Mental Capacity & Deprivation of Liberty Safeguards (DoLS)

Policy and Procedure

August 2026

ENFIELD Council

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Contents

1. Overview

This policy and procedure has been produced to assist health and social care staff in Enfield to empower and protect people who may be unable to make some decisions for themselves. This may include people with dementia, learning disabilities, autism, mental health conditions, brain injuries, stroke-related impairments or other conditions affecting decision-making.

The Mental Capacity Act 2005 provides a statutory framework for supporting people to make decisions and, where they lack capacity, for making decisions or taking actions in their best interests. The Act is underpinned by five statutory principles, including the presumption of capacity, the need to support decision-making, the right to make unwise decisions, best interests, and the requirement to use the least restrictive option.

The Deprivation of Liberty Safeguards provide a legal framework for authorising arrangements in a hospital or registered care home where a person aged 18 or over lacks the relevant capacity and is deprived of liberty for the purpose of receiving care or treatment. The safeguards ensure that any deprivation of liberty is lawful, necessary, proportionate, in the person's best interests and subject to representation, review and challenge.

Following Attorney General for Northern Ireland Reference [2026] UKSC 16 (AGNI), the former Cheshire West acid test is no longer the determinative test for deprivation of liberty. Practitioners must now undertake a multifactorial assessment of the person's concrete situation, considering all relevant circumstances including the type, duration, effects and manner of implementation of restrictions, the person's wishes and feelings, evidence of objection, whether valid consent can be inferred, the purpose of the arrangements, the normality of the setting and whether restrictions arise mainly from the person's own condition rather than external control.

2. Purpose of this Policy

The purpose of this policy is to:

- provide guidance on the Mental Capacity Act 2005;
- provide guidance on the Deprivation of Liberty Safeguards;
- reflect current case law following Attorney General for Northern Ireland Reference [2026] UKSC 16 (AGNI);
- help staff identify when care or treatment may amount to a deprivation of liberty;
- promote lawful, proportionate and least restrictive care arrangements;
- support accurate recording of capacity assessments, best interests decisions and DoLS assessments;
- ensure the person's wishes, feelings and rights remain central to decision-making;
- clarify the roles of Managing Authorities, Supervisory Bodies, Relevant Person's Representatives, IMCAs and paid representatives.

This policy does not replace the Mental Capacity Act 2005, Schedule A1, the MCA Code of Practice, the DoLS Code of Practice, the Human Rights Act 1998, the Mental Health Act 1983 or any subsequent statutory guidance or case law. Staff must have regard to the relevant Codes of Practice and seek legal advice where the legal position is unclear.

3. Part 1: Mental Capacity Act 2005

3.1 Definition of mental capacity

A person lacks capacity in relation to a matter if, at the material time, they are unable to make a decision for themselves because of an impairment of, or disturbance in the functioning of, the mind or brain. Capacity is decision-specific and time-specific. A person may have capacity to make some decisions but not others, and may have capacity at some times but not at others.

To make a decision, a person must be able to:

- understand the information relevant to the decision;
- retain that information long enough to make the decision;
- use or weigh that information as part of the decision-making process;
- communicate the decision by any means.

3.2 The five statutory principles

All staff must apply the five statutory principles of the Mental Capacity Act 2005:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person must not be treated as unable to make a decision unless all practicable steps to help them do so have been taken without success.
3. A person must not be treated as unable to make a decision merely because they make an unwise decision.
4. An act done or decision made for or on behalf of a person who lacks capacity must be done or made in their best interests.
5. Before an act is done or a decision is made, regard must be had to whether the purpose can be achieved in a way that is less restrictive of the person's rights and freedom of action.

3.3 Assessing capacity

Capacity assessments must be decision-specific and must address the two-stage test:

Stage 1: Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?

Stage 2: Does that impairment or disturbance mean the person is unable to make the specific decision at the material time?

The assessment must record what practicable steps were taken to support the person, including communication aids, interpreters, alternative times of day, familiar people, accessible information, visual prompts or other relevant support.

3.4 Recording capacity assessments

A formal record should be completed for complex, significant or disputed decisions. Records should include:

- the decision being assessed;

- evidence of impairment or disturbance;
- how the person was supported;
- questions asked and responses given;
- analysis of understanding, retention, use and weighing, and communication;
- the reason the inability to decide is because of the impairment or disturbance;
- whether capacity is likely to fluctuate or return;
- the assessor's name, role, date and conclusion.

3.5 Best interests decision-making

Where a person lacks capacity, any act or decision must be in their best interests. The decision-maker must consider all relevant circumstances, including:

- the person's past and present wishes and feelings;
- the person's beliefs and values;
- the views of family, friends, carers, attorneys, deputies or advocates;
- whether the person may regain capacity;
- whether the decision can be delayed;
- the least restrictive option;
- risks, benefits and burdens of each option.

A balance sheet approach should be used where the decision is complex or serious.

3.6 Restraint and restriction of liberty

Restraint may only be used where the person using it reasonably believes it is necessary to prevent harm to the person who lacks capacity, and the amount or type of restraint and the duration of restraint are proportionate to the likelihood and seriousness of that harm.

Section 5 of the Mental Capacity Act does not provide protection for acts that amount to a deprivation of liberty. Where arrangements go beyond restraint or restriction and amount to deprivation of liberty, they require lawful authorisation through DoLS, the Mental Health Act, or the Court of Protection depending on the circumstances.

3.7 LPAs, deputies and advance decisions

Staff must check whether the person has:

- a registered Health and Welfare Lasting Power of Attorney;
- a registered Property and Financial Affairs Lasting Power of Attorney;
- a Court of Protection deputy;
- a valid and applicable advance decision to refuse treatment;
- any written statement of wishes and feelings.

A Health and Welfare LPA or deputy may make decisions within the scope of their authority where the person lacks capacity. A property and affairs attorney does not have authority to make health and welfare decisions unless separately appointed for that purpose.

3.8 IMCA

An Independent Mental Capacity Advocate must be instructed where required by

the MCA, including where a person who lacks capacity has no appropriate family or friends to consult and decisions concern serious medical treatment or long-term accommodation changes. IMCA involvement must also be considered in safeguarding, care reviews and DoLS matters where the statutory criteria apply.

3.9 Court of Protection

The Court of Protection may be required where:

- there is a serious dispute about best interests;
- a proposed decision significantly affects human rights;
- there is disagreement about residence, care or contact;
- there is doubt about capacity or an advance decision;
- a deprivation of liberty is required outside a hospital or care home;
- existing legal powers are insufficient.

