It is the managing authority that is responsible for complying with the law in this situation. Should the supervisory body have continuing doubts about the matter, it should consider alerting the monitoring body.

81. The best interests assessor will need to give reasons for their conclusion in the report of their assessment. If they do not support deprivation of liberty, they may wish to consider how best to frame their report in order for it to be useful to the commissioners and providers of care in deciding on future action, for example recommending how deprivation of liberty could be avoided.

82. **Eligibility assessment** – This assessment relates to the person's status, or potential status, under the Mental Health Act 1983. For most authorisations sought by care homes it will effectively be irrelevant.

83. If the proposed authorisation relates to deprivation of liberty in a care home, or in a hospital for purposes other than the treatment of mental disorder, then the person will be eligible unless:

    - they are detained in hospital under the Mental Health Act 1983 and will continue to be at the time the authorisation is intended to take effect – although in practice there should not have been a request for an authorisation in such cases; or

    - the authorisation would be inconsistent with an obligation placed on them under the Mental Health Act 1983, for example a requirement that they reside somewhere else. This will only affect people who are on leave of absence from detention under the Mental Health Act 1983 or who are subject to guardianship, supervised community treatment or conditional discharge.

84. If the proposed authorisation relates to deprivation of liberty in a hospital wholly or partly for the purpose of treatment of mental disorder, then the person will be eligible unless:

    - they are already detained in hospital under the Mental Health Act 1983 and will continue to be at the time the authorisation is intended to take effect (again there should not have been a request in such a case);

    - the person is liable to be detained under the Mental Health Act 1983 but is on leave of absence, or is subject to Supervised Community Treatment or conditional discharge. This is because if treatment in hospital is necessary, the person should be recalled to hospital under the Mental Health Act 1983 itself;

    - the authorisation would be inconsistent with an obligation placed on them under the Mental Health Act 1983, for example a requirement that they reside somewhere else. Again this will only affect people who are on leave of absence from detention under the Mental Health Act 1983 or who are subject to guardianship, Supervised Community Treatment or conditional discharge;

- they object to being admitted to hospital for that purpose, or to some or all the treatment for mental disorder they will receive there, and they meet the criteria for an application for admission under section 2 or section 3 of the Mental Health Act 1983.

85. In the last case, in determining whether a patient objects, the assessor must consider the question of whether the person objects in the round, taking into account all the circumstances so far as they are reasonably ascertainable. In many cases, the patient will be perfectly able to state their objection. But in other cases, especially where the patient is unable to communicate (or only to a limited extent), assessors will need to consider the patient's behaviour, wishes, feelings, views, beliefs and values, both present and past, so far as they can be ascertained. If there is reason to think that a patient would object, if able to do so, then the patient should be taken to be objecting. Occasionally, it may be that the patient's behaviour initially suggests an objection, but is in fact not directed at the treatment at all. In that case the patient would not be taken to be objecting. But assessors should always bear in mind that their job is to establish whether the patient objects to treatment – the reasonableness of that objection is not the issue.

86. Even where a patient does not object, and a Bournewood authorisation is possible, it should not be assumed that such an authorisation is invariably the correct course. There may be other factors which suggest the Mental Health Act 1983 should be used (for example where it is thought likely that the person will recover relevant capacity and will then refuse to consent to treatment, or where it is important for the hospital managers to have a formal power to retake a person who goes absent without leave.)

87. If the best interests' assessor believes that the patient is not eligible, but that they nevertheless need to be deprived of liberty, the assessor should immediately take steps to arrange for appropriate action to be taken under the Mental Health Act 1983. The same applies if, for any other reason, the assessor considers that the use of the Mental Health Act 1983 should be considered.

88. In the case of someone already subject to the Mental Health Act 1983, the assessor should contact the relevant responsible clinician (i.e. the clinician in overall charge of the patient's treatment) or, if the person is subject to guardianship, the relevant local social services authority. Otherwise, the assessor should take steps to arrange for the patient to be further assessed with a view to an application being made for admission to hospital under the Mental Health Act 1983. Assessors will need to be familiar with local arrangements for doing that.

89. Supervisory bodies may consider it appropriate for the mental health and eligibility assessments to be undertaken by the same person in cases in which it appears that there might be the potential for the use of the Mental Health Act 1983 rather than the Bournewood provisions.

