Deprivation of Liberty Safeguards

Annual Monitoring Report for Health and Social Care

1 April 2010 - 31 March 2011

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DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

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Foreword

It gives us great pleasure to introduce this annual report for 2010 – 2011, which looks at the second year of the operation of the Deprivation of Liberty Safeguards in Wales. This year as the two Inspectorates charged with monitoring the use of the Safeguards in hospitals and care homes, we have chosen to produce a joint report which looks at the emerging trends, similarities and differences in the two sectors.

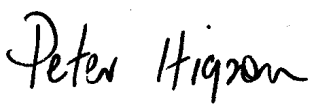
Anyone of us or our loved ones could temporarily or permanently lose the capacity to make decisions about how we wish to be cared for, whether as a consequence of a sudden injury, a slow-developing degenerative condition or a life-long impairment. The Safeguards provide a framework to ensure that any individual in a vulnerable situation is only deprived of their liberty so they can receive care when there is an absolute need to, when it is in the individual's best interests to do so and when other less restrictive arrangements have been considered but found to be inappropriate. The Safeguards have the human rights of individuals at their core and ensure that decisions are made in a transparent manner that can be challenged.

Whilst the numbers of individuals affected are relatively small, the impact on their lives and the lives of those who care for them can be considerable. We are committed to ensuring that we play our part to safeguard them, through the monitoring activities we undertake and the actions of any of our staff who come into contact with individuals who may be deprived of their liberty, their families, carers and friends. We would like to take this opportunity to remind the organisations we inspect that they have a statutory duty to ensure they have taken the appropriate steps to ensure the legality of their actions and that they have the necessary authority to make decisions involving people who lack capacity.

This second year has given us more information to establish the picture in Wales, and to begin to identify trends in practice. This year has also seen developments in the interpretation of the legislation as cases have been taken to the Court of Protection and Court of Appeal. Similarly, we have seen press coverage of a number of cases with moves to open up the workings of the Court of Protection.

This requires a difficult balance between helping the public to understand how such decisions are made and preserving the privacy of individuals, families and those closely involved in their care arrangements.

We are extremely grateful to all those people who helped us to compile this report, in particular those who work hard to ensure their organisations understand and meet their responsibilities under the Safeguards and the Mental Capacity Act. We hope that the information set out in this report will be of interest not only to those responsible for making decisions about and providing care to individuals who cannot make their own choices, but also to individuals and their families who are or could be in need of health and social care services in the future.



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Executive Summary

Background

Mental capacity is taken for granted by most adults until it is lost. Some never achieve this state of independence because of conditions that arise in childhood. In either case the Mental Capacity Act offers a framework focussed on the best interests of individuals within which other people can assist with decision making or make decisions where necessary. The Safeguards deal with situations where someone may need to be deprived of their liberty in order to receive care in hospital or in a care home and set out why this loss of freedom must only occur in ways that are controlled, monitored and open to appeal.

The Safeguards provide no absolute definition of what is a deprivation of liberty, or when a combination of restrictions of liberty may result in a deprivation. Whether a deprivation exists is a decision based on a set of assessments and consideration of each person's circumstances and needs. So it is possible that a similar set of restrictions may amount to a deprivation that is in one person's best interests but not in another's.

The Safeguards place responsibilities on health and social care organisations and their staff which have to be understood and implemented. These responsibilities and the associated terminology are set out briefly in the Key Terms section at the back of the report.

This year, the Safeguards have continued to be used to protect the rights of individuals who have lost mental capacity or whose mental capacity fluctuates. Their use has to be monitored to make sure they are applied properly for patients and care home residents. This report combines the findings of both Healthcare Inspectorate Wales (HIW) and Care and Social Services Inspectorate Wales (CSSIW). Our key findings below are drawn from information gathered from health and social care organisations, and are intended to give a brief overview. More detailed information

is contained in the full report and in the statistical briefing published at the same time.

We have found that:

- The provisions within the Safeguards, which allow family members and others to ask for a review, highlight concerns or challenge authorisations continued to be used infrequently. We still believe that this is due to a lack of information available to the public.
- Opportunities to offer support from statutory Independent Mental Capacity Advocates (IMCAs) have rarely been taken by supervisory bodies.
- The total number of applications made under the Safeguards was 488. This is fewer than the 547 applications made last year. Care homes made 71% (346) of the applications, while hospitals made 29% (142).
- 19% of applications related to women over 85 years old resident in a care home.
- There was a significant fall in applications concerning people under the age of 65 years.
- Overall, the use of urgent authorisations remains higher than anticipated with 161 made by care home managers, and 88 made in hospital.
- 277 applications became standard authorisations; 203 in social care and 74 in health. This is higher than last year.
- There continued to be wide variation in the number of applications made by health and social care organisations and the number authorised. For example, the rate of authorisations per 100,000 population in local authorities ranged between 0 – 26 and in health boards between 0 - 8.
- Local authorities and health boards need to assure themselves that appropriate arrangements are in place to separate their two key roles of supervisory body and managing authority. They also need to have in place systems to monitor their own performance and report this at the highest level in their organisations.

Conclusions

The information gathered in the second year of the Safeguards has shown some changes from the first year. However it is too soon to identify whether trends are developing, given the very different needs of the individuals for whom an application under the Safeguards was made.

It is clear that public understanding of the Safeguards and the Mental Capacity Act remains underdeveloped even though media interest has increased. The apparent lack of access to clear information and knowledgeable support, the low level of referrals to IMCAs to support the relevant person, their family and friends and rare use of reviews to challenge individual authorisations or to confirm that they continue to meet needs are matters of concern.

Case law coming out of the Court of Protection judgements point to key areas of practice, which need to be understood and disseminated by senior managers in all health and social care organisations. While a lot of good work continues, supervisory bodies and managing authorities cannot be complacent. They have a corporate responsibility to give priority to safeguarding individuals in situations that make them vulnerable. They need to ensure they have appropriate governance arrangements in place to assure themselves at the highest levels that the rights of individuals and their families are being recognised and upheld through compliance with the requirements of the legal frameworks.

We will continue our work to monitor the Safeguards in Wales and highlight trends as they become clearer. We will engage with practitioners, other interested organisations and individuals and their families whose care has been considered or authorised under the Safeguards to listen to their experiences and concerns. We will also consider how the findings this year can be built into our ongoing work to inspect and regulate health and social care organisations.

Chapter 1: The Safeguards

The Deprivation of Liberty Safeguards (the Safeguards) are there to protect people whose mental capacity is compromised, who either live in a care home or are patients on a hospital ward. These Safeguards were developed to ensure that the human rights of such individuals are maintained. The legislation introduced new terminology which is explained in the Key Terms in Appendix A.

While on the ward, or in the care home, staff may need to deprive people of their liberty in order to provide the care and treatment they require. The Safeguards aim to provide a clear legal framework to ensure that this only done in ways which promote the individual's best interests. The circumstances of each case will be unique to each individual, called the **relevant person** in the legislation, and can vary according to the nature of the care setting. The Safeguards require a set of assessments to be undertaken and the requirements of each assessment have to be met before a deprivation can be authorised. Unauthorised deprivations of liberty are unlawful.

The Safeguards are accompanied by a Code of Practice[1] which sets out:

- The process for making an application for the authorisation of a deprivation of liberty.
- Details of how an application for authorisation should be assessed.
- What requirements must be fulfilled for an authorisation to be given.
- The process for reviewing an authorisation.
- Details of the support and representation that must be provided to; individuals who are subject to an authorisation.
- The way in people can challenge authorisations.

[1] Deprivation of Liberty Safeguards Code of Practice. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf

When might the Safeguards be used in a hospital?

Some years ago, Mr J had a bad accident and suffered serious head injuries, which have left him with problems with his memory and understanding. He is in hospital having investigations to identify the cause of a number of physical symptoms he has experienced but his brain injury can cause him to become agitated and confused. He has tried to leave the ward and staff have brought him back for his own safety. He also becomes agitated and difficult when staff try to perform the necessary medical tests.

The care team are considering how best to care for him in order to complete the investigations that he needs and have discussed the possibility of restraining him either physically or by using sedation. Mr J also gets very upset when his family visits and this triggers some of his attempts to leave. Staff consider that it may be better for him if they only allow the family to visit once a week.

Mr J's care team are therefore considering whether it is appropriate to request an assessment under the Safeguards to ensure that they have the proper authority to implement their decisions.

When might the Safeguards be used in a care home?

Mrs B has been diagnosed with dementia. She lives at home with her increasingly frail husband who has been providing most of her care, although they also receive home care. The social worker suggests respite care in a nearby care home. However, Mrs B cannot be persuaded to go and look at the care home. When her husband is admitted to hospital as an emergency, Mrs B has to be admitted to the care home immediately by her daughter. Very quickly she becomes agitated, and tries to leave. Her family all agree that she must stay there to give their father chance to recover. An application is made for a standard authorisation, so that she can be cared for legally while her husband is not able to care for her. The

care home manager has to carefully consider whether they are already depriving Mrs B of her liberty; if so an urgent authorisation should be put in place.

The Safeguards were implemented on 1 April, 2009. They place a duty on Welsh Ministers to monitor their implementation in Wales, which Healthcare Inspectorate Wales (HIW) and Care and Social Services Inspectorate Wales (CSSIW) undertake on their behalf. The Safeguards also require us to publish an annual report on these activities. We published reports[2] on the first year's use of the Safeguards in March 2010, in which we explained in some detail how the Safeguards work and the respective duties of health boards, local authorities, hospitals and care homes. These were accompanied by a statistical briefing document and data tables.

For the monitoring year of 2010 - 2011, the two Inspectorates have produced this joint report, building on the findings and details contained in their previous reports. Again it is accompanied by a statistical briefing document and data tables, which can be accessed on the website of both organisations. We have not gone into as much detail on the workings of the Safeguards this year, but this report includes a number of appendices with additional information to support understanding of the Safeguards in Wales. **Appendix A** contains a glossary of key terms used throughout the report, **Appendix B** shows the locations of the seven health boards and the 22 local authorities which act as supervisory bodies in Wales and **Appendix C** provides a list of documents and information sources used during the development of this report.

As in 2009 – 2010 supervisory bodies have been required to submit to us information regarding every application they have received under the Safeguards. The data collected from supervisory bodies has remained the same, except for the addition of information about the use of Independent Mental Capacity Advocates (IMCAs). Where the information for 2010 – 2011 identified possible practice issues, these were followed up with the managing authorities or supervisory bodies by the relevant

[2] HIW report;
http://www.hiw.org.uk/page.cfm?orgid=477&pid=52820
CSSIW report:
http://wales.gov.uk/cssiwsubsite/newcssiw/publications/ourfindings/allwales/2011/dolsreport/?lang=en

Inspectorate to confirm the validity of the data or understand the circumstances that led to the particular decision or concern.

This year we did not collect supplementary information about policy, procedures, training undertaken and administrative arrangements as little is likely to have changed from the first year. We have continued to liaise with the Mental Capacity Act network, DoLS practitioners and advocacy services to maintain their understanding of current arrangements.

Chapter 2: The individual and ensuring their rights are respected

Empowerment and protection of individuals are the central principles of the Safeguards. Whether in a care home or hospital, arrangements to provide care or treatment must be undertaken in the least restrictive way compatible with preventing harm to them, while being in their best interests. The Safeguards and Code of Practice set out a number of requirements. These centre upon making sure that an individual is properly represented and has a voice both at the time an application to deprive them of their liberty is made and, and if granted, during the lifetime of the authorisation.