3.10 Safeguarding and section 44

Ill-treatment or wilful neglect of a person who lacks capacity may be a criminal offence under section 44 of the Mental Capacity Act 2005. Staff must follow safeguarding procedures where abuse, neglect, coercion, unlawful restraint or unauthorised deprivation of liberty is suspected.

4. Part 2: Deprivation of Liberty Safeguards

4.1 Introduction to DoLS

The Deprivation of Liberty Safeguards apply to people aged 18 or over who are in hospitals or registered care homes and who may be deprived of liberty for the purpose of receiving care or treatment. DoLS authorisation is required where all qualifying requirements are met.

The safeguards are intended to ensure that any deprivation of liberty is lawful, necessary, proportionate, in the person's best interests, subject to regular review, and capable of challenge before the Court of Protection.

If a person is in supported living, shared lives, an ordinary tenancy or their own home, DoLS cannot authorise the deprivation of liberty. If deprivation of liberty is required in those settings, an application to the Court of Protection may be needed.

4.2 Legal update following AGNI

On 2 June 2026, the Supreme Court gave judgment in Attorney General for Northern Ireland Reference [2026] UKSC 16. The Court concluded that the former Cheshire West acid test was wrongly decided and should be overruled. The former test asked whether a person was under continuous supervision and control and not free to leave. Following AGNI, those factors remain relevant but are no longer determinative.

The correct approach is now a multifactorial assessment of the person's concrete situation. The assessment must take account of a range of factors, including:

- the type of restrictions;
- the duration of restrictions;
- the effects of restrictions;
- the manner in which restrictions are implemented;
- the purpose of the restrictions;
- the person's wishes and feelings;
- the presence or absence of objection;
- whether valid consent can be inferred;
- the type and normality of the setting;
- whether restrictions arise from the person's own condition or from externally imposed controls;
- how close the person's situation is to the paradigm case of confinement in a prison cell.

No single factor is determinative. Restrictions must be considered cumulatively and in combination.

4.3 Key principle: do not apply the acid test as a shortcut

The former Cheshire West formulation of “continuous supervision and control and not free to leave” must no longer be treated as the automatic test for deprivation of liberty. Those matters may still be relevant, but staff and assessors must not conclude that DoLS is required solely because those factors are present.
Equally, staff must not assume that no deprivation of liberty exists simply because care is protective, therapeutic, kind, necessary or in the person’s best interests. The question remains whether the person’s overall concrete situation, considered in the round, amounts to a deprivation of physical liberty.

4.4 Identifying possible deprivation of liberty

Managing Authorities must remain alert to circumstances that may amount to deprivation of liberty. A referral should be considered where there are significant restrictions upon the person’s physical liberty, especially when several restrictions operate together.
Relevant indicators include:

- locked doors or coded exits;
- preventing or returning the person if they try to leave;
- one-to-one or two-to-one supervision;
- restraint or physical intervention;
- seclusion or isolation;
- covert medication;
- sedating medication used to manage objection or behaviour;
- restrictions on contact with others;
- restrictions on community access;
- staff exercising complete or substantial control over residence, care, treatment or movement;
- refusal of discharge to family or carers;
- strong objection by the person or those interested in their welfare.

The DoLS Code of Practice states that managing authorities should have procedures to identify whether deprivation of liberty is or may be necessary, what steps should be taken to assess whether authorisation should be sought, and how cases should be reviewed.

4.5 Multifactorial assessment

When determining whether deprivation of liberty is occurring, assessors must consider the following factors.

Type of restrictions

Record the practical restrictions placed on the person, including supervision, locked doors, physical restraint, medication, seclusion, restrictions on contact, restrictions on community access, care planning controls and staff decisions about movement or residence.

Duration
Consider how long the restrictions apply, whether they are temporary, indefinite, continuous, intermittent, short-term or long-term. Duration is relevant but not determinative.

Effects
Consider how the restrictions affect the person in practice. This includes distress, social isolation, loss of autonomy, loss of meaningful community access, emotional impact, frustration, behavioural response, or whether the person experiences the arrangements as supportive and acceptable.

Manner of implementation
Consider whether restrictions are implemented through encouragement, reassurance and ordinary support, or through force, restraint, sedation, coercion, compulsion or repeated intervention.

Purpose
Consider whether the restrictions are protective and therapeutic, punitive, disciplinary, administrative or primarily for the convenience of the service. Protective purpose may weigh against a finding of deprivation, but it does not automatically prevent such a finding.

Cumulative effect
Restrictions must be considered together. A single minor restriction may not amount to deprivation of liberty, but several restrictions operating together may do so.

4.6 Valid consent under Article 5
Following Attorney General for Northern Ireland Reference [2026] UKSC 16, a person may lack capacity under the Mental Capacity Act 2005 to decide about residence and care but may nevertheless be able to express valid consent for Article 5 purposes. Lack of MCA capacity must not automatically be treated as absence of valid consent.

Assessors must consider whether the person:

- is conscious of their environment;
- has a basic understanding of where they live;
- has a basic understanding of their living circumstances;
- expresses contentment or acceptance;
- regards the placement as home;
- can express a view through words, behaviour, gesture, facial expression or other communication;
- has a consistent positive attitude to the arrangements.

Compliance alone is not valid consent. Passive acceptance, lack of objection or inability to complain should not be treated as consent without further evidence. Relevant legal guidance indicates that it is not enough that the person does not object; there must be evidence of a positive attitude to the care arrangements through their wishes and feelings.
Where there is serious doubt about the person’s true wishes or preferences, valid consent should not be inferred.

4.7 Objection, wishes and feelings

Assessors must actively consider whether the person objects to residence, care, treatment or restrictions. Objection may be verbal, behavioural, historical or situational.

Evidence of objection may include:

- saying they want to go home;
- asking to leave;
- attempting to leave;
- resisting personal care;
- refusing medication;
- requiring covert medication because of refusal;
- physical resistance to interventions;
- distress during care;
- trying to remove equipment;
- agitation when prevented from doing something;
- repeated attempts to avoid staff;
- behaviours that appear linked to the care regime or restrictions.

Evidence against objection may include:

- positively saying they are happy;
- saying they want to stay;
- seeking out staff support;
- enjoying the placement;
- treating the placement as home;
- showing settled routines;
- participating willingly in care and activities.