90. Regulations specify that anybody that the supervisory body considers to be appropriate, by virtue of possessing the skills and experience to perform the role, may undertake the eligibility assessment, including a person conducting one or more of the other assessments.

91. It may well be known in advance of the assessment that a decision is likely to have to be made about whether the patient should be assessed with a view to an application under the Mental Health Act 1983 rather than being made subject to a Bournewood authorisation. In such cases, steps should be taken, where practicable, to arrange assessments in a way that minimises the number of separate interviews or examinations to which the person concerned is subject.

92. Where the eligibility assessor and best interests' assessor are different people, the eligibility assessor, in undertaking the assessment, must, where appropriate, seek information from the best interests' assessor about the person's attitude to the arrangements being made for their care and treatment. This will be appropriate in a case where a person is receiving, or is to receive, treatment for a mental disorder in a hospital setting and where, if they can be said to be objecting to the treatment, it would be appropriate to consider using the provisions of the Mental Health Act 1983 rather than the Bournewood provisions.

93. **No refusals assessment** - The purpose of the no refusals assessment is to establish whether the authorisation would conflict with other authority for decision making for people who lack capacity to consent. If so, the no refusals assessment qualifying requirement will not be met and a standard authorisation for deprivation of liberty may not be given. The following constitute a "refusal" for Bournewood purposes:-

    i. If the relevant person has made an advance decision that remains valid and is applicable to some or all of the treatment that the person would receive if authorisation were granted. (Sections 24 to 26 of the Mental Capacity Act 2005 regarding the making, validity, applicability and effect of advance decisions are relevant here.)

    ii. If the proposal for the relevant person to be accommodated in the relevant hospital or care home for the purpose of receiving some or all of the relevant care or treatment in circumstances that amount to deprivation of the person's liberty, or to be in the hospital or care home at all, would be in conflict with a valid decision of an attorney or a deputy appointed by the court.

94. Regulations specify that anybody that the supervisory body considers to be appropriate, by virtue of possessing the skills and experience to perform the role, may undertake the 'no refusals' assessment, including a person conducting one or more of the other assessments.

Access to information and keeping of records

95. Assessors may, at all reasonable times, examine and take copies of records which they consider may be relevant to their assessment.

96. Assessors must keep written records of their assessments and, as soon as practicable after carrying out assessments, must give copies of the assessments to the supervisory body.

Minimum number, independence and suitability of assessors

97. There is no reason in principle why assessments cannot (where relevant) cover more than the particular qualification requirement, for example if an assessment can usefully be combined with an interview or examination for a potential application under the Mental Health Act 1983, or for service provision. Such coordination would avoid unnecessary burdens. However, in the interests of ensuring that an appropriate degree of objectivity is brought to the assessment process and to avoid the risk that arbitrary decisions will be taken about deprivation of liberty:-

- There must be a minimum of two assessors and the mental health and best interests' assessors must be different people.

- The best interests' assessor, while they can be an employee of the supervisory body or managing authority, must not otherwise be involved in the care of the person they are assessing, or in decisions about their care. Nor may they be on the staff of the care home concerned, where the assessment relates to a care home placement, or, in the case of a hospital placement, on the staff of the hospital concerned. (Also see paragraph 100 below where the supervisory body and managing authority are the same body.)

- None of the assessors may have a personal financial interest in the care of the person they are assessing. In addition, the assessor must not be related to the person being assessed or to a person with a personal financial interest in the person's care.

Note : It is intended that the matters dealt with in the latter two bullet points will be covered in regulations.

98. The supervisory body must also, in appointing assessors, have regard to their suitability taking account of the reason for the deprivation of liberty, the experience of the potential assessor in working with the client group from which the person being assessed comes and the cultural background of the person being assessed.

99. Assessors act as individual professionals and are personally accountable as such for their decisions. It would be wholly inappropriate for managing authorities or supervisory bodies to seek to dictate or influence their decisions. However, the supervisory body retains the duty

to ensure that sufficient assessors are available and that they have the skills, qualifications and training to perform the function. Supervisory bodies should consider what arrangements need to be put in place in order to afford assessors the necessary opportunities to maintain their skills and knowledge (of legal developments, for example) and share, audit and review their practice.