The Mental Capacity Act 2005 set out five key principles:

- We must begin by assuming that people have capacity.
- People must be helped to make decisions if they need help.
- Unwise decisions do not necessarily mean lack of capacity.
- Decisions must be taken in the person's best interests.
- Decisions must be the least restrictive of freedom as is possible.

The Safeguards are a specialist area of the Mental Capacity Act. Some evidence of incapacity should already be apparent, before the managing authority and others consider their use.

There were 1169 care homes registered to admit adults in Wales at the end of March 2010. This compares with 2009-10 when the number was very slightly higher at 1186. CSSIW aims to visit each home at least once during the year. Some will have been visited more often, especially if a complaint has been made. Inspectors always follow up the outcomes for any individuals who are the subject of an authorisation at the time they visit, as well as looking out for individuals who may be deprived of their liberty in an unauthorised way. Inspectors have discussions with care home managers which prompt reflection on the Mental Capacity Act in general, and the Safeguards in particular. Inspectors may make a third party application to

the appropriate supervisory body if they consider a resident is being deprived of their liberty and the managing authority has not themselves applied for assessment or has plans to make changes to the regime of care in place. They may also approach the local social services authority in which the care home is located; if they think that circumstances indicate that there is an adult protection concern.

At the end of March 2010 Wales had 133 NHS hospitals with 12,129 inpatient beds[3]. A further 45 independent acute or mental health hospitals and hospices are registered with HIW. A range of inspection and review activities are undertaken in these hospitals and teams will look at the circumstances of the care of individuals who lack capacity, as well as testing the staff knowledge and understanding of the Mental Capacity Act and the Safeguards. In particular reviewers visit mental health wards, and whilst they focus on the application of the Mental Health Act, they will also pick up on individuals admitted to wards voluntarily who appear to be subject to restrictions on their liberty, whether or not they have capacity to agree to this.

Who has been affected by the Safeguards?

In total 488 applications were made under the Safeguards in Wales in 2010 – 2011, which resulted in 277 standard authorisations. In 249 of these applications, urgent authorisations had already been put in place by the managing authority. For two applications, it was not possible to determine whether an urgent authorisation already existed. The distribution of the two types of authorisation across health and social care is shown in Table 1.

Table 1: Authorisations put in place in Wales 2010 – 2011.

	Urgent Authorisations	Standard Authorisations
Health	88	74
Social Care	161	203
Wales	249	277

[3] Health Statistics Wales 2011.

Social care applications involved 215 individuals and health applications 105. We know that some individuals will have been counted twice as some people were subject to the Safeguards in both a hospital and a care home setting during the year.

19% of all applications made in Wales concerned women over 85 years old being cared for in a care home. In hospital more men than women were the subject of applications for authorisations; similarly more men have a deprivation of their liberty authorised. As Charts 1 and 2 demonstrate, the largest proportion of people of either gender for whom an application is made are aged between 65 – 84 years, and this is true in both in both health and social care settings. No ethnic minorities are over-represented, with 98% of applications concerning someone whose ethnic origin is reported to be white.

Chart 1: Age and gender of individuals – all applications.

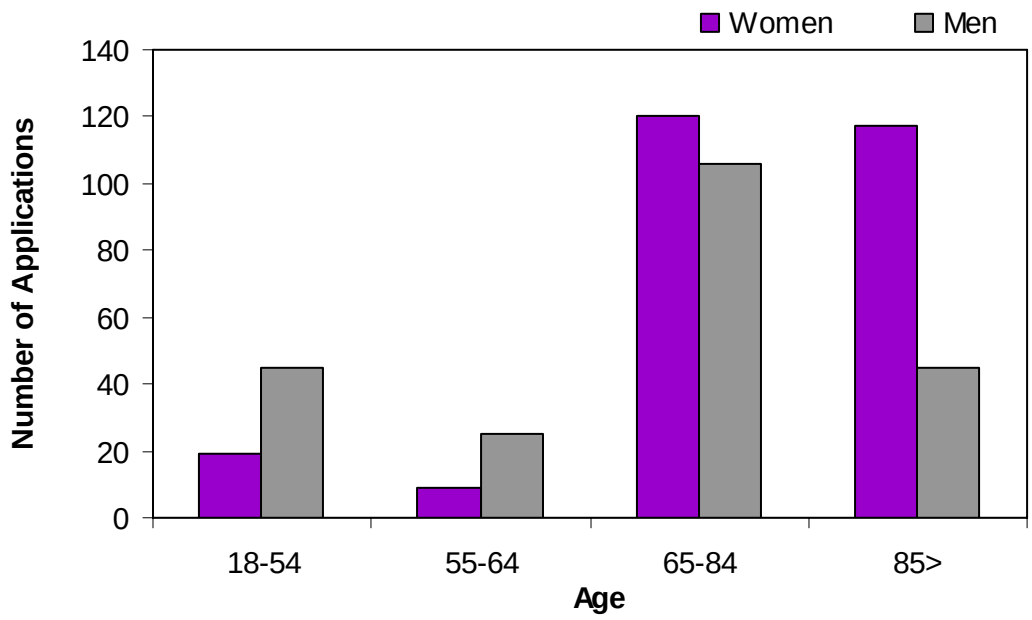
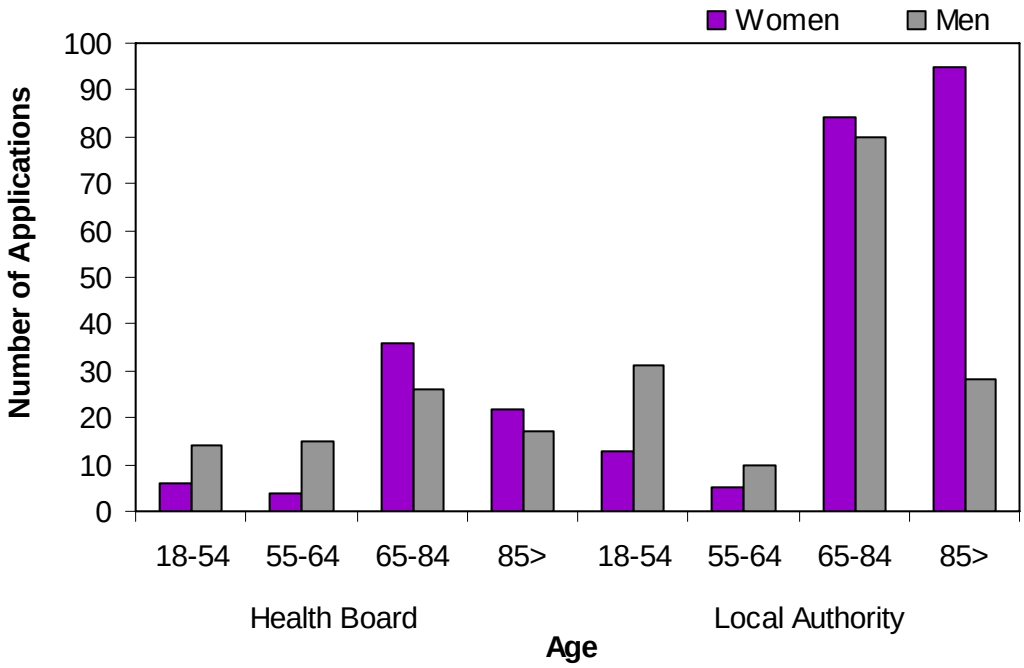


Chart 2: Age and gender of individuals in applications made from health and social care.



Whilst the number of applications has not changed significantly over the last year for people over the age of 65, (down to 388 from 398) there has been a significant decrease in applications for people under 65 years of age. In social care there were 59 applications compared with 107, while in health there were 39 applications, compared with 71 in the first year.

Chart 3 shows the levels of authorisations following applications for men and women and Chart 4 for individuals of different age groups. More details about authorisation levels for standard authorisations are discussed later in the report.

Chart 3: Authorisations granted for individuals in health and social care by gender.

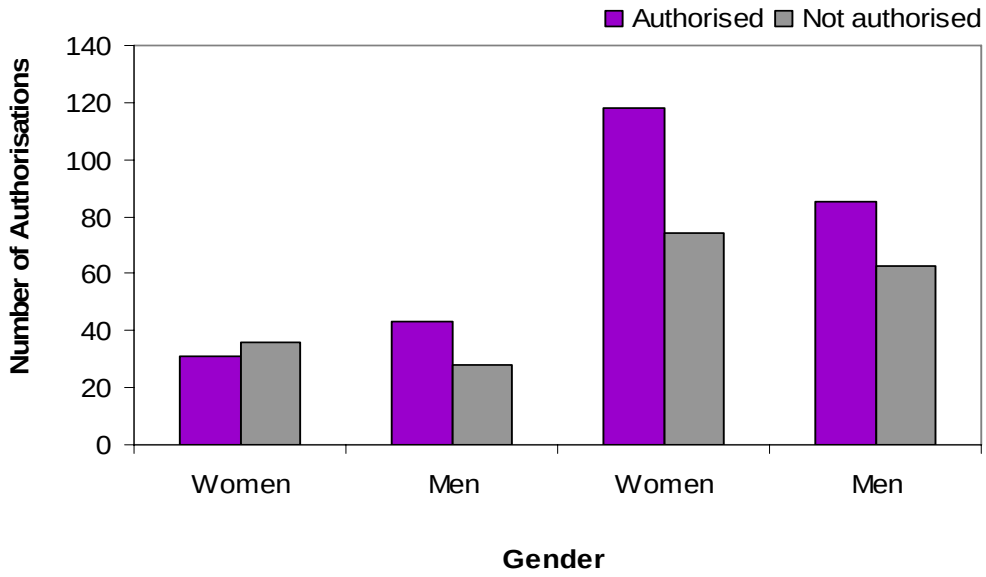
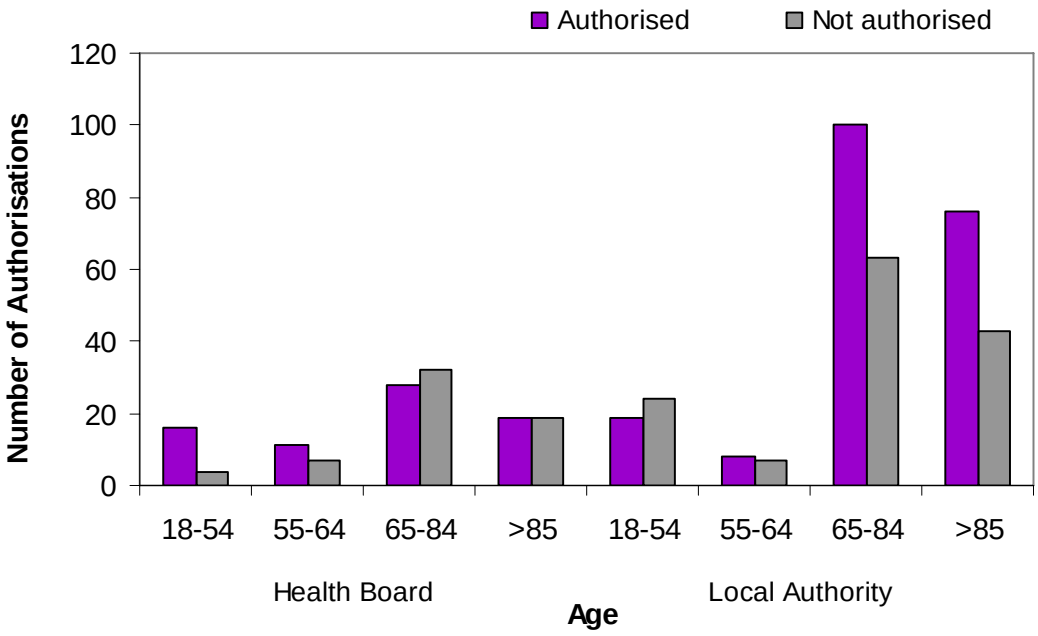


Chart 4: Authorisations granted for individuals in health and social care by age.