Assessors should consider whether apparent objection is actually linked to the placement or restrictions, or whether it relates to pain, communication difficulty, sensory distress, dementia, autism, trauma, unfamiliar staff or the nature of a particular care task. This analysis must be recorded.

4.8 Relative normality and setting

The type and normality of the setting are relevant. The Supreme Court recognised that restrictions in a person's own home, a family home, supported living, foster care or ordinary residential care may have a different character from restrictions in a psychiatric hospital, secure unit or prison-like setting.

Assessors should consider:

- whether the setting is the person's home;
- how long the person has lived there;
- whether the person regards it as home;
- whether family and social contact are maintained;
- whether community access is supported;
- whether arrangements resemble ordinary life for a person with similar

needs;
- whether the restrictions go beyond ordinary care, support and risk management.

A restrictive hospital or secure setting may more readily indicate deprivation of liberty. A settled, homely, non-secure placement where the person is content may weigh against deprivation, although the full circumstances must still be assessed.

4.9 Restrictions arising from the person's own condition

Assessors must consider whether the person's inability to leave or move freely arises mainly from their own physical or cognitive condition, rather than from restrictions imposed by others. The Supreme Court judgment confirms that "liberty" means physical liberty and that, where a person is unable to conceptualise leaving or physically achieve leaving because of profound disability, they may not be being prevented by a third party from doing something.

This does not mean that people with profound disabilities can never be deprived of liberty. It means the assessor must distinguish between:

- limitations caused by illness, impairment or disability; and
- restrictions imposed by staff, professionals, services or the state.

Where externally imposed restrictions are significant, coercive, intensive or operate cumulatively, deprivation of liberty may still be established.

4.10 Comparing with the prison-cell paradigm

In borderline cases, assessors should consider how close the person's circumstances are to the paradigm case of deprivation of liberty, namely confinement in a prison cell. The closer the situation is to confinement, detention, coercion, seclusion or institutional control, the more likely it is to amount to deprivation of liberty.

Factors moving a case closer to deprivation may include:

- locked or secure environment;
- no meaningful freedom to leave;
- coercive return if leaving;
- seclusion;
- sedation;
- physical restraint;
- social isolation;
- denial of contact with family or carers;
- lack of meaningful community access;
- opposition from the person;
- overriding the person's expressed wishes.

Factors moving a case away from deprivation may include:

- ordinary, homely or non-secure surroundings;
- the person clearly regarding the placement as home;
- settled routines and positive engagement with care;
- meaningful family, social and community contact;
- restrictions arising mainly from the person's own condition rather than external control;
- support delivered through encouragement and ordinary care rather than coercion, restraint or force;
- positive evidence of the person's wishes, feelings and contentment with the arrangements;
- less restrictive alternatives having been considered and used where practicable.

4.11 When to make a DoLS application

A Managing Authority must request a standard authorisation where it appears that a person is, or is likely to be, deprived of liberty within the next 28 days in a hospital or care home and the person lacks the relevant capacity.

A request should not be made automatically for every person who lacks capacity or receives 24-hour care. Managing Authorities should screen each case using the multifactorial approach and should provide detailed evidence rather than generic phrases such as "24-hour care". The 2015 forms guidance states that descriptions should include the environment, who determined where the person lives, whether the arrangement is temporary or permanent, and how restrictions operate in practice.

4.12 Standard authorisation

A standard authorisation is given by the Supervisory Body following statutory assessments and may authorise deprivation of liberty for a period of up to 12 months. The period must be no longer than necessary and must be justified by the evidence.

The Managing Authority must submit the appropriate request form to the Enfield DoLS Service by secure email.
Contact: dols@enfield.gov.uk
The Managing Authority must inform relevant family members, carers, representatives and advocates that an application has been made, unless there is a lawful reason not to do so.

4.13 Urgent authorisation

An urgent authorisation may be granted by the Managing Authority where the need for deprivation of liberty is so urgent that it must begin before the standard authorisation process is completed. It may last up to seven days and may be extended once by the Supervisory Body for up to a further seven days in exceptional circumstances.

Urgent authorisations should not be used as a routine substitute for planned standard authorisations.

4.14 The assessment process

The Supervisory Body must commission the required assessments:

- age assessment;
- no refusals assessment;
- mental capacity assessment;
- mental health assessment;
- eligibility assessment;
- best interests assessment

The Best Interests Assessor must determine whether deprivation of liberty is occurring or is likely to occur using the AGNI multifactorial framework. If there is no deprivation of liberty, the assessment should stop and the standard authorisation should not be granted.

4.15 Best Interests Assessment following AGNI

The Best Interests Assessment must address:

1. The person's concrete situation.
2. The type, duration, effects and manner of implementation of restrictions.
3. The purpose of restrictions.
4. Whether restrictions are imposed externally or arise mainly from the person's own condition.
5. The person's wishes and feelings.
6. Evidence of objection.
7. Whether valid Article 5 consent can be inferred.
8. Relative normality of the placement.
9. Comparison with the prison-cell paradigm where relevant.
10. Whether deprivation of liberty is necessary to prevent harm.
11. Whether deprivation of liberty is proportionate to the likelihood and seriousness of harm.
12. Whether deprivation of liberty is in the person's best interests.

The assessor must not simply state that the person lacks capacity and is under continuous supervision and control. That is not sufficient under AGNI.

4.16 Authorisation granted

A standard authorisation may be granted only where all qualifying requirements are met. The Supervisory Body must scrutinise the assessments and record why each requirement is satisfied.

Where authorisation is granted, the Supervisory Body must specify the period of authorisation, the date from which it takes effect, any conditions attached to the authorisation, the reasons why each qualifying requirement is met, and the arrangements for appointing and notifying the Relevant Person's Representative.

4.17 Authorisation not granted

Authorisation must not be granted where any qualifying requirement is not met. This includes cases where the multifactorial assessment shows that the

arrangements do not amount to deprivation of liberty.

Where authorisation is not granted, the Managing Authority must amend the care arrangements or consider alternative legal routes if restrictions remain necessary. Where deprivation of liberty continues without lawful authority, safeguarding action and/or legal advice may be required.

4.18 Conditions

Conditions must relate to the deprivation of liberty and must not be used to address ordinary care planning matters. The 2015 forms guidance suggests asking whether the person would still need the matter addressed if they were not deprived of liberty; if yes, it is likely to be a care planning issue rather than a DoLS condition.