Arrangements when the same body is both the supervisory body and the managing authority

100. The fact that a single body is both supervisory body and managing authority, for example where a local authority itself provides a residential care home rather than purchasing the service from another organisation, does not prevent it from acting in both capacities**.** However, in England, regulations specify that, in such a situation, the best interests assessor cannot be an employee of the supervisory body/managing authority. **[Note: The Welsh Assembly Government are separately considering what regulations should be prepared on this aspect in relation to Wales.]**

Use of existing assessments

101. Where, in respect of any of the assessments covered in paragraphs 58 to 94, an “equivalent assessment” has already been obtained, it may be relied upon instead of obtaining a fresh assessment. An equivalent assessment is an assessment that has been carried out in the preceding 12 months, not necessarily for the purpose of a deprivation of liberty authorisation, as long as it meets all the requirements of the deprivation of liberty assessment and the supervisory body are satisfied that there is no reason why the assessment should no longer be accurate. Where the required assessment is an age assessment, there is no time limit on the use of an equivalent assessment.

Action to be taken if any assessment is negative

102. If, at any stage in the assessment process, it becomes apparent that any one or more of the qualifying requirements are not met, the assessment process should be discontinued. The supervisory body should inform anyone still engaged in carrying out an assessment that they are not required to complete it. If any of the assessments conclude that one of the qualifying requirements is not met, the authorisation may not be given.

103. If, in the light of the assessments, the supervisory body does not give a standard authorisation, it must, as soon as practicable after it becomes apparent to it that it is prohibited from giving the authorisation, notify the managing authority, the relevant person, any IMCA involved and every interested person consulted by the best interests assessor accordingly. It must provide the managing authority, the relevant person and any IMCA involved with copies of those assessments that have been carried out.

This should be done as soon as possible because in some cases different arrangements will need to be made for the person's care.

104. If the reason the standard authorisation cannot be given is because the eligibility requirement is not met, it may, if the person is not already subject to the Mental Health Act 1983, be necessary to consider making the person subject to that Act, in which case it may be possible to use the same assessors to make that decision, thereby minimising the assessment processes.

105. If the supervisory body are commissioning the care, they will need to do so in such a way that makes it possible for the managing authority to provide the care in accordance with the outcome of the Bournewood assessment process.

Responsibilities of the managing authority and the commissioners of care if a request for an authorisation is turned down

106. The managing authority is responsible for ensuring that they do not deprive a person of their liberty without an authorisation. The commissioners of care are responsible for ensuring that the care package is commissioned in compliance with the Bournewood safeguards. The action they will need to consider if a request for an authorisation is turned down will depend on the reason why the authorisation has not been given, for example:-

- If the best interests assessor concluded that the person was not in fact being, or going to be, deprived of liberty, no action is likely to be necessary.

- If the best interests' assessor concluded that the proposed deprivation of liberty was not in the person's best interests, the care home or hospital will need to consider, in conjunction with the commissioner of the care, how the care plan could be changed to avoid deprivation of liberty. In doing so they will want to have regard to the reasons given in the best interests' assessor's report. If the person is not yet a resident in the care home or hospital, the outcome may be that the admission does not take place.

- If the mental capacity assessor concluded that the person has capacity to make decisions about their care, the care home or hospital will need to consider, in conjunction with the commissioner of the care, how to support the person to make such decisions.

- If the person was identified as not eligible to be subject to a Bournewood authorisation it may be appropriate to assess whether an application should be made to detain the person under the Mental Health Act 1983.

Giving of a standard authorisation

107. The supervisory body must give a standard authorisation if all the assessments are positive and the supervisory body have written copies of all the assessments. The supervisory body cannot otherwise give a standard authorisation.

108. When the supervisory body give a standard authorisation, it must be in writing and must state the following:-

- The name of the relevant person.
- The name of the relevant hospital or care home.
- The period during which the authorisation is to be in force (which may not exceed the period recommended by the best interests' assessor).
- The purpose for which the authorisation is given.
- Any conditions subject to which the authorisation is given (as recommended by the best interests' assessor).
- The reason why each qualifying requirement is met.