How do relevant people have their rights upheld?

It is a continuing challenge for supervisory bodies and managing authorities to ensure that individuals and their representatives understand the implications of the Safeguards are aware of their rights and can act on them. The information we have

gathered has shown that many of the provisions within the Safeguards for highlighting and challenging decisions are not often taken up. It is not clear why this is, but it highlights the need for supervisory bodies and managing authorities to ensure that the relevant person, their family, friends and carers have access to straightforward information about the Safeguards and their rights. Supervisory bodies also need to fulfil all of their statutory responsibilities as detailed in the sections below.

The Best Interests Assessor

Six assessments are needed before a deprivation of liberty can be granted. The Best Interests Assessor plays a central part in seeking the views of a range of people interested in the welfare of the relevant person, including the individual in question and their family and friends. The Best Interests Assessor determines whether the relevant person is deprived of their liberty and if so, whether this is in their best interests. It is vital that they are able to undertake this role effectively, and this issue is explored further in Chapter five.

Third Party Requests

If there are concerns about the manner in which someone is being cared for, relatives, friends, advocates and other people concerned with their well being may approach the supervisory body to request that they consider whether the Safeguards need to be applied. This is known as a third party request. Information from supervisory bodies suggests that this opportunity is not well known, as it is not often taken up. In addition some of the information we received incorrectly identified a number of applications as third party requests when they had been received from managing authorities. We are aware of requests from one relative and a number of social workers and psychiatrists. Even if a third party request does not result in a standard authorisation; it allows each individual's circumstances to be thoroughly assessed and necessary changes to be made to their personal plan of care. This is likely to promote the welfare of the relevant person.

The Relevant Person's Representative

A key safeguard for the relevant person is their representative. If an authorisation is granted, the supervisory body must appoint a relevant person's representative, who could be a family member or friend. In some circumstances it may be more appropriate for a suitable professional to be appointed. The managing authority has the duty to record and note whether the relevant person's representative visits regularly, and should highlight any concerns about the relevant person's representative to the supervisory body. The appointed relevant person's representative does not have to agree with the deprivation of liberty and the appointment can be changed to another suitable person during the lifetime of an authorisation.

The Code of Practice notes that the relevant person's representative should represent and support the relevant person *'in all matters relating to the Safeguards, including, if appropriate, triggering a review, using an organisation's complaints procedure on the person's behalf or making an application to the Court of Protection'.*

Table 2: Types of people appointed as relevant person's representatives.

	Carer / Relative / Friend	Other
Health Board	57	17
Local Authority	147	54
Total	204	71

As can be seen from Table 2 above the majority of relevant person's representatives are relatives, with friends acting as relevant person's representatives in a few cases. Most relevant person's representatives described as *'other'* were identified as advocates, although a solicitor was appointed in one case. In almost all cases, only one relevant person's representative had been in place for the duration of the authorisation, which should make monitoring of their input more straight forward for managing authorities. This should allow analysis of the quality of input from the relevant person's representative by supervisory bodies.

Although there is an option in Wales[4] for supervisory bodies to make a payment to any relevant person's representative for out of pocket expenses, this has only occurred where an advocate has been appointed. Supervisory bodies should examine their current practice to ensure that it does not disadvantage non-professional relevant person's representatives who have taken on this important role.

Reviews

Where an application under the Safeguards has been authorised the managing authority must monitor the case to see if the person's circumstances change and ask the supervisory body for a review if appropriate. The relevant person or the relevant person's representative can also ask for a review. Supervisory bodies must respond to requests for a review of standard authorisations in a timely way. Supervisory bodies are themselves also able to call for a review if they feel it is necessary.

Table 3: Number of reviews requested in health and social care, and by whom.

	Health	Social Care
Relevant person	0	2
Relevant person's representative	0	3
Managing authority	1	6
Supervisory body	0	10

As Table 3 shows only five reviews were requested by the relevant person, or their representative and only 22 reviews were held in total. Only one review was held by a health supervisory body. Although their authorisations are generally shorter, this contrasts with last year where nine reviews were held.

[4] The Regulatory framework differs from that in England, where only professional relevant person's representatives can be paid.

Reviews are crucial to ensuring that the deprivation continues to be necessary and justified. As part of the unified assessment process, care management reviews should be held as a minimum once every twelve months to ensure that the best outcomes for the individual are obtained. Such care management reviews could highlight changes which should trigger a review of a standard authorisation. However the figures in Table 3 make it apparent that there is no connection between the unified assessment process and the use of the Safeguards.

Court of Protection

As was highlighted last year, the Court of Protection continues to offer a process of review, in case of dispute or where a potential deprivation occurs in settings other than a hospital or a care home. In the last year more cases went forward and judgements are beginning to have an impact on practice. Steven Neary's experience of being deprived of his liberty is an example of this, the judgement[5] of which was delivered in June 2011. In Steven's case his father's efforts to allow his son to return home through the Court of Protection were successful. This case has been given a high profile and it highlighted the role and workings of the Court.

There is evidence, both from this case and local experience that legal advice is not easily available to the relevant person or their representative. This may be due to a lack of understanding about the legally aided status of the relevant person and their representative, as well as there being only a few solicitors' firms that offer specialist support for such cases.

Independent Mental Capacity Advocates (IMCAs)

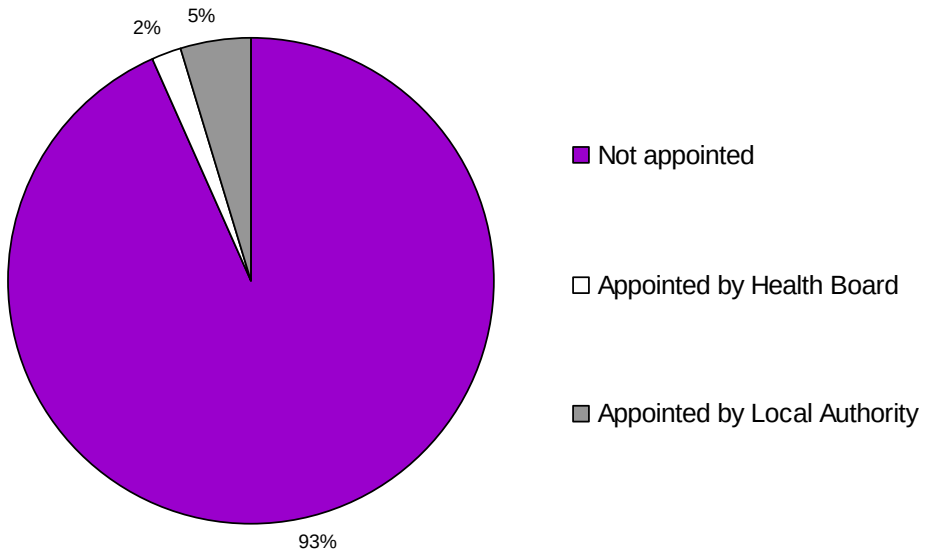
This year we have collected information about the appointment of IMCAs. There are three specified situations in the Safeguards when IMCAs can be appointed.

[5] Re Steven Neary; LB Hillingdon v Steven Neary (2011) EWHC 1377 (COP). http://www.bailii.org/ew/cases/EWHC/COP/2011/1377.html

- There is the **Section 39A IMCA** who is involved at the outset whilst an application is being considered for a vulnerable individual with no discernable family or friends (the *'un-befriended'*). They must represent the individual to enable their voice to be heard.
- The **Section 39C IMCA** can take on the role of the relevant person's representative if the original representative ceases to hold that role, until another is appointed.
- The supervisory body can refer the relevant person or their representative to a **Section 39D IMCA**. This IMCA's responsibility is to advise and inform them, and in particular to make use of the review process or gain access to the Court of Protection.

Chart 5 shows the proportion of applications for which a Section 39A IMCA was appointed. Our data indicates that 31 out of 488 applications involved such appointments. Supervisory bodies should monitor trends in the use of IMCAs and examine how un-befriended people are identified and supported.

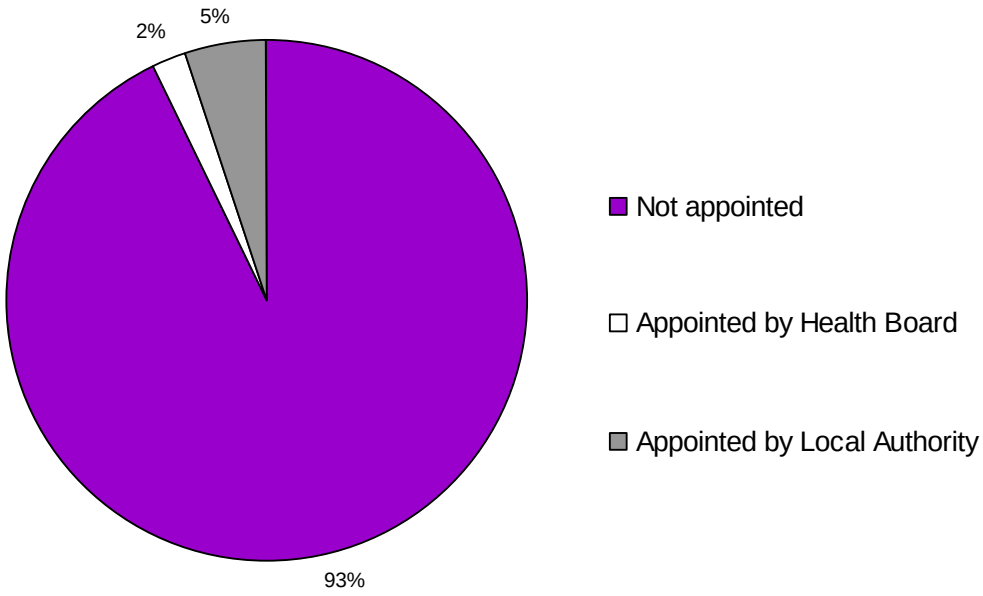
Chart 5: Proportion of applications for which Section 39A IMCAs were appointed.



There were no Section 39C IMCAs appointed by any supervisory body. This is not surprising as in most cases only one relevant person's representative was appointed for the duration of each authorised deprivation, so the situation in which such an appointment would be made did not arise.

Chart 6 demonstrates the number of authorisations where a Section 39D IMCA was appointed to support the relevant person or their representative. There were 20 cases in which this occurred, which represents 7% of all authorisations. There was significant variability between the practice of individual supervisory bodies in making such appointments. As we have noted, the majority of representatives are family and friends and few requested reviews of authorisations from supervisory bodies or the Court of Protection. Section 39D IMCAs can play a significant role in ensuring that the voices of individuals deprived of their liberty and their friends and family are properly heard, as demonstrated in Steven Neary's case. As highlighted in last year's reports, supervisory bodies need to examine their practices in relation to making applications for IMCA services and strengthen their arrangements for monitoring their use.

Chart 6: Proportion of authorisations for which Section 39D IMCAs were appointed.



Chapter 3: Applications for Authorisation

This year there were 488 applications for standard authorisations, compared with 547 last year. 71% of the applications were for people in care homes and the remaining 29% were for people in hospital. When the Safeguards were being developed, it was forecast that there would be around 630 applications in Wales each year. This continuing evidence of lower than expected use of the Safeguards should be monitored by supervisory bodies.