Examples of matters that may be recommendations rather than conditions include medication review, improved care planning, family contact planning, activities provision or general service quality issues.

4.19 Relevant Person's Representative

Every person subject to a standard authorisation must have a Relevant Person's Representative. The RPR's role is to maintain contact with the person, represent and support them in matters relating to the authorisation, request reviews where appropriate and support access to the Court of Protection.

Where the person has capacity to select a representative, they should be supported to do so. Where they lack capacity, the BIA should recommend a suitable person or a paid representative if no suitable person is available.

In cases where the person objects or where there is reason to believe their rights may not otherwise be challenged, particular care must be taken to ensure the representative is willing and able to act independently and effectively.

4.20 IMCA and PRPR

An IMCA must be instructed in DoLS cases where statutory criteria are met, including where there is no appropriate person to consult or where support is needed to exercise rights of review or Court of Protection challenge.

A Paid Relevant Person's Representative should be appointed where there is no suitable unpaid representative.

4.21 Review of authorisation

A review must be considered where:

- the person's circumstances change;
- the person no longer appears to meet a qualifying requirement;
- the person objects to the arrangements;
- the RPR requests review;
- the Managing Authority requests review;
- conditions need amendment;
- the restrictions have reduced or increased;
- the person's wishes and feelings change;
- AGNI analysis indicates the person may now be giving valid consent or may

no longer be deprived of liberty.

Existing authorisations should not simply expire without consideration of whether a further authorisation, review or termination is required.

4.22 Ending an authorisation

A standard authorisation ends where:

- it expires and is not renewed;
- the person dies;
- the person moves and a new authorisation is granted elsewhere;
- the person no longer meets a qualifying requirement;
- a review concludes that the authorisation should end;
- the Court of Protection orders that it should end.

Managing Authorities must notify the Supervisory Body promptly where circumstances change.

4.23 Safeguarding and unauthorised deprivation of liberty

Safeguarding procedures must be considered where:

- deprivation of liberty is occurring without authorisation;
- authorisation is refused but restrictions continue;
- restrictions are excessive, abusive or punitive;
- restraint, seclusion, neglect or coercion is suspected;
- conditions attached to an authorisation are not being met;
- care arrangements appear unsafe or unlawful.

The Best Interests Assessor, Managing Authority, Supervisory Body or any concerned person may raise a safeguarding concern where appropriate.

4.24 Interface with the Mental Health Act

Where the person is in hospital for treatment of mental disorder and objects, or would object if able to do so, careful consideration must be given to whether the Mental Health Act rather than DoLS is the appropriate legal framework.

The 2015 forms guidance states that a person lacking capacity cannot be made subject to DoLS in hospital for psychiatric treatment if they could be detained under sections 2 or 3 of the Mental Health Act and are objecting, unless the relevant legal conditions involving welfare LPA or deputy consent apply.

Legal advice should be sought in complex eligibility cases.

5.Appendices

Appendix 1: MCA and Best Interests Recording Tool

The Enfield Mental Capacity Assessment and Best Interest Decision Recording Tool

Guidelines for Use of
The Mental Capacity Assessment and Best Interest Decision Tool

How to use the Tool
This guidance should be used with the Mental Capacity and Best Interest Decision Tool. The Tool should be used to help you record that you are using the Mental Capacity Act. Practitioners are encouraged to read and use the Mental Capacity Code of Practice, when working with people who may lack mental capacity. In the remainder of this document, 'P' will refer to someone who lacks mental capacity.

Recording your use of the Mental Capacity Act
Paid professionals using the Mental Capacity Act should record how they have applied it. If you work with people who lack mental capacity and do not record how you use the Act, you may be personally accountable for your decision-making. See section 5 of the Code of Practice for further information.

The Five Principles of the Act
It is important to use and remember the 5 Principles of the Act when working with people who lack capacity:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success. (remember to use all possible methods of communication / media).
3. A person is not to be treated as unable to make a decision merely because they make an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
5. Before the act is done, or the decision is made, it should be considered whether the same outcome can be achieved in a way that is less restrictive of the person's rights and freedom.

Who should assess mental capacity
Capacity should be assessed by the person who is directly concerned with the individual at the time of the decision. All decisions should be time-specific and decision-specific. For example, decisions about medical treatment may be best assessed by a doctor or nurse, while decisions about day-to-day care may be best assessed by the person's carer. This means that different people may assess the person's capacity to make different decisions at different times. Where the issue is complex, consider whether additional assessment tools, specialist input or professional advice are required.

Context of the Assessment

The assessor needs to decide whether the person has capacity for a specific question or decision. The matter may relate to a Safeguarding Adults concern; for example, does the person have capacity to contribute to their safeguarding plan?

Two Stage Capacity Test

1) For Stage 1, answer 1a on page 1. State whether there is a formal diagnosis and explain how this is known, for example from medical notes or a care plan. A formal diagnosis is not always required, but there must be a reasonable belief that the person has an impairment of, or disturbance in the functioning of, the mind or brain. For example, the person may be confused because of a urinary tract infection. If the case is complex, a medical opinion may be needed to confirm Stage 1 and this can be sought retrospectively where appropriate.

2) Stage 2 consists of the four questions in 2a, 2b, 2c and 2d. If the person is unable to do any one of these because of the impairment or disturbance identified at Stage 1, they lack capacity for that specific decision. The assessor must support the person to participate in the assessment, including by using interpreters, communication aids, pictures or visual prompts where appropriate.

Where a person has fluctuating or temporary capacity, assessors should consider delaying the decision if this is possible and in the person's interests, so that the person may be able to make the decision for themselves. If the decision is needed immediately, remember that capacity is time-specific and record the date and time of the assessment.

Best Interests Decisions

Once it has been established that the person lacks capacity, decisions should be made in their best interests. If there is no other authority to make a decision, this may need to be made by a professional. For decisions that may have serious consequences it may even be necessary for the Court of Protection to decide what is best for P.

IMCA involvement

If P has no friends or family then you need to consider whether an Independent Mental Capacity Advocate (IMCA) should be contacted. See no.3 on page 2.