109. A standard authorisation should only be given for as long as the best interests' assessor considers that the person is likely to meet all of the qualifying requirements. The authorisation may be for quite a short period, for example if the reason that the deprivation of liberty is in the person's best interests is because their usual care arrangements have temporarily broken down or if there are likely to be changes in the person's mental health, for example if the person is in rehabilitation following brain injury. For the maximum 12 month period to apply, the assessor will need to be confident that there is unlikely to be a change in the person's circumstances, which would affect the authorisation, within that timescale.

110. A standard authorisation may provide for the authorisation to come into force at a time after it is given. But care needs to be exercised with regard to gaps between authorisations being given and their coming into force since, if an authorisation is given too far in advance of its coming into force, the person's circumstances might have changed in the intervening period to the extent that the suitability of the authorisation when it actually comes into force is thrown into doubt.

111. The supervisory body must, as soon as practicable after they give a standard authorisation, give a copy of the authorisation to the managing authority, the relevant person, the relevant person's representative, any

IMCA involved and every interested person consulted by the best interests assessor.

Urgent authorisations

112. Where the managing authority:-

- is required to make a request to the supervisory body for a standard authorisation but believes that the need for a person to be deprived of liberty is so urgent that it is appropriate to begin the deprivation before the request is made, or

- has made a request for a standard authorisation but believes that the need for a person to be deprived of liberty has now become so urgent that it is appropriate to begin the deprivation before the request is dealt with by the supervisory body,

it may itself give an urgent authorisation for deprivation of liberty.

113. The managing authority must decide the period for which the urgent authorisation is given, but this must not exceed seven days. The authorisation must be in writing and must state:-

- The name of the relevant person.

- The name of the relevant hospital or care home.

- The period for which the authorisation is to be in force.

- The purpose for which the authorisation is given.

114. There may be cases in which managing authorities are considering giving an urgent authorisation that will be linked to a change of location for the person to whom the authorisation relates. This might occur, for example, when thought is being given to admitting a person living at home, perhaps with relatives, into a hospital care regime that would deprive them of their liberty. For some people, such a change of location would have a detrimental effect on their mental state, which might significantly distort their presentation during any assessment process.

115. In such a case, the consideration of the appropriateness of giving the urgent authorisation and admitting the person to hospital should encompass a weighing up of the benefits of leaving the person in their existing location, for what may be a more accurate assessment to take place. This would involve looking carefully at the existing care arrangements, and consulting with any carers involved, in order to establish whether or not the person could safely and beneficially be cared for in that environment while the assessment process takes place.

116. The managing authority must keep a written record of any urgent authorisations given, and must give a copy of the authorisation to the relevant person and any IMCA involved. The managing authority must also seek to ensure that, as far as practicable, the relevant person understands the effect of the authorisation and the right to challenge the authorisation via the Court of Protection. Appropriate information must be given both orally and in writing. The managing authority should notify the person's family, friends and carers in order to enable them to offer informed support to the person.

117. The managing authority may, if necessary, ask the supervisory body to extend the duration of the urgent authorisation for a maximum of a further seven days. The managing authority must keep a written record of the reason for making the request. The supervisory body may only extend the duration of the urgent authorisation if it appears to them that:-

- The managing authority has made a request for a standard authorisation.
- There are exceptional reasons why it has not yet been possible to decide the request.
- It is essential for the deprivation of liberty to continue while the supervisory body decide the request.

118. It is intended that extension should only occur rarely in exceptional circumstances. An example of when an extension would be justified might be where the supervisory body was satisfied that a person who needed to be contacted by the best interests assessor had been uncontactable, that the assessment could not be relied upon without their input and that extension for the specified period would enable them to be contacted.

119. The supervisory body should notify the managing authority of the length of any extension granted and must vary the original urgent authorisation so that it states the extended duration. Only one request for the extension of an urgent authorisation is permitted.

120. If the supervisory body decide not to extend the urgent authorisation, it must inform the managing authority of its decision and the reasons for it. The managing authority must give a copy of the notice to the relevant person and any IMCA involved.

121. If an urgent authorisation is in force while an application for a standard authorisation is being assessed, the urgent authorisation terminates if a managing authority receive notice from the supervisory body that the authorisation will not be granted. It will not then be lawful to continue to deprive the person of their liberty.