Applications were received from 34 hospitals (142 applications) and 172 care homes (346 applications). All but one application from the health sector came from the NHS, with the one independent setting being a hospice. Eighteen applications were in respect of individuals from Wales receiving care in England; six from hospitals, three of which were granted, and 12 from care homes, with eight granted. These applications were made by two hospitals and 10 different care homes, most of which were close to the Welsh border, but some care homes were as far away as the West Country and the South Coast.

There are still some difficulties in identifying the supervisory body in social care settings, where residents may come from a wide geographical area. Under the Safeguards the supervisory body is considered to be the local authority social services department who arranged the individual's place in the care home, because they were originally resident in their area, or in the case of people who are funding their own care, the local authority in which they were previously resident.

Managing authorities are able to grant themselves urgent authorisations, if they feel they are already depriving someone of their liberty, before applying to the supervisory body for a standard authorisation. The Code of Practice gives the following advice about urgent authorisations:

'In the vast majority of cases, it should be possible to plan in advance so that a standard authorisation can be obtained before the deprivation of liberty begins. There may, however, be some exceptional cases where the need for the deprivation of liberty is so urgent that it is in the best interests of the person for it to begin while the application is being considered'.

This year, more care homes (nearly 15% of all care homes) used the Safeguards. In 161 cases, they granted themselves an urgent authorisation before applying for a standard authorisation. There were 183 applications for a standard authorisation alone. (For two applications, it was not possible to determine whether an urgent authorisation already existed.) The number of applications following an urgent authorisation is lower than last year indicating that fewer people were deprived of their liberty before a thorough assessment had been carried out, in accordance with the advice in the Code of Practice.

In hospitals, 88 urgent authorisations were made, which is 62% of the total number of applications. By contrast, 54 applications were made for a standard authorisation. It is understandable that urgent authorisations are more likely to occur in health settings as many admissions are unplanned; however urgent authorisations are still contrary to the spirit of the Code of Practice.

The number of applications made to supervisory bodies varies considerably and does not correlate to population size or the number of care homes and hospitals in the area. Application rates also vary considerably between supervisory bodies in the same region, and in some areas more applications were made by hospitals than care homes, contrary to the national trend. In the charts that follow local authorities are organised by region, and the health boards follow the same regional order.

Chart 7: Number of applications to health boards and number of identifiable individuals involved.

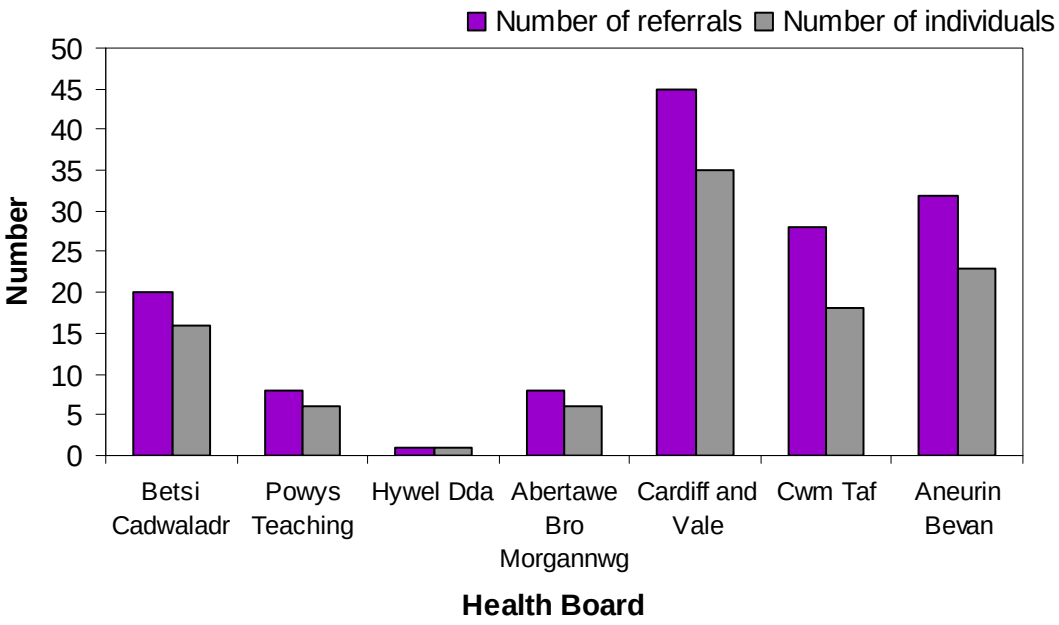
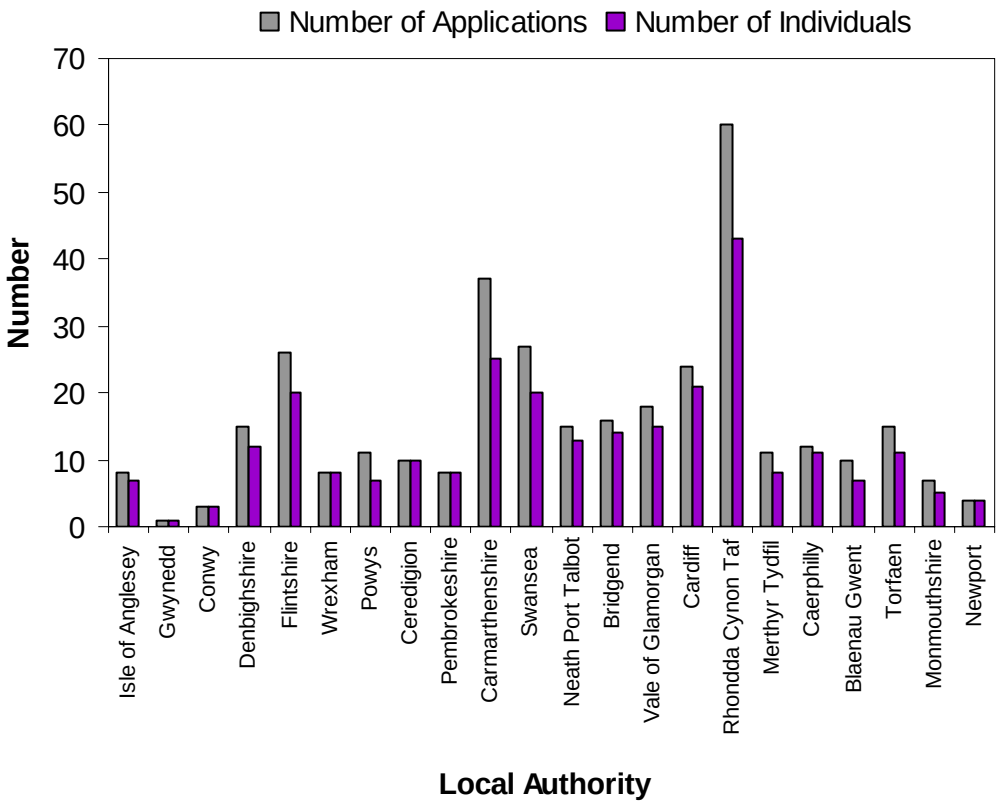


Chart 8: Number of applications to local authorities and number of identifiable individuals involved.



Charts 7 and 8 show that the most applications were made to Rhondda Cynon Taf County Borough Council followed by Cardiff and Vale University Health Board. The lowest number of applications were received by Gwynedd County Council and Hywel Dda Health Board. As can be seen from Charts 9 and 10 below, where the numbers have been expressed as proportions of the population of each supervisory body, the variation in the rates of applications is considerable.

Chart 9: Applications to health boards as a proportion per 100,000 population.

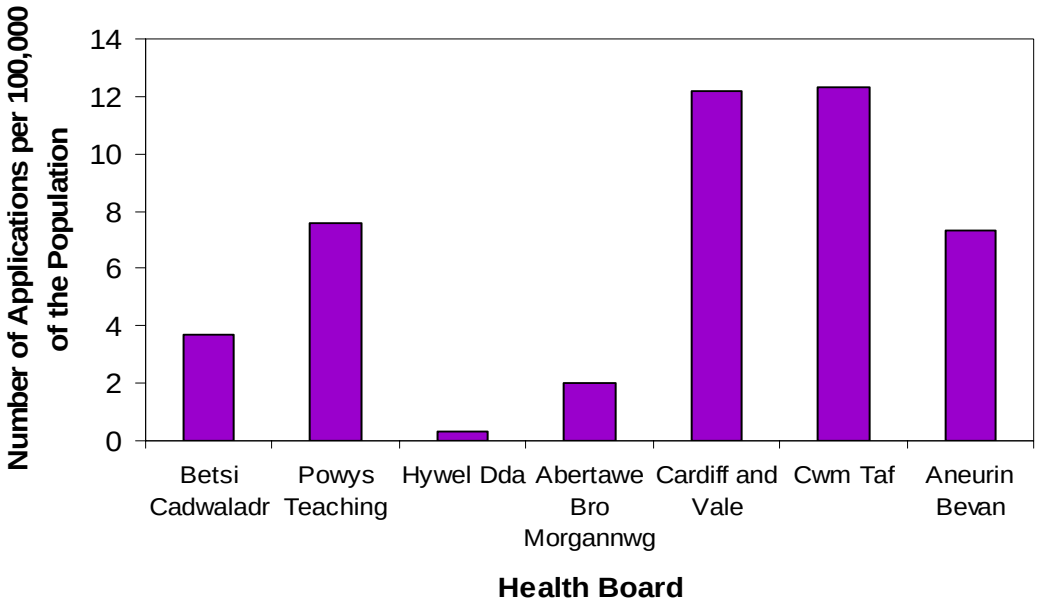
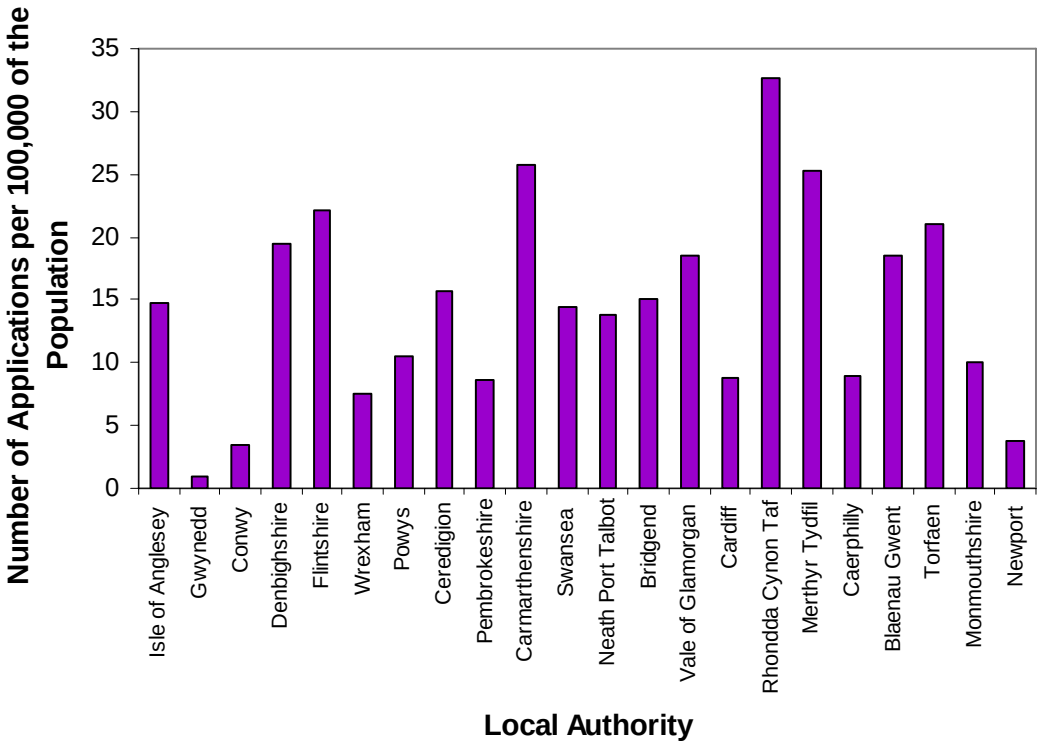


Chart 10: Applications to local authorities as a proportion per 100,000 populations.