If P is 'unbefriended' you have to instruct an IMCA when:

- P will be in hospital for more than 28 days, or a care home for more than 8 weeks
- P needs serious medical treatment to be given or withdrawn, e.g. a feeding through a tube
- Accommodation change is planned for P in a care home or a hospital

You may also wish to instruct an IMCA (because it is good practice) when:

- P has no one to speak on their behalf and a care review is planned
- P has friends or family, but there are Safeguarding Adults Concerns about them not being motivated by P's best interests

In Enfield, Barnet and Haringey the IMCA provider is POhWER. You can contact them on 0300 456 2370, alternatively you can email them: imca@pohwer.net and they will send you a form to complete in order to refer this person to them. In case of an emergency you should go ahead with the best interest decision and you do not need to consult with an IMCA.

Other authority to make decisions

- If there is a Court Order relating to the decision, this should be followed.
- P could have a Deputy appointed by the Court of Protection, who has the authority to make ongoing decisions.
- If P has made an Advance Directive about not receiving medical treatment and this treatment is now being proposed, the advanced decision must be followed.
- If the decision relates to treatment that could preserve P's life, it should be given special consideration. You may need to consider whether you should approach the COP for these decisions.

- If P has written down wishes or feelings about the proposed action, these should be given special consideration.
- A registered Health and Welfare Lasting Power of Attorney may make decisions within the scope of their authority where the person lacks capacity. Property and Financial Affairs attorneys cannot make health and welfare decisions unless they also hold a separate Health and Welfare LPA.
- Under no circumstances can a next of kin make decisions (e.g. health and welfare decisions) on behalf of P, however their views are important and should be considered by the decision maker.
- If a friend or family says they are a Lasting Power of Attorney (LPA) this would be either for Financial Decisions or Health & Welfare Decisions. Sometimes the LPA is set up to manage both. They would be able to show you confirmation that the LPA has been registered with the Court of Protection (Office of the Public Guardian – the administrative office of the Court of Protection). Enduring Power of Attorneys (EPAs) are registered with the Court of Protection (COP) in the same way as an LPA. EPA's are however, only valid for finance decisions. If the LPA or EPA is not registered with the COP, then it is not valid. You can contact the Office of the Public Guardian to check if it is registered, for a small fee. Check their website for contact details.
- If you think the LPA or EPA is not motivated by P's best interests then you can ask the COP to investigate them.
- P should be given an opportunity to share their wishes and feelings and make the decision, if they have capacity to do so; even if they have a registered LPA or EPA.
- If there is a dispute with anyone about a particular decision, which may have an impact on P's Human Rights, e.g. a move to a Care Home, or contact with friends / family, all efforts should be made to resolve it. If it cannot be resolved and the decision is likely to affect P long term, then you may wish to consider going to the COP for a decision about it.

Best Interest Checklist

When best interest decisions are considered the Best Interest Checklist should be used:

- Encourage participation of P - e.g. use communication aids and interpreters
- Identify all relevant circumstances relating to P
- Find out P's views (past and present – regard their culture etc.)
- Avoid discrimination
- Consider whether the person might regain capacity
- If the decision concerns life-sustaining treatment, it should be given special consideration
- Consult others (document at No.3 – 7 p.2)
- Avoid restricting P's human and civil rights
- Take all of this into account and weigh up what is in P's best interests.

Options and the balance sheet approach

Write down all the different options that have been, or are being, explored. Use a balance sheet approach and record the risks and benefits of each option. Each option considered should state the likely outcome for P, friends, family and professionals. Remember that leaving the situation as it is, or doing nothing, is also an option. Record this at No.8 on page 3.

Assessment Summary

Document the outcome of the decision that has been reached and state why this option was found to be in P's best interests. Explain where the assessment is to be kept and who has been informed of the decision. Finally write your name and date of the decision at the end of the form.

Specialist Advice

For advice regarding Enfield residents, contact the MCA / DoLS Manager in the Safeguarding Service to discuss your case. Telephone: 020 8132 0376. Email: dols@enfield.gov.uk.

Enfield Mental Capacity Assessment and Best Interest Decision Tool					
Name		**Date of Birth**		**Carefirst/Rio/NHS Number**	
Assessor Name		**Role of Assessor**		**Assessment Date**	

Context

What are the questions or decisions to be addressed by this assessment?
Details:

Two Stage Capacity Test *(This is specific, not general determination .Reference any documentation used)*

1. Does the person have an impairment or disturbance of the brain or mind?	**Permanent impairment**		**Temporary impairment**		**No**	

Details (please state any clinical diagnoses):

	If yes, how was this indicated?	**If no, why not?**
2a. Is the person able to understand the information relevant to the decision?		
2b. Is the person able to retain the information relevant to the decision?		
2c. Is the person able to use or weigh up the relevant information and understand the consequences of that decision?		

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Name		**Date of Birth**		**Carefirst/Rio/NHS Number**	
2d. Does the person have the ability to communicate their decision, by any means?					
Is this Person likely to regain capacity in the near future?				**Yes**	**No**
Is a Best Interest Decision now required?	**Yes**	**No**		**Assessors Signature**	
Best Interest Decision					
1. What is the nature of the decision to be made? **Details:**					
Name of Decision Maker		**Role of Decision Maker**			
2. Is it possible to delay the decision if capacity will be regained?	**Yes**	**No**	**Not Appropriate to delay**		
3. Does the person have friends or family who are appropriate to consult with, or is an IMCA required?	**Has Friends/ Family**	**IMCA Required**			
Referral to IMCA Service	**Yes**	**No**	**Date Completed**		
4. Is there an Advance Decision: Lasting Power of Attorney: Court of Protection Deputy or Court order that has the authority to make the decision? **Details**:					

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5. Have the present wishes and feelings of the person been taken into account?			**Yes**	**No**	
If yes, what are these wishes?					
6. Have their past wishes and feelings been taken into account including cultural and religious beliefs (whether explicit or implied)?		**Yes**	**No**	**Where was this information sourced, and what were these wishes?**	
7. Views of others (friends / family) or IMCA					
Name of Person Consulted State Relationship to individual	**Views**			**Date information received**	

8. What Options were explored? Please list the benefits and risks below

	Option	Benefits (+)	Risks (-)	Outcome
1				
2				

Enfield Mental Capacity Assessment and Best Interest Decision Tool					
Name		**Date of Birth**		**Carefirst/Rio/NHS Number**	
3					
Is Court of Protection input required to make the decision? (e.g. serious disputes or complex decisions relating to accommodation changes : tenancy agreements or issues that could affect the				**Yes**	**No**
Assessment summary					
Considering all the factors what final decision has been reached? **Details:**					
Actions to be taken as a result of the assessment					
Care Plan Amended & Assessment Recorded	**Yes**	**No**	**Date Completed**		
Involved Parties Informed of Decision	**Yes**	**No**	**Date Completed**		
Decision Maker Signature		**Date of Decision**			