122. Supervisory bodies and managing authorities should have a policy/protocol in place that identifies what action should be taken when it is necessary to make use of the urgent authorisation process, by whom the action should be taken and within what timescale. The processes surrounding the giving of urgent authorisations should be clearly recorded, and regularly monitored and audited, as part of an organisation's governance structure.

Duties of managing authorities and supervisory bodies while an authorisation is in force

To provide information about the authorisation and the rights of the person

123. As soon as possible after the authorisation is issued, the managing authority must take such steps as are practicable to ensure that the person concerned understands the effect of the authorisation, the right to request a review and the right to make an application to the Court of Protection in connection with the giving of the authorisation. This information should be given verbally and in writing and also made available to the person's representative. In providing information to the person and their representative, the managing authority should take account of communication and language needs, and those of their representative. It would be good practice to consider this provision of information as an ongoing responsibility rather than a one-off activity.

To support access to the relevant person's representative and inform the supervisory body if contact is not maintained

124. It is important that the person should be in ongoing contact with their representative, and the care home or hospital should accommodate visits by the representative at reasonable times. If the representative ceases to maintain contact for whatever reason, the person may effectively be unable to access their review and appeal rights. For this reason the managing authority are required to check that the representative maintains regular contact with the relevant person and to inform the supervisory body if they do not. This is a matter about which the managing authority will need to exercise discretion. The managing authority might consider it appropriate to raise the matter with the representative initially, before notifying the supervisory body if there were unresolved concerns.

Conditions

125. It is the responsibility of the managing authority to ensure that any conditions attached to the authorisation are complied with and they may need to be added to the person's care plan. If the person's circumstances change in such a way that the conditions cannot be met, for example if there is a requirement that they are taken out but they are no longer well enough for this to be possible, this would be grounds to trigger a review which may result in the conditions being varied.

Review of authorisations

Keeping cases under review

126. The managing authority has a duty to monitor each person's case and to request a review if circumstances change. The managing authority will need to consider how it will undertake this role in order to ensure that it requests a review if necessary, who will be responsible for the monitoring and when it will be done. It will be relevant to bear in mind the individual circumstances, for example a person whose condition is changing is likely to need more frequent consideration. Each person's records should include information about any reviews that have been undertaken, whether formal or informal.

127. A Bournewood authorisation only allows for a person to be deprived of their liberty, it does not require them to be deprived of liberty. If, therefore, the managing authority considers that the criteria for deprivation are no longer met, it should not continue to implement a care regime that deprives the person of their liberty, and should apply to the supervisory body for a review of the authorisation.

128. At any time during the period of an authorisation, either the person concerned or their representative can request the supervisory body to review the authorisation. The grounds for requesting a review are that:-

- The relevant person does not meet all the qualifying requirements.
- The reason why the relevant person meets a qualifying requirement is not the reason stated in the authorisation.
- There has been a change in the relevant person's case and, because of the change, it would be appropriate to vary the conditions to which the authorisation is subject.

129. The supervisory body must carry out a review if requested to do so by the person concerned, their representative or the managing authority, and may also carry out a review at any other time. The supervisory body must tell the relevant person, their representative and the managing authority if they are going to carry out a review.

The review process

130. If it appears to the managing authority that:-

- the relevant person no longer fulfils the age, mental health, mental capacity, best interests or no refusals criteria for detention,
- or the person is ineligible because they now object to receiving mental health treatment in hospital,

- or the reason why the person fulfils one of the criteria has changed,
- or there has been a change in their case which would make it appropriate to vary the conditions attached to their authorisation,

then the managing authority must request a review of the authorisation. The person who lacks capacity and their personal representative are also able to request a review on any of these grounds at any time, and the supervisory body must consider the request.

131. On receipt of a request for a review, the supervisory body must first decide which, if any, of the qualifying requirements appear to be reviewable. If the supervisory body conclude that none of the qualifying requirements are reviewable, it need take no further action. If one or more of the qualifying requirements appear to be reviewable, the supervisory body must arrange for a separate review assessment to be carried out in relation to each reviewable requirement.