The variability also extends to the proportion of applications made where an urgent authorisation was already in place, as demonstrated in Charts 11 and 12. In some supervisory bodies all applications followed an urgent authorisation, whereas in other areas the majority of applications were for a standard authorisation alone. Discussions with the Mental Capacity Act Network, a group of professionals involved in administering the Safeguards, have highlighted that in some settings it may be difficult to predict and plan who will need the Safeguards.

Chart 11: Types of applications for authorisations made to health boards.

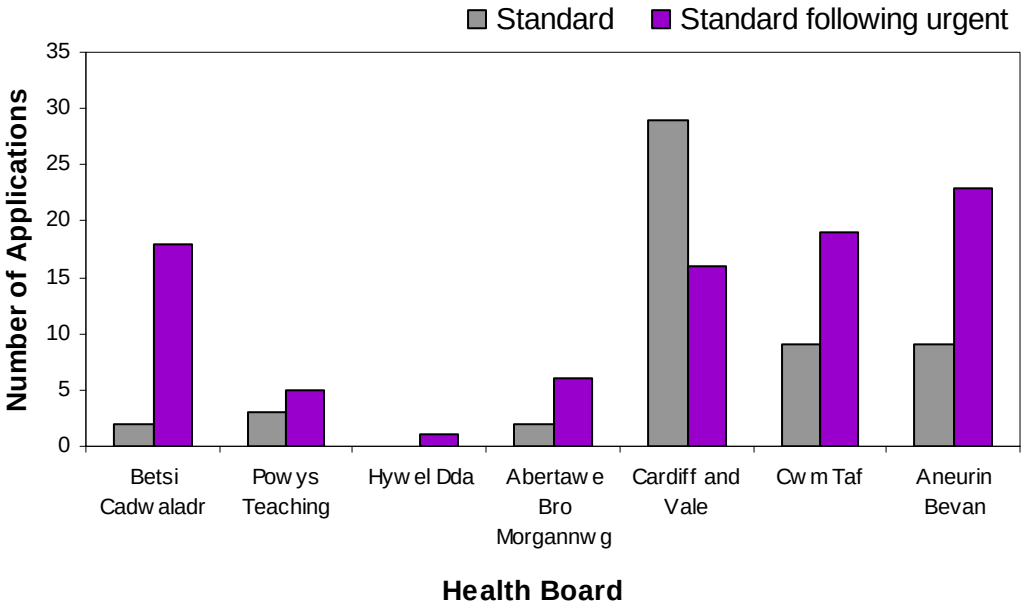
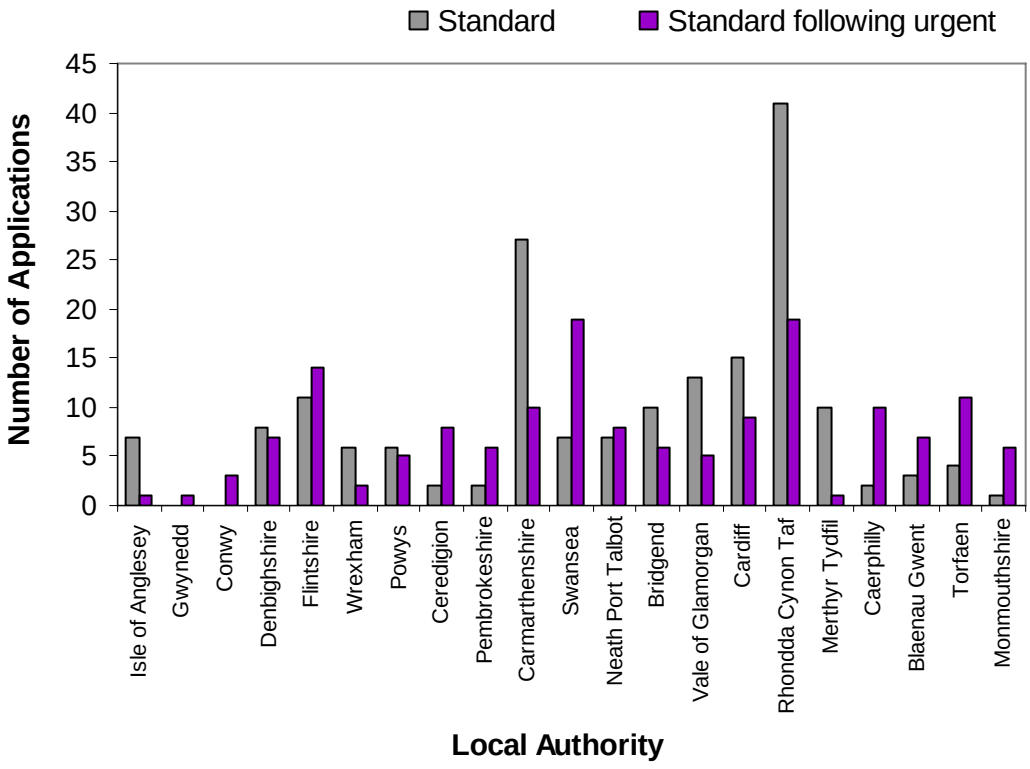


Chart 12: Types of applications for authorisations made to local authorities.



Chapter 4: Authorisations granted

Every application for a standard authorisation made by a managing authority, whether there has been an urgent authorisation or not, triggers the assessment process. There are six assessments, and all have to be satisfied for a deprivation of liberty to be authorised.

There were 277 standard authorisations across Wales. 73% (203) were granted by local authorities, and 27% (74) were granted by health boards in their capacity as supervisory bodies. This is more than last year, even though numbers of applications have fallen. It is too early to predict whether this will be a future trend.

Table 4: numbers and percentages of applications granted and not granted. Percentages for 2010 – 11 do not add up to 100% as a number of applications were still in progress on 1 April 2011.

	Health Board		Local Authority	
	Granted	**Not granted**	**Granted**	**Not granted**
Number				
2009 - 10	77	58	177	229
2010 - 11	74	64	203	141
Percentage				
2009 - 10	57	43	44	56
2010 - 11	52	45	59	41

This year 59% of applications made by managing authorities in social care were granted, whereas last year applications were more likely to be refused than granted.

Following on from the variation in applications, there is inconsistency in the number and distribution of authorisations, as shown in Charts 13 and 14.

Chart 13: Numbers of applications authorised and not authorised by health board supervisory bodies.

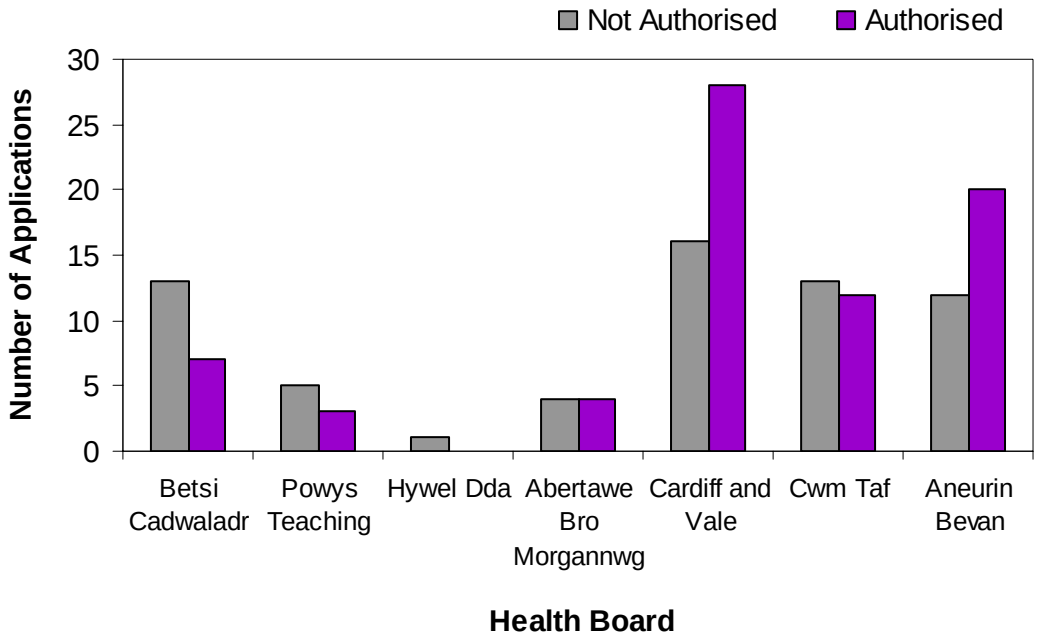
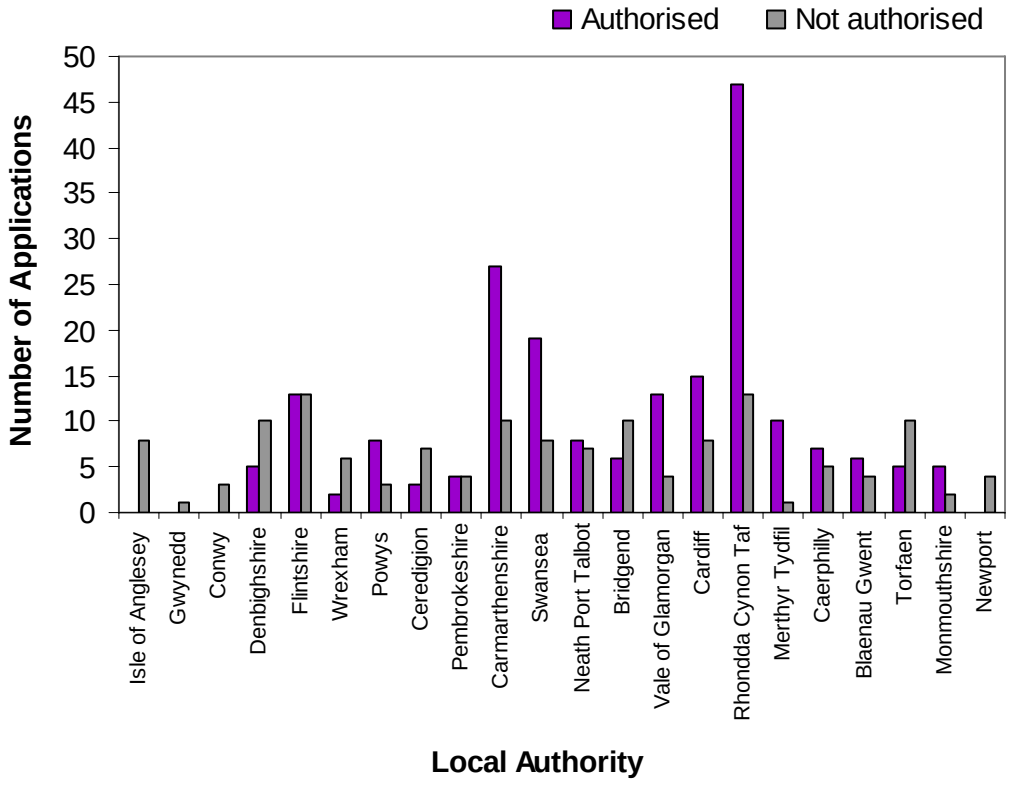


Chart 14: Numbers of applications authorised and not authorised by local authority supervisory bodies.