Appendix 2: DoLS Screening Checklist following AGNI

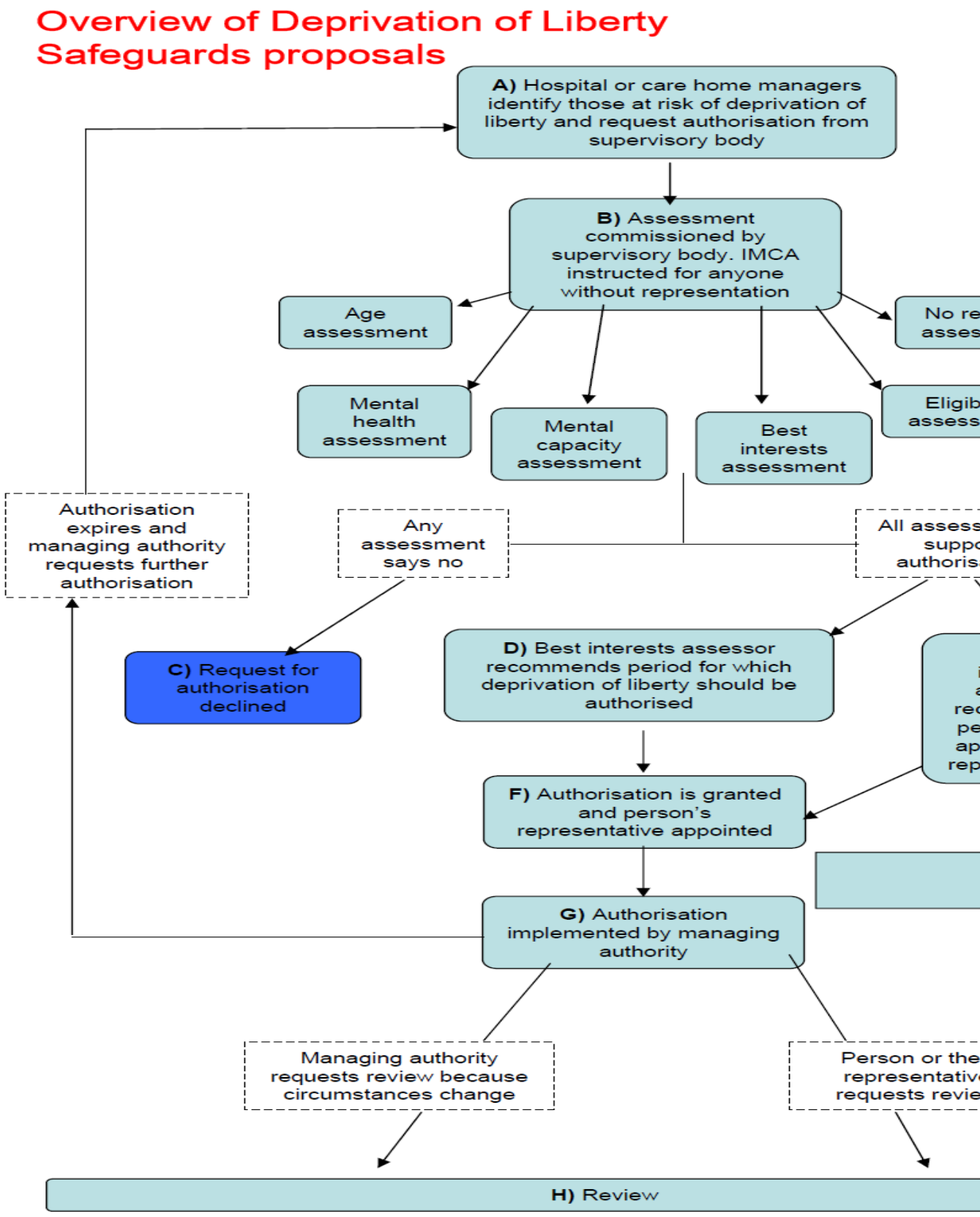
Managing Authorities should complete this short screening before requesting a DoLS authorisation. The purpose is to decide whether the person's care or treatment arrangements may amount to a deprivation of liberty and whether a standard authorisation, urgent authorisation, review, or alternative legal route is required.

1. Is the person aged 18 or over and currently in a hospital or registered care home?
2. Does the person appear to lack capacity to consent to the relevant residence, care or treatment arrangements?
3. Have all practicable steps been taken to support the person to make the decision, including communication support, accessible information, interpreters, familiar people or choosing the best time of day?
4. What are the person's wishes and feelings about the placement, care and restrictions?
5. Is there evidence of objection, distress, resistance, repeated attempts to leave, refusal of care or objection from those interested in the person's welfare?
6. Is there positive evidence that the person is content with, accepts or regards the arrangements as home? If so, record the evidence carefully and do not rely only on compliance or lack of objection.
7. What restrictions are in place, including locked doors, coded exits, supervision, restraint, covert medication, sedating medication, restricted contact, restricted community access, or staff control over residence, movement, care or treatment?
8. How long do the restrictions apply and are they temporary, intermittent, continuous, long-term or indefinite?
9. What is the practical effect of the restrictions on the person's physical liberty, autonomy, wellbeing, family contact and community access?
10. Are restrictions implemented through ordinary support and encouragement, or through coercion, restraint, force, sedation or repeated intervention?
11. Do the restrictions arise mainly from the person's own physical or cognitive condition, or are they externally imposed by staff, services or professionals?
12. Is the setting ordinary, homely and non-secure, or does it resemble confinement, institutional control, seclusion or detention?
13. Have less restrictive alternatives been considered, tried and recorded?
14. Looking at all factors together, does the person's concrete situation appear to amount to a deprivation of liberty?
15. If yes, is the deprivation necessary to prevent harm, proportionate to the likelihood and seriousness of that harm, and in the person's best interests?
16. If DoLS appears required within the next 28 days, has a standard authorisation request been prepared with clear supporting evidence?
17. If the deprivation must begin immediately and cannot wait for the standard process, has an urgent authorisation been granted and submitted with the standard authorisation request?

18. If DoLS is not available because the person is not in a hospital or care home, has legal advice or Court of Protection authorisation been considered?
19. Have the person, family, carers, advocate, attorney, deputy or other interested people been informed or consulted where appropriate?
20. Has the screening decision, evidence, rationale and next action been recorded in the person's care records?