132. For the most part, the arrangements for obtaining assessments for standard authorisation purposes apply equally to review assessments. However, where the supervisory body decide that the best interests requirement is reviewable because the conditions attached to the authorisation need to be changed rather than because there has been a significant change in the person's case, there is no need for a full reassessment. Instead, the supervisory body must simply vary the conditions attached to the authorisation as appropriate.

133. If the review relates to any of the other requirements, or to a significant change in the person's situation under the best interests requirement, the supervisory body must obtain a new assessment in relation to all those requirements that have been questioned. If the assessment shows that the requirement is still met, then the supervisory body must consider whether the reason that they are met has changed from the reason originally stated on the authorisation and make any appropriate amendments. In addition, if the review relates to the best interests requirement, the supervisory body must consider whether any conditions should be varied in view of the outcome of the assessment. If any of the criteria are not fulfilled then the authorisation must be terminated with immediate effect.

134. There are separate review arrangements in cases in which the eligibility requirement ceases to be met for a short period of time to permit a brief spell of treatment under the Mental Health Act 1983. If this occurs then the managing authority must notify the supervisory body, who will suspend the authorisation. If the person becomes eligible, again within 28 days then the managing authority must again notify the supervisory body who will remove the suspension. If no such notice is given then at the expiry of the 28-day period the authorisation will cease to have effect.

When an authorisation ends

135. If the managing authority considers that a person will still need to be deprived of liberty after the authorisation ends, they need to request a further standard authorisation to begin immediately after the expiry of the existing authorisation.

136. There is no specified time limit on how far in advance of the expiry of one authorisation the application for a renewal authorisation may be made. It will need to be far enough in advance for the renewal authorisation to be given before the existing authorisation terminates but managing authorities will need to bear in mind that requests for assessments of qualifying requirements made too far in advance may render it impossible for an assessor to make a meaningful assessment of the circumstances as they are likely to be when the renewal authorisation is due to come into force.

137. Once under way, the process for renewing a standard authorisation is basically the same as for obtaining an original authorisation, with the same assessment processes needing to take place. However, the need to appoint an IMCA will not usually arise because most people at this stage will already have a person appointed to represent their interests.

The relevant person's representative

Appointment

138. The supervisory body must appoint a "relevant person's representative" for every person in respect of whom they issue a standard authorisation for deprivation of liberty, in compliance with the relevant appointment regulations **[Note: Yet to be made]**. The role of the representative will be to maintain contact with the relevant person and to represent and support the person in all matters relating to the authorisation, if appropriate triggering a review or an application to the Court of Protection.

139. To be eligible to be a relevant person's representative, a person:-

- Must be over 18 years of age.
- Must be willing to be appointed.
- Must be able to keep in touch with the relevant person, and must not be prevented by ill health from carrying out the role of representative.
- Where appointed by the supervisory body from among family, friends and informal carers, must not be employed by, or paid for activity at,

the relevant hospital, care home or supervisory body in a capacity in which they are, or could be, involved in the person's case.

- Where appointed by the supervisory body as a paid representative, must not be employed by, or paid for activity at, the relevant hospital, care home or supervisory body other than in a representative capacity.

- Where appointed by the supervisory body as a paid representative, must have completed Mental Capacity Act 2005 training, including a Bournewood module.

140. The best interests assessor must, as part of the assessment process, consider whether it is possible to recommend a person to become the relevant person's representative. The assessor should firstly establish whether the person potentially being deprived of liberty has capacity to select their own representative and, if so, invite them to do so. If the relevant person has capacity and chooses an eligible person, the best interests assessor must recommend that person. If there is an attorney, or deputy appointed by the court, with the appropriate authority, they may select the person to be recommended as the relevant person's representative where the relevant person lacks capacity to do so. The best interests' assessor must decide whether the proposed representative(s) is/are eligible.

141. If neither the person concerned, nor an attorney or deputy, make a selection then the best interests assessor must consider whether they are able to identify someone who could act as the relevant person's representative. In making a recommendation, the assessor will wish to consider, and balance, factors such as whether the representative would be able to keep in touch with the person, whether the person appears to trust and feel comfortable with them, whether they would be able to represent the person effectively, and whether they would be likely to act in the person's best interests. It should not be assumed that the representative needs to be someone who supports the deprivation of liberty. In most cases, the best interests' assessor will be able to check at the same time that the person is willing to be the representative.