Again this variability remains when authorisations are expressed as a proportion of the population, as in Charts 15 and 16 below.

Chart 15: Applications authorised by health boards as a proportion per 100,000 population.

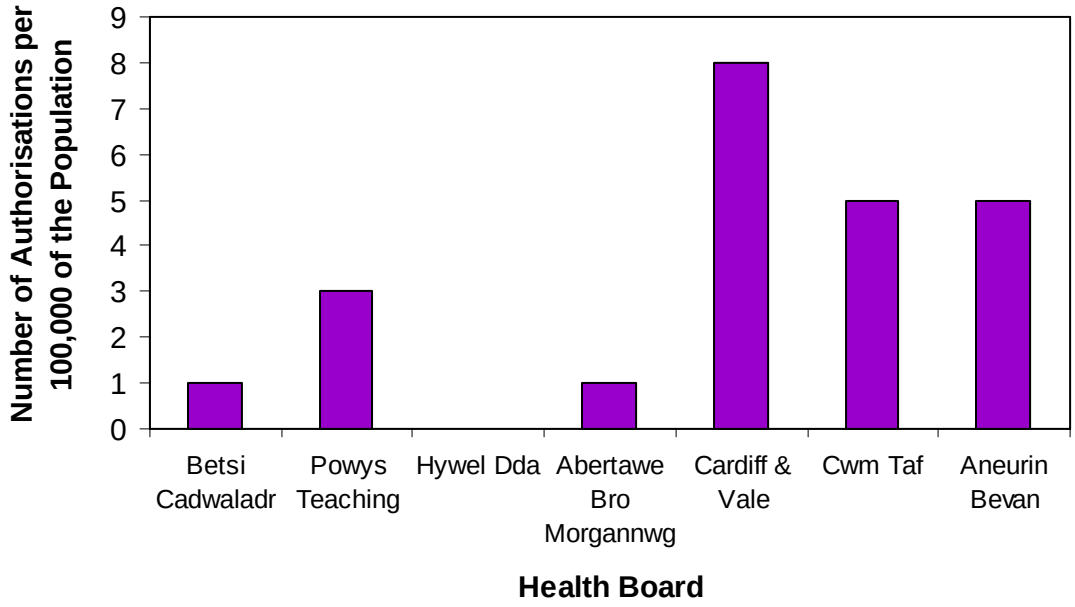
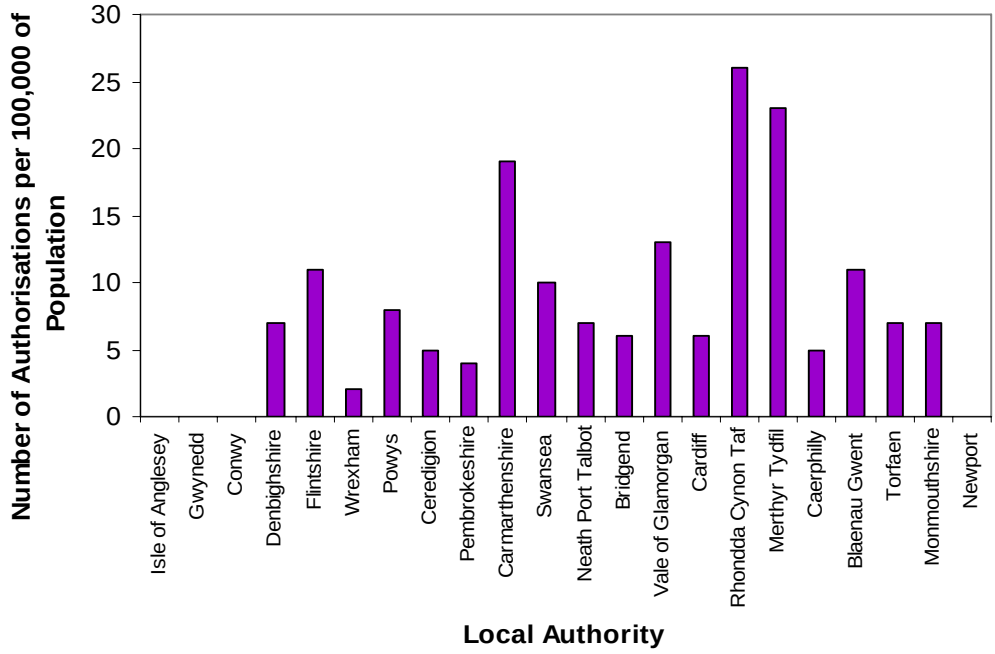


Chart 16: applications authorised by local authorities as a proportion per 100,000 population.



Timescales for assessment

These are set out in the legislation and regulation and are very important, particularly where urgent authorisations are in place. Overall, in 93% of cases considered by health supervisory bodies a decision was reached in 15 days or less. In local authorities, this was achieved in 76% of cases. Of 249 applications following on from an urgent authorisation, nine took more than 15 days to complete, which is outside of the statutory requirement. Five of these were dealt with by one team working across health and social care, suggesting there may be a resource issue.

The timescales are calculated differently for applications for standard authorisations from those where urgent authorisations are already in place. In Wales, standard authorisations should be completed within 21 days[6] once the assessors have been instructed. Supervisory bodies should monitor the time taken by their teams to complete assessments, as in one case this took 115 days, with 24 others taking between 29 and 67 days.

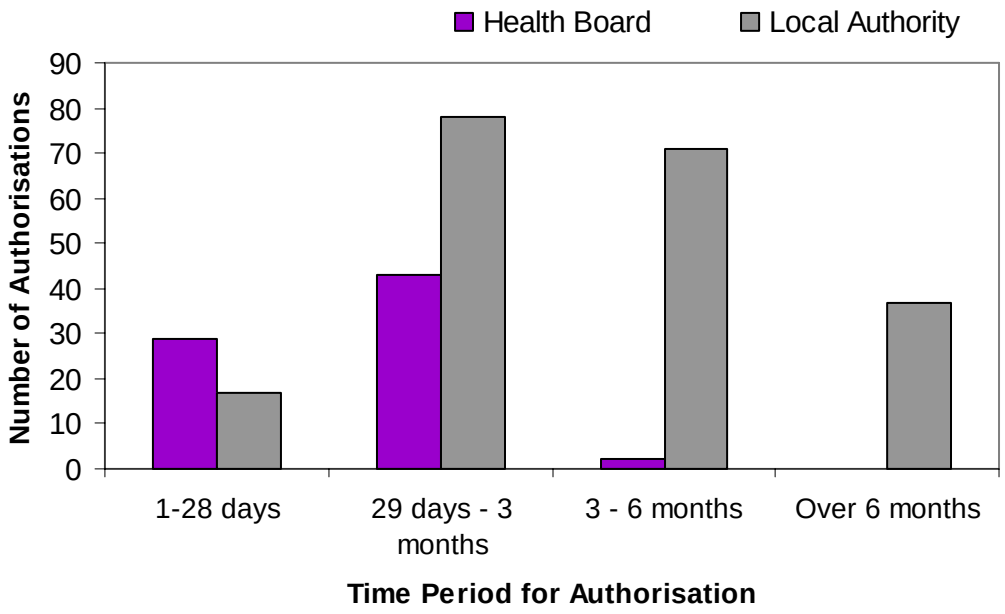
Length of authorisations

When granted an authorisation has an expiry date which cannot be extended, and it cannot last more than 12 calendar months. If a deprivation is still required, a new application has to be made and the circumstances have to be re-examined. The average length of authorisations granted was different in health and social care. This year no health boards granted authorisations for longer than six months and 97% of authorisations in health were valid for less than three months. This can be explained by the short term nature of most hospital stays. In social care, care homes often provide a home for life. This is reflected in the fact that a number of authorisations had a full 12 months period of validity. However most Best Interests Assessors recommended a period of six months or less, recognising that this could be less restrictive.

[6] The regulatory position differs in Wales from England, where time limits for completing standard authorisations are measured from the point when an application is received. The position in Wales means there is no fixed time limit to complete assessments after an application is received.

Chart 17 shows the differing patterns in the periods for which authorisations are granted.

Chart 17: Time period for which authorisations are valid.



Conditions and reasons for not granting authorisations

Conditions can be placed on any authorisation and most authorisations granted did make conditions which focussed on the individual needs of the relevant person. However, 22% of authorisations in Wales had no conditions attached to them. There were examples of authorisations that were granted for 12 months without any conditions attached to them. Supervisory bodies who did not apply conditions to authorisations need to examine whether this is best practice.

Authorisations are granted for different reasons reflecting individual need. The overall intention is to keep people safe and allow them to receive care and support even if they do not want to be in a hospital or a care home. However, there are already some patterns emerging. Some local authority supervisory bodies were more likely to use the Safeguards to restrict access by relatives where there are concerns. Health board supervisory bodies appeared to be more likely to use the

Safeguards where the individual is fit to leave hospital, but there are barriers to discharge. It should however be noted that the Code of Practice states that:

> *'1.14 … Deprivation of liberty should not be extended due to delays in moving people between care or treatment settings, for example when somebody awaits discharge after completing a period of hospital treatment'.*

The boxes below contain examples of conditions applied to authorisation that have been shared with the Inspectorates[7].

Examples of conditions applied to authorisations in social care settings

- Nurse & Occupational Therapy assessments to be undertaken with regard to use of lap strap whilst in wheelchair.
- Managing authority staff to accompany P when her husband takes her out in the car.
- Individual to be offered the opportunity to go out with his wife or members of staff. Any new staff should be trained to deal with any attempts made by individual to leave the home.
- The physical intervention plans for client to be reviewed every four weeks.
- Staff to support regular contact with brother. Liaise with involved agencies. Promote healthy diet to assist P's stated aim of losing weight. Liaise with paid representative.
- Staff at the care home will consider activities resident may find enjoyable and stimulating and will include any successful activities on his care plan. Family members note that resident enjoys certain television programmes.
- A need to speak their mother tongue to prevent isolation, to receive further stimulation, to review the contact arrangements with daughter and son in law.

[7] The inclusion of these conditions in the report is for illustration only and does not imply endorsement by the Inspectorates as examples of good practice.

Examples of conditions applied to authorisations in healthcare settings

- Referral to psychiatrist. Arrange for visit from wife (disabled care home resident) to allow private discussion about future care. Escorted walks in grounds of hospital with staff support. Liaise with local authority staff about conditions and discharge arrangements.
- Multi disciplinary team to implement discharge package asap to appropriate nursing home.
- 1. P to receive one to one nursing escort day and night in order to prevent him from leaving the ward and compromising his safety.
  2. To have limited freedom to access the cafeteria with the one to one escort and his RPR. No other individual to accompany him instead of the RPR.
  3. To expedite the neuro-rehabilitation process.
- Management plan for requests to leave. Opportunity to smoke outside the ward. Choice in TV viewing. Further assessments. Liaison with local authority about discharge arrangements. Escorted leave to be considered.
- All discharge assessment, planning and decision making happens to ensure that client remains on the ward for the shortest period necessary to enable them discharge from hospital. Client is enabled as far as possible to have time off the ward (supervised as required) to ease agitation at remaining at the ward.