Screening outcome: If the answer to question 14 is "yes" or "unclear", the Managing Authority should seek advice and consider submitting a DoLS request. If the answer is "no", the rationale should still be recorded, especially where restrictions are present but are not considered to amount to deprivation of liberty.

Overview of the Deprivation of Liberty Safeguards Process



Appendix 3: Supervisory Body and DoLS Service Responsibilities

Summary of key responsibilities of **Enfield Council** (Supervisory Body)

In Enfield, the statutory duties of the Supervisory Body are managed as part of the Safeguarding Adults Service.

The key responsibilities for the Supervisory Body are:

- To co-ordinate a dedicated interagency Deprivation of Liberty Safeguards Service to undertake the work related to the deprivation of liberty.
- To ensure there is a clear referral pathway for all Managing Authorities.
- To recruit assessors that have the necessary skills, qualifications and experience as outlined in the Code of Practice.
- To ensure there are sufficient numbers of assessors to undertake the volume of assessments required.
- To ensure all staff working as assessors or in any capacity within the DOLS service receive adequate training to perform their role, including training in equality and diversity issues.
- To coordinate and deliver training to those services with statutory responsibilities for the safeguards and advise on integrating the requirements across other relevant service provision.
- To ensure consistency in equality of access to, and outcomes from, Deprivation of Liberty Safeguards services.
- To have overall responsibility for granting or refusing authorisations for deprivation of liberty and to be responsible for signing authorisations.
- When giving authorisations for deprivation of liberty, to specify the duration of the deprivation of liberty, which cannot exceed 12 months and should be for the shortest possible practicable time.
- To attach appropriate conditions to the authorisation and make recommendations based on the best interests of the relevant person.
- To make this document available to all local authority and independent care homes, hospitals and relevant staff from Supervisory Body and to ensure information pertaining to the procedures and processes contained within this document is communicated in a timely and effective manner.
- To record management information and use it to measure the effectiveness of the process outlined within this document and to assess the nature of the authorisations both granted and refused in light of the local population of Enfield.

- To use management information and reviews to develop good practice and communicate this information to relevant departments, such as those involved with commissioning care and support services.
- To collect equalities monitoring information for deprivation of liberty cases and to use this information to monitor any differential impact on particular groups and enhance anti-discriminatory practices.
- To enhance contract monitoring of care homes and hospitals through combined intelligent information and intelligence (not personal data) arising from assessments of care plans and levels of restrictive practices.

Summary of the key responsibilities of the ***DOLS Service***:

- To provide Managing Authorities with standard forms for use when requesting a standard authorisation of deprivation of liberty and to ensure referral processes are effective, secure and safe.
- To receive applications from Managing Authorities for Standard Authorisations of deprivation of liberty and to respond to applications within the specified timescales.
- To appoint assessors, IMCAs and relevant person's representatives.
- To facilitate and conduct the six necessary assessments of the relevant person to ascertain whether or not they meet the qualifying requirements for a Standard Authorisation to be given.
- To give notice of the decision in writing to the requisite people and to other persons entitled to notice by the most appropriate means.
- To access relevant resources that will enhance the quality of the assessment process e.g. specialist opinion, interpreters etc.
- To respond to requests to review an authorisation for deprivation of liberty, to record assessment information and outcomes in accordance with statutory requirements, and to complete necessary management monitoring information.

Appendix 4: Supervisory Body Scrutiny Checklist

Purpose of the checklist

This checklist is for Supervisory Body managers and DoLS officers when scrutinising requests, assessments and authorisation decisions. It should be used alongside the DoLS Code of Practice, current statutory guidance, local procedures and the AGNI multifactorial approach.

1. Referral screening and allocation

- Check that the request has been submitted by the Managing Authority using the correct form and secure route.

- Confirm that the person is aged 18 or over and is in a hospital or registered care home.
- Check whether the request is for a standard authorisation, urgent authorisation, review or further authorisation.
- Check ordinary residence and confirm that Enfield is the correct Supervisory Body.
- Check whether the application includes sufficient supporting evidence, including care plans, risk assessments, capacity evidence, best interests information and details of restrictions.
- Screen for any immediate safeguarding concerns, including unauthorised deprivation of liberty, excessive restrictions, restraint, neglect or unsafe care.
- Allocate the case promptly and record the date of receipt, priority, timescale and responsible officer.

2. IMCA and representation checks

- Consider whether a section 39A IMCA must be instructed because there is no appropriate person to consult.
- Check whether there is an attorney, deputy, advance decision, court order or other legal authority relevant to the decision.
- Ensure the person, family, carers and interested parties are identified and consulted where appropriate.
- Consider any potential conflict of interest before appointing assessors or recommending a representative.
- Ensure arrangements are in place to appoint a Relevant Person's Representative if authorisation is granted.

3. Statutory assessments

- Commission the required statutory assessments within the relevant timescales.
- Ensure assessors have the required skills, qualifications and independence.
- Confirm that the age, mental health, mental capacity, no refusals, eligibility and best interests requirements have each been addressed.
- Ensure the Best Interests Assessor has considered AGNI, including the person's concrete situation, wishes and feelings, objection, valid consent, relative normality, type and effect of restrictions, and whether restrictions arise from the person's own condition or external control.
- Ensure the assessment does not rely solely on continuous supervision and control or a lack of freedom to leave.
- Stop the process and refuse authorisation where any qualifying requirement is not met.

4. Scrutiny before authorisation

- Check that each qualifying requirement is evidenced and clearly reasoned.
- Check that the proposed authorisation period is justified, proportionate and no longer than necessary.
- Check any proposed conditions to ensure they relate to the deprivation of liberty and are not ordinary care planning recommendations.
- Check that any less restrictive alternatives have been considered and recorded.

- Check whether the person objects or may need support to challenge the authorisation.
- Ensure any refusal, reduced period or amended condition is clearly recorded with reasons.

5. Decision and notifications

- Record whether the authorisation is granted or refused.
- If granted, record the start date, end date, maximum period, purpose, reasons, conditions and Relevant Person's Representative arrangements.
- Notify the Managing Authority, the relevant person, the Relevant Person's Representative, any IMCA, family members, carers and other interested parties as required.
- Ensure the person and representative receive information about review rights and the right to challenge the authorisation in the Court of Protection.
- Record all notices, forms, communications and decisions on the DoLS record system.