142. Where more than one person is identified, whoever made the selection must rank them in order of appropriateness. The best interests assessor should be well placed to make this judgement on the basis of information gleaned through the best interests assessment process.

143. The supervisory body must invite the person recommended by the best interests assessor (the first choice if there is more than one) to become the relevant person's representative. If the person is willing to become the representative, the supervisory body must appoint them. If the person is unwilling, the supervisory body must invite any other people recommended by the best interests assessor, in the order in

which the assessor has ranked them, to become the relevant person's representative.

144. It is important that the representative is appointed at the time the authorisation is granted or very shortly thereafter and so the process of appointing a representative should begin as soon as possible. This should be when the best interests assessor is appointed. This should be the case even if one or more of the other assessments has not yet been completed. This does leave a risk of the process being commenced but assessments subsequently concluding that the authorisation should not be granted. Nevertheless, it is important that the process is commenced so that the representative can be in place within an appropriate timescale.

145. If the best interests assessor is unable to recommend anybody to be the relevant person's representative, possibly because the person has no relatives or friends taking an interest in their well-being, or because none of the possible people are willing to accept appointment, the supervisory body must itself identify an eligible person to be appointed as the representative, and invite them to accept appointment. They may commission this service through an agency for advocacy services, ensuring that the service provides effective independent representation for the person deprived of liberty. This process will continue until an eligible person is appointed. When appointing a representative for a person who has no relatives or friends taking an interest in their well-being, the supervisory body should pay particular attention to the communication and cultural needs of the relevant person.

146. The appointment of a relevant person's representative by the supervisory body must be in writing, and notice of the appointment must be given to the relevant person, any IMCA involved, every interested person consulted by the best interests assessor and the managing authority of the relevant hospital or care home. The person appointed must be asked to confirm in writing that they are willing to take on the role and should be informed about sources of support and information available to help them in the role.

147. There is no presumption that a person's representative should be the same as the person who would be their nearest relative for the purposes of the Mental Health Act 1983, even where the person is likely to be subject simultaneously both to an authorisation under these safeguards and a provision of the Mental Health Act 1983.

Termination of appointment

148. The appointment of a relevant person's representative will terminate in any of the following circumstances:-

- The relevant person's representative dies;

- The standard authorisation comes to an end and a new authorisation is not applied for or, if applied for, is not granted;
- The representative informs the supervisory body in writing that they are no longer willing or eligible to continue in the role;
- The relevant person, if they have capacity to do so, chooses a different person to be their representative, and that person is eligible;
- An attorney or deputy, if it is within their authority to do so and the relevant person lacks the capacity to decide, chooses a different person to be the representative, and that person is eligible;
- The supervisory body becomes aware that the relevant person's representative is not keeping in touch with the person;
- The supervisory body becomes aware that the relevant person's representative is no longer eligible.

149. If the supervisory body considers that the representative may not be keeping in touch, or is no longer eligible, it should contact the representative to clarify the position before terminating the appointment.

150. When the appointment of a relevant person's representative ends, the supervisory body must give notice to the representative, the relevant person, every interested person consulted by the best interest's assessor and the managing authority of the relevant hospital or care home. The notice must be given within seven days of the appointment ending or as soon as practicable thereafter, and must state when the appointment ended, and the reason why.

151. A person who is being deprived of their liberty will be in a particularly vulnerable position during any gaps in the appointment of a relevant person's representative since there may be nobody to represent their interests or to apply for a review on their behalf. At such times, it will be particularly important for supervisory bodies to consider exercising their discretion to carry out a review should there be any significant change in the person's circumstances.

152. If the appointment of a relevant person's representative for a person who is already subject to a standard authorisation is terminated in circumstances in which the managing authority is satisfied that there is nobody, other than a person engaged in providing care and treatment for the relevant person in a professional capacity or for remuneration, who can support and represent the person, the managing authority must notify the supervisory body, who must instruct an IMCA to represent the relevant person until a new representative is appointed.