Some conditions attached to authorisations did not seem to be directly linked to the circumstances of the deprivation, but were more actions that needed to be undertaken to ensure the general well-being of the individual, for example

> *'Local Authority Care Plan has not been updated and the needs of client are not reflected in the care plan dated 2008. This needs to be actioned'.*

Conditions have also been used as a way of ensuring care staff understand and follow both the processes of the Safeguards and other requirements of the Mental Capacity Act, for example:

> *'Staff involved in the patient's support will be mindful that while this Deprivation of Liberty Standard Authorisation permits staff to require him to remain in the care of the hospital, limit his free access to areas on a ward or within the hospital and can authorise a high degree of surveillance, other aspects of his medical assessment, care and treatment are not authorised by this document but may be permissible and correct as necessary actions taken in his 'best interest' as prescribed in the Mental Capacity Act Code of Practice. Staff at the Managing Authority and staff otherwise connected with patient's care and treatment will seek further legal advice if required'.*

> *'Multi disciplinary team to engage relatives in supporting resident & to consider Court of Protection to manage finances.'*

> *'The home to apply to Supervisory Body on SA5 if a further period of authorisation is required prior to the expiry of this authorisation'.*

Reasons for not granting authorisations

Most authorisations were not granted because one of the assessments undertaken identified that a required condition had not been met. In some cases applications were withdrawn due to changes in circumstances, such as the individual moving or another local authority being identified as the correct supervisory body. Applications are more likely to be withdrawn by healthcare settings where the length of stay is likely to be short. Table 5 shows the reasons given for authorisations not being granted.

Table 5: Reasons why authorisations are not granted.

	Health	Social Care	Wales
Not a Deprivation	39%	39%	39%
Best Interest	23%	41%	36%
Mental Capacity	13%	8%	9%
Eligibility	6%	4%	5%
Mental Health	2%	3%	2%
Withdrawn	17%	5%	9%

There were a number of cases where authorisations were not granted as the relevant person was judged by an independent assessor to have the capacity to make decisions about their care. In some cases individuals' capacity can fluctuate, or improve along with their physical condition

Case study 1 – changes in capacity

Ms S has dementia and a long term alcohol problem. She was admitted to hospital as a consequence of her deteriorating liver, toxins from which were circulating in her blood stream and causing her to be far more confused than normal. Staff put an urgent authorisation in place to allow her to be held in the hospital and applied for a standard authorisation. During the course of the assessment process she was receiving treatment for her liver complaint and in fact made a swifter recovery than expected, so that before the assessment process was completed she had regained her capacity and an authorisation was no longer required

The cases where authorisation was refused due to eligibility issues relate to situations where an assessor felt that an individual was eligible to be detained under the Mental Health Act. However we have been advised of a number of individuals being cared for on mental health wards who are considered to be ineligible for the Safeguards and who also do not meet the threshold for detention under the Mental Health Act. The two case studies below demonstrate different ways in which the position of individuals caught in between the two frameworks has been considered.

One case leads to a clear outcome on the individual's position, the other does not. Case law[8] has made it clear that the Safeguards can be used in mental health wards where individuals do not meet the threshold for detention under the Mental Health Act.

Case study 2 - The interface of the Safeguards and the Mental Health Act

Mrs A is a very elderly lady who has been admitted to a general ward in a small rural hospital. The staff think she is being deprived of her liberty, so put an urgent authorisation in place and apply for a standard authorisation. At this point it is felt it might be more appropriate to care for her on a psychiatric ward using the powers of Mental Health Act to detain her. This makes Mrs A ineligible for the Safeguards, and the application automatically fails. Steps are taken to undertake a Mental Health Act assessment on Mrs A, following which it is decided her condition does not meet the threshold to be detained under that legislation.

However, ward staff still feel Mrs A is being deprived of her liberty. As the assessments under the Safeguards were not completed, the question of whether a deprivation was occurring was never properly examined. Staff make another application under the Safeguards and a Best Interests Assessor examines the circumstances of Mrs A's care. They decide she is **not** being deprived of her liberty. Staff carry on with the arrangements to care safely for Mrs A, secure in the knowledge that they are not acting unlawfully.

[8] BB v AM (2010) EWHC 1916 (Fam).

Case study 3 - the interface of the Safeguards and the Mental Health Act

Mr C is a patient on a ward for elderly people with a mental illness. He is not detained under the Mental Health Act but it has been determined that he lacks capacity to make certain decisions and has been appointed an IMCA to support him. They visit him on the ward and are concerned the restrictions being placed on him may mean he is deprived of his liberty. The advocate raise these issues with ward staff, who after some deliberation decide to apply for an authorisation under the Safeguards. It takes them some time to establish how to do this.

An independent psychiatrist visits Mr C and thinks he is sufficiently ill to be detained under the Mental Health Act, so the application fails. Mr C undergoes a Mental Health Act assessment following which he is not detained.

The arrangements for his care do not change for several months, and the IMCA continues to be concerned a deprivation is occurring. No further assessments are made to whether or not Mr C is being unlawfully deprived of his liberty and his legal position is unclear throughout this period.

In a number of cases the assessors felt a deprivation was occurring but that it was not in the individual's best interests to authorise it. Some of these individuals were referred for Mental Health Act assessments and for others changes were made to their care plan or to the location in which they were receiving care.

Lengths of time that individuals are subject to an authorisation

Table 6 shows how many of those authorisations that came to an end in 2010 – 2011 lasted for the full duration of the period for which they were granted. The different experiences in health and social care can be seen, once again probably due to the short term nature of most hospital admissions. It should be

noted that in health last year more authorisations lasted their intended period than did not, the opposite of the experience this year.

Table 6: Numbers of authorisations that ran for their full period of validity.

	Health	Social Care
Ran for the Full Period	26	78
Did not Run for the Full Period	42	35

Chapter 5: Organisational arrangements to support compliance with the Safeguards

Most supervisory bodies have continued with the arrangements they put in place in the first year. However, the reorganisation of the Health Service in 2009 had left one health board with two different arrangements, which this year were reconciled. There continue to be some joint team arrangements where local authorities and health boards work together. In other areas local authorities and health boards act on their own behalf.

Managing authorities are much more variable, from small and large care homes with a variety of providers (independent or local social services) to health boards with thousands of in-patients. Regardless of size, it is their responsibility to ensure their managers and staff understand the Safeguards and are able to identify when they should be considering their use and how to make applications, as a judgement[9] this year has made very clear

Evidence from our inspections of care homes and hospitals demonstrate that understanding of the Safeguards is very patchy. There are competent practitioners who promote the rights of the individual. However, we have identified examples of individuals whose liberty is clearly being curtailed without consideration of whether the Safeguards should be considered.

During the year a number of cases have been considered by the Court of Protection which has lead to further clarification about the roles and responsibilities of supervisory bodies and managing authorities. The implications of these judgements should be considered by these bodies and appropriate action taken. Court of Protection judgements are normally anonymised, but the Court has already used its powers to name authorities where it feels there has been sufficient concern about practice. The Court can also award costs and damages where appropriate. There has been a growing media interest in the work of the Court and the cases it

[9] G v E, Manchester City Council and F (2010) EWHC 2042 (Fam). http://www.mentalhealthlaw.co.uk/G_v_E,_Manchester_City_Council_and_F_(2010)_EWHC_2042_(Fam))

considers. The reputational risks and financial implications for organisations of failing to implement the correct legal frameworks can be considerable.

Alongside other Court of Protection judgements, the judgement on Steven Neary's circumstances highlights that the supervisory body is responsible for scrutinising the assessments it receives and should do this with the independence and care appropriate to the seriousness of the decision and to the circumstances of the individual case. The judgement states '*Where … the supervisory body grants authorisations on the basis of perfunctory scrutiny of superficial best interests' assessments, it cannot expect the authorisations to be legally valid*'.

Last year we highlighted the position where best interests' assessors do not have to complete an accredited course in Wales. The situation has not changed, although many supervisory bodies continue to seek a solution with academic bodies.

We are aware that there has been reduction of resources for some teams, which includes the availability of assessors and support staff. This may account for some of the delays in completing assessments and undertaking reviews in a timely way. Similarly the over-reliance on a small pool of individuals continues to be an issue.

Separation of managing authority and supervisory body roles

Our own experiences of working with organisations which hold both the supervisory body and managing authority roles, that is, health boards and local authorities, highlight the complexity and the need for clarity of responsibilities for each role. The Code of Practice and Welsh Government Guidance clearly set out the need for separation of duties to avoid any potential conflict of interest. The judgement on Steven Neary's situation highlights the consequences of failing to do this. It also underlines the importance of robust decision making by an appropriately independent and senior person in the supervisory body.

Example of arrangements to separate the functions of supervisory body and managing authority where they are the same body

Abertawe Bro Morgannwg University Health Board is both the supervisory body for health in its region and a managing authority with regards to the hospitals it runs. It has divided its operations into three locality teams, based on the local authority areas within its borders. When a hospital in locality A applies for an authorisation under the Safeguards, the case is managed and assessments undertaken by staff from locality B, thus ensuring there are no links between those assessing and making a decision and the those responsible for the day to day management of the relevant person's care and planning their onward discharge to the community.

There is no evidence that the wider Mental Capacity Act issues have been any better understood by staff in health and social care this year. For example, when looking at care homes CSSIW inspectors still come across staff who do not recognise that residents may lack capacity to make some decisions, but can still make everyday choices. The provision of support to assist communication and understanding can also be lacking.

Chapter 6: Conclusions, recommendations and next steps

The information gathered in this second year of the Safeguards has shown some changes from the first year. However it is too soon to identify whether trends are developing, given the very different needs of the individuals involved.

It is clear is that public understanding of the Safeguards and the Mental Capacity Act remains underdeveloped even though media interest has increased. The apparent lack of access to clear information and knowledgeable support, the low level of referrals to IMCAs to support the relevant person, their family and friends as well as the lack of challenge to authorisations and rare use of reviews to challenge individual authorisations or to confirm that they continue to meet needs are matters of concern. Supervisory bodies should look at how they enable staff to respect relevant persons' rights to freedom, a family life and to have the lawfulness of detention reviewed speedily by a court.

While a lot of good work continues, supervisory bodies and managing authorities cannot be complacent. They have a corporate responsibility to give priority to safeguarding individuals in situations that make them vulnerable. As a consequence they need to ensure they have appropriate governance arrangements to assure themselves at the highest levels that the rights of individuals and their family are being recognised and upheld through compliance with the requirements of the legal frameworks. Quality assurance and monitoring arrangements need to be put in place to enable organisations to identify local trends and practice issues that need to be followed up. Supervisory bodies and managing authorities should ensure that sufficient resources are made available to effectively operate the Safeguards.

Supervisory bodies and managing authorities also need to be up to date with the changing interpretation of the Safeguards as case law develops and ensure this is taken into account in local practice. They should also be aware that the Code of Practice does not reflect these judgements, the Welsh regulations, or the interface with new developments such as the Mental Health (Wales) Measure.

We will continue our work to monitor the use of the Safeguards in Wales and highlight trends as they become clearer. We will engage with practitioners, other interested organisations and individuals and their families whose care has been considered or authorised under the Safeguards to listen to their experiences and concerns. We will also consider how this year's findings can be built into our ongoing inspection and regulation of health and social care organisations

Appendix A

Key terms used in the Annual Report

The table below is a list of key terms used in this report. Where necessary it may expand on particularly important tasks carried out by significant people.