6. Reviews, further authorisations and ending authorisations

- Consider a review where circumstances change, conditions need amendment, restrictions increase or reduce, the person objects, the RPR requests review, or any qualifying requirement may no longer be met.
- Ensure further authorisation requests are considered in good time before expiry where deprivation of liberty remains necessary.
- End or review the authorisation promptly where the person moves, dies, regains relevant capacity, no longer meets a qualifying requirement, or is no longer deprived of liberty.
- Record any suspension, termination, further authorisation or review decision clearly.
- Consider safeguarding action or legal advice where restrictions continue without lawful authorisation.

7. Governance and quality assurance

- Maintain accurate records of applications, assessments, decisions, timescales, authorisations, reviews, conditions and outcomes.
- Use management information to monitor demand, timeliness, quality, equality and outcomes.
- Audit assessments and authorisation decisions to ensure consistency with the DoLS Code of Practice, AGNI, local procedures and current case law.
- Identify learning for Managing Authorities, assessors, commissioners, safeguarding, contract monitoring and quality assurance processes.
- Escalate themes, risks and repeated concerns through appropriate governance routes.

<u>Appendix 5: Managing Authority Responsibilities</u>

Care homes and hospitals are the Managing Authorities under the Deprivation of Liberty Safeguards. They are responsible for identifying when the care or treatment arrangements for a person aged 18 or over may amount to a deprivation of liberty, and for taking prompt action to ensure that any

deprivation of liberty is lawful, necessary, proportionate and in the person's best interests.
Managing Authorities must not make DoLS applications automatically for every person who lacks capacity or receives continuous care. They must consider the person's concrete situation, including the type, duration, effect and manner of any restrictions, the person's wishes and feelings, evidence of objection, whether there is positive evidence from which valid Article 5 consent can be inferred, the normality of the setting, and whether restrictions arise mainly from the person's own condition or from externally imposed controls. Mere compliance, passive acceptance or lack of objection should not be treated as valid consent without further evidence of the person's wishes and feelings.

The key responsibilities of the Managing Authority are:

- To provide care and treatment in the least restrictive way that is practicable, necessary and proportionate to the risk of harm.
- To ensure that staff understand the Mental Capacity Act 2005, the Deprivation of Liberty Safeguards, the DoLS Code of Practice, the current legal test for deprivation of liberty following AGNI, any updated public or statutory guidance, and the organisation's internal referral procedures.
- To assess and record whether the person has capacity to consent to the relevant care, treatment, residence or admission arrangements.
- To consider whether there is positive evidence that the person can give valid consent for Article 5 purposes, even where they lack capacity under the Mental Capacity Act, and not to infer consent from mere compliance or absence of objection alone.
- To keep the person's wishes, feelings, objections, communication needs, cultural background and relationships under review and to record how these have informed care planning.
- To identify and record any restrictions, including locked doors, supervision, restraint, covert medication, restricted contact, restricted community access or staff control over movement, residence or care.
- To consider whether the cumulative effect of restrictions may amount to deprivation of liberty and whether less restrictive alternatives have been considered.
- To request a standard authorisation from the Supervisory Body where it appears that the person is, or is likely to be, deprived of liberty within the next 28 days in a hospital or care home.
- To submit the correct DoLS request form and provide clear supporting evidence, including care plans, risk assessments, capacity assessments, best interests records and details of restrictions.
- To grant an urgent authorisation only where there is no practicable alternative, the deprivation of liberty needs to begin immediately before the standard authorisation process can be completed, and the standard authorisation request is submitted at the same time.
- To ensure that an urgent authorisation is not used routinely or as a substitute for timely care planning.
- To comply with any conditions attached to a standard authorisation and to update the care plan to reflect those conditions.

- To inform the relevant person, their representative, family members, carers, advocates and other interested parties of the application and authorisation outcome, unless there is a lawful reason not to do so.
- To support visits and contact from the Relevant Person's Representative, IMCA or Paid Relevant Person's Representative, and to alert the Supervisory Body if the representative is not maintaining appropriate contact.
- To request a review where the person's circumstances change, restrictions increase or reduce, the person objects, conditions need amending, any qualifying requirement may no longer be met, or the person may no longer be deprived of liberty.
- To request a further authorisation in good time where deprivation of liberty is still required beyond the expiry date of the existing authorisation.
- To notify the Supervisory Body promptly if the authorisation should end, the person moves, the person dies, or the arrangements no longer amount to deprivation of liberty.
- To notify the Care Quality Commission where required under applicable notification requirements, including any required notification following the death of a person subject to DoLS.
- To make alternative lawful arrangements where authorisation is refused but restrictions remain necessary, including seeking legal advice or considering Court of Protection involvement where appropriate.
- To raise safeguarding concerns where deprivation of liberty is unauthorised, restrictions appear excessive, conditions are not being met, or there are concerns about abuse, neglect, coercion or unlawful restraint.
- To maintain accurate records of applications, authorisations, urgent authorisations, reviews, conditions, notifications, care plan amendments and communication with the person and their representatives.
- To have regard to the DoLS Code of Practice while applying it in light of AGNI, current case law and any updated statutory or public guidance.

Appendix 6: IMCA and PRPR Services

An Independent Mental Capacity Advocate (IMCA) provides independent support and representation for a person who lacks capacity where the statutory criteria are met. In DoLS cases, an IMCA may be required before, during or after the authorisation process, including where there is no appropriate person to consult, where the person or their representative needs support to request a review, or where support is needed to exercise the right to challenge the authorisation in the Court of Protection.

A Relevant Person's Representative (RPR) must be appointed for every person subject to a standard DoLS authorisation. The RPR's role is to maintain contact with the person, represent and support them in matters relating to the authorisation, request a review where appropriate, and support access to the Court of Protection where this is needed.

A Paid Relevant Person's Representative (PRPR) should be appointed where there is no suitable unpaid person who is willing and able to act as the RPR. A PRPR must be able to act independently, maintain appropriate contact with the person, understand the authorisation, and take steps to protect the person's rights, including requesting a review or supporting a challenge where required.

IMCA provider in the London Borough of Enfield

For more information visit: www.enfield.gov.uk

IMCA referrals can be sent to the coordinator at:

IMCA - POhWER,
PO Box - 14043
Birmingham,
B6 9BL.

Telephone: 0300 435 2370

Email: imca@pohwer.net
Webpage: https://www.pohwer.net/