153. The role of the IMCA during their period of appointment is essentially the same as that of the relevant person's representative. Once a relevant person's representative is appointed, the role of the IMCA falls away. However, the IMCA may still apply to the Court of Protection for permission to take the relevant person's case to the Court in connection with the giving of a standard authorisation but, in doing so, the IMCA must take the views of the relevant person's representative on the matter into account.

Appointment of a relevant person's representative when a vacancy arises

154. The supervisory body must, as soon as practicable after it becomes aware of the actual or potential vacancy, identify a suitable person to become the relevant person's representative if such a vacancy arises while a standard authorisation is in force. In selecting a new representative, the supervisory body should take account of any recommendations made by the best interests' assessor and, if the reason for the termination of the former representative's appointment is that they were no longer eligible, consider the views of the former representative on who might replace them. The person identified as most suitable should then be invited to accept appointment. This process should continue until an eligible person is willing to accept appointment.

Record keeping

155. Clear and precise records about relevant person's representatives should be kept in clinical notes and should be regularly monitored and audited, as part of an organisation's governance structure.

Reviews of decisions by the Court of Protection

156. In order to comply with Article 5(4) of the ECHR, it is necessary to provide anybody deprived of liberty in accordance with these provisions with the right of speedy access to a court for a review of the lawfulness of their detention. The Court of Protection, established by the Mental Capacity Act 2005, is the court for this purpose.

157. The relevant person or someone acting on their behalf may make an application to the Court of Protection in respect of an aspect of the assessment process before a decision has been reached on an application for authorisation but it will be for the Court of Protection to decide whether or not to consider such an application.

158. Where a standard authorisation has been given, the relevant person or their representative has, with exemption from the permission requirement, the right of application to the Court of Protection to determine any question relating to the following matters:-

- Whether the relevant person meets one or more of the qualifying requirements.

- The period during which the standard authorisation is to be in force.
- The purpose for which the standard authorisation is given.
- The conditions subject to which the standard authorisation is given.

159. Where an urgent authorisation has been given, the relevant person or any other person acting on his or her behalf has, with exemption from the permission requirement, the right of application to the Court of Protection to determine any question relating to the following matters:-

- Whether the urgent authorisation should have been given.
- The period during which the urgent authorisation is to be in force.
- The purpose for which the urgent authorisation is given.

160. Where a standard or urgent authorisation has been given, any other person may make application to the Court of Protection for permission to take the relevant person's case to the Court in connection with the giving of the authorisation but it will be for the Court of Protection to decide whether or not to consider such an application.

161. The Court may make an order:-

- Varying or terminating a standard or urgent authorisation.
- Directing the supervisory body (in the case of a standard authorisation) or the managing authority (in the case of an urgent authorisation) to vary or terminate the authorisation.

Independent monitoring and provision of information for monitoring purposes

[Note: Paragraphs 162 to 164 describe the regulation-making powers around the monitoring of the operation of the Bournewood safeguards that it is proposed to introduce into the Mental Capacity Act 2005 via the Mental Health Bill. The detail of how these regulation-making powers should be used remains under consideration.]

162. There is a regulation-making power by which:-

- Prescribed bodies may be required to monitor, and report on, the operation of the deprivation of liberty procedures in relation to England.
- The National Assembly for Wales will be enabled to monitor, and report on, the operation of the deprivation of liberty procedures in relation to

Wales, and will be able to direct one or more persons or bodies to carry out the monitoring functions on its behalf.

163. It is currently envisaged that the regulation-making power will be used to establish a monitoring function for the Bournewood safeguards with the regulatory bodies for care homes and hospitals for England. In Wales, Welsh Ministers will require the appropriate powers to undertake any monitoring regime deemed appropriate at the due time. The focus of the monitoring will be on the operation of the Bournewood procedures by care homes and hospitals and care will be taken to ensure that the monitoring role does not cut across the role of the Court of Protection.

164. There is also a regulation-making power by which supervisory bodies and managing authorities may be required to disclose prescribed information to prescribed bodies. Only information relevant to the deprivation of liberty procedures may be prescribed. The regulations will be used to require supervisory bodies and managing authorities to provide relevant information to any body or bodies that are given monitoring responsibilities. The actual information to be prescribed will be discussed with the potential monitoring body/ies.