Advocacy	Independent help and support with understanding issues and putting forward a person's own views, feelings and ideas.
Assessment for the purpose of the deprivation of liberty safeguards	All six assessments must be positive for an authorisation to be granted.
• **Age assessment**	An assessment of whether the relevant person has reached age 18.
• **Best interests assessment**	An assessment of whether deprivation of liberty is in the relevant person's best interests is necessary to prevent harm to the person and is a proportionate response to the likelihood and seriousness of that harm. This must be decided by a Best Interests assessor.
• **Eligibility assessment**	An assessment of whether or not a person is rendered ineligible for a standard deprivation of liberty authorisation because the authorisation would conflict with requirements that are, or could be, placed on the person under the Mental Health Act 1983.
• **Mental capacity assessment**	An assessment of whether or not a person has capacity to decide if they should be accommodated in a particular hospital or care home for the purpose of being given care or treatment.
• **Mental health assessment**	An assessment of whether or not a person has a mental disorder. This must be decided by a medical practitioner.

• **No refusals assessment**	An assessment of whether there is any other existing authority for decision-making for the relevant person that would prevent the giving of a standard deprivation of liberty authorisation. This might include any valid advance decision, or valid decision by a deputy or done appointed under a Lasting Power of Attorney.
Assessor	A person who carries out a deprivation of liberty safeguards assessment.
Capacity	Short for mental capacity. The ability to make a decision about a particular matter at the time the decision needs to be made. A legal definition is contained in section 2 of the Mental Capacity Act 2005.
Care Home	A care facility registered under the Care Standards Act 2000.
CSSIW	Care and Social Services Inspectorate Wales is responsible for regulating, inspecting and reviewing social care services. It makes professional assessments and judgements about social care, early years and social services and encourages improvement by raising standards, improving quality and promoting best practice.
Carer	People who provide unpaid care and support to relatives, friends or neighbours who are frail, sick or otherwise in vulnerable situations.
Conditions	Requirements that a supervisory body may impose when giving a standard deprivation of liberty authorisation, after taking account of any recommendations made by the Best Interests Assessor.
Consent	Agreeing to a course of action – specifically in this report to a care plan or treatment regime. For consent to be legally valid, the person giving it must have the capacity to take the decision, have been given sufficient information to make the decision, and not have been under any duress or inappropriate pressure.
Court of Protection	The specialist court for all issues relating to people who lack capacity to make specific decisions.

Deprivation of Liberty	Deprivation of liberty is a term used in the European Convention on Human Rights about circumstances when a person's freedom is taken away. Its meaning in practice is being defined through case law.
Deprivation of Liberty Safeguards	The framework of safeguards under the Mental Capacity Act 2005 for people who need to be deprived of their liberty in a hospital or care home in their best interests for care or treatment and who lack the capacity to consent to the arrangements made for their care or treatment.
HIW	Healthcare Inspectorate Wales is the leading regulator of healthcare in Wales. Its purpose is to provide independent and objective assurance on the quality, safety and effectiveness of health services, making recommendations to healthcare organisations to promote improvements.
Health Board	Health Boards fulfil both the supervisory body function for healthcare and managing authority function for NHS services. They work alongside partner local authorities, usually in the same geographical area, in planning long-term strategies for dealing with issues of health and well-being.
Independent Hospital	As defined by the Care Standards Act 2000 – a hospital, the main purpose of which is to provide medical or psychiatric treatment for illness or mental disorder or palliative care or any other establishment, not being defined as a health service hospital, in which treatment or nursing (or both) are provided for persons liable to be detained under the Mental Health Act 1983.
Independent Mental Capacity Advocate (IMCA)	A trained advocate who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service was established by the Mental Capacity Act 2005 whose functions are defined within it.

Local Authority	In the deprivation of liberties context, the local council responsible for social services in any particular area of the country. Senior managers in social services fulfil the supervisory body function for social care services. Different social services managers are responsible for the managing authority role, where the local authority also provides care home facilities.
Managing authority	The person or body with management responsibility for the particular hospital or care home in which a person is, or may become, deprived of their liberty. They are accountable for the direct care given in that setting.
Maximum authorisation period	The maximum period for which a supervisory body may give a standard deprivation of liberty authorisation, which cannot be for more than 12 months. It must not exceed the period recommended by the best interests' assessor, and it may end sooner with the agreement of the supervisory body.
Mental Disorder	Any disorder or disability of the mind, apart from dependence on alcohol or drugs. This includes all learning disabilities.
Mental Health Act 1983	Legislation mainly about the compulsory care and treatment of patients with mental health problems. It includes detention in hospital for mental health treatment, supervised community treatment and guardianship.
Qualifying requirement	Any one of the six qualifying requirements (age, mental health, mental capacity, best interests, eligibility and no refusals) that need to be assessed and met in order for a standard deprivation of liberty authorisation to be given.
Relevant hospital or care home	The particular hospital or care home in which the person is, or may become deprived of their liberty.
Relevant person	A person who is, or may become, deprived of their liberty in a hospital or care home.

Relevant person's representative	A person, independent of the particular hospital or care home, appointed to maintain contact with the relevant person and to represent and give support in all matters relating to the operation of the deprivation of liberty safeguards.
Restriction of liberty	An act imposed on a person that is not of such a degree or intensity as to amount to a deprivation of liberty.
Review	A formal, fresh look at a relevant person's situation when there has been, or may have been, a change of circumstances that may necessitate an amendment to, or termination of, a standard deprivation of liberty authorisation.
Standard authorisation	An authorisation given by a supervisory body, after completion of the statutory assessment process, giving lawful authority to deprive a relevant person of their liberty in a particular hospital or care home.
Supervisory body	A local authority social services or a local health board that is responsible for considering a deprivation of liberty application received from a managing authority, commissioning the statutory assessments and, where all the assessments agree, authorising deprivation of liberty. They must also respond to concerns from third parties, who believe that a person is being deprived of their liberty without authorisation.
Third party Requests	If anyone (in addition to the relevant person themselves) is concerned that a person is being deprived of their liberty without authorisation they should draw this to the attention of the managing authority. If no change occurs, they should inform the relevant supervisory body.
Unauthorised deprivation of liberty	A situation in which a person is deprived of their liberty in a hospital or care home without the deprivation being authorised by either a standard or urgent deprivation of liberty authorisation.

Urgent authorisation	An authorisation given by a managing authority to itself for a maximum of seven days, which subsequently may be extended by a maximum of a further seven days by a supervisory body. This gives the managing authority lawful authority to deprive a person of their liberty in a hospital or care home while the standard deprivation of liberty authorisation assessment is undertaken.

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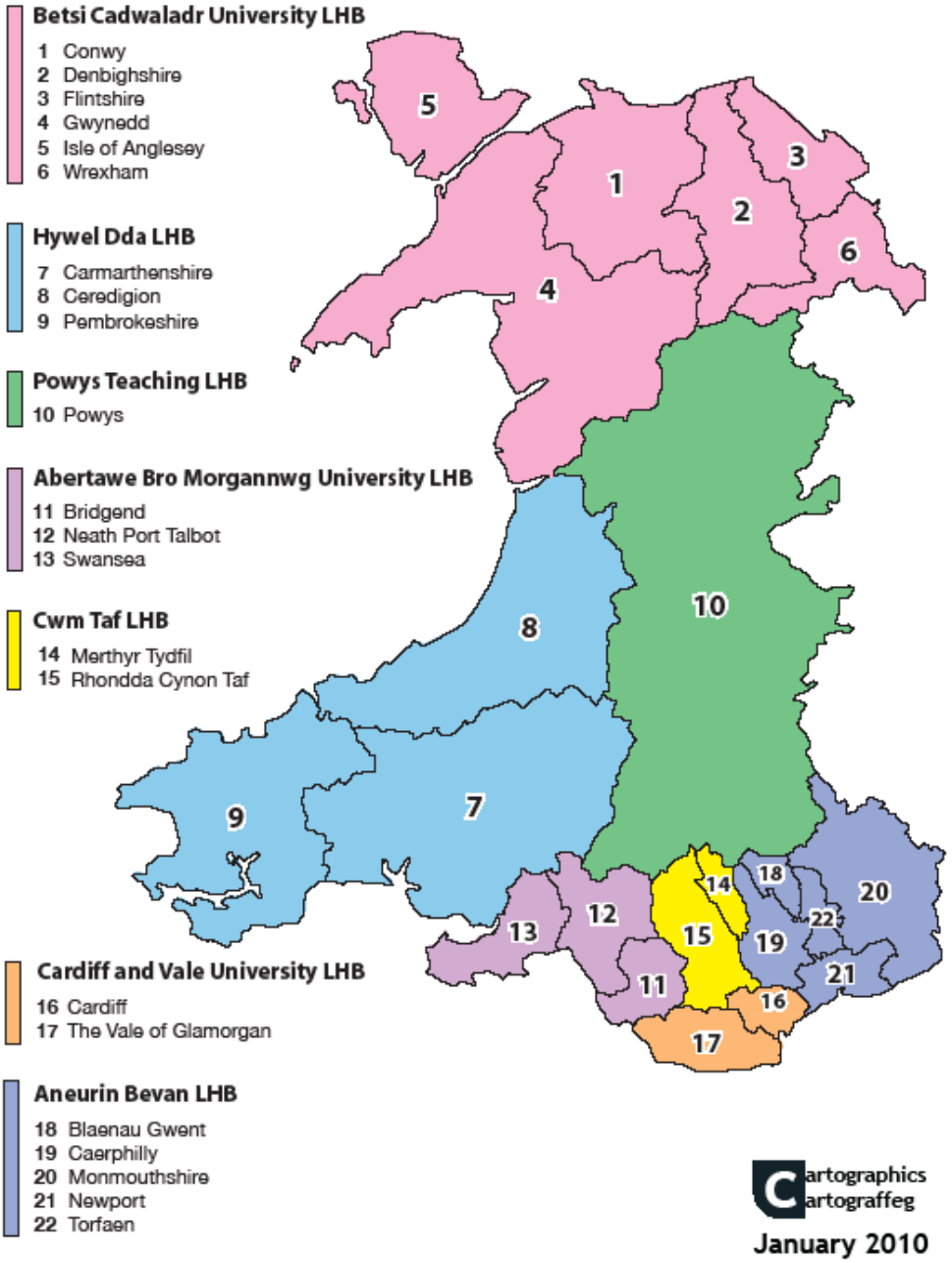

Appendix C

List of Relevant Guidance and Information

Documents Published to Support Understanding of the Safeguards:

Mental Capacity Act, 2005 – Code of Practice, issued by the Lord Chancellor on 23 April 2007 in accordance with sections 42 and 43 of the Act.

Deprivation of Liberty Safeguards – Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice, Laid before Parliament by the Ministry of Justice.

Mental Health Act 1983 Code of Practice for Wales. Issued by the Welsh Assembly Government 2008.

Guidance to Supervisory Bodies working within the Mental Capacity Act Deprivation of Liberty Safeguards. Issued by the Welsh Assembly Government, February 2009.

Guidance for Managing Authorities working within the Mental Capacity Act Deprivation of Liberty Safeguards. Issued by the Welsh Assembly Government, February 2009.

Standard forms and letters for the Mental Capacity Act Deprivation of Liberty Safeguards. Issued by the Welsh Assembly Government, February 2009.

Mental Capacity (Deprivation of Liberty: Appointment of Relevant person's Representative) (Wales) Regulations 2009.

Mental Capacity (Deprivation of Liberty: Assessments, Standard Authorisations and Disputes about residence) (Wales) Regulations 2009.

Other documents which were considered when compiling the Annual Report:

Statistics produced by the NHS Information Centre.

Judiciary of England and Wales, *'Court of Protection Report 2010' (*July 2011).

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