Capacity (Bailiwick of Guernsey), 2020 Law – Code of Practice

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This is the consultation draft of the Code of Practice for the Capacity (Bailiwick of Guernsey) Law, 2020 issued by the Committee for Health & Social Care on 20th January 2023 for comment.

1. Introduction

The Capacity (Bailiwick of Guernsey) Law, 2020 provides a modern legal framework to support and protect people who lack capacity to make decisions for themselves, and to allow others to act on their behalf in their best interests. This Code of Practice is intended to give clear and accessible guidance to practitioners and others performing duties and exercising powers under the Law.

The Committee *for* Health & Social Care takes seriously its responsibility to safeguard the rights of people who lack capacity, as well as promoting opportunities for those people to make their own decisions. It is also committed to ensuring the highest professional standards are demonstrated by all those involved when the Law is being used, so far as it is able.

The Committee has therefore updated its policies and practices, provided practical training, and worked with other stakeholders to ensure that the Law is implemented across the Bailiwick in a consistent and practical manner.

This Code of Practice has been comprehensively researched and written, with widespread consultation with service users (as well as the groups which represent them) and those who currently provide services or support to them. The Committee is grateful for the comments and suggestions received from all consultees.

The Committee is confident that this new Code of Practice will meet the unique needs of all those within the Bailiwick.

Deputy Al Brouard
Committee *for* Health & Social Care

2. Capacity

2.1 The term capacity describes a person's ability to make a specific decision at the time that this needs to be made. A key principle of the Capacity (Bailiwick of Guernsey) Law 2020 is the presumption of capacity. It should be assumed that the person has the capacity to make their own decision, unless it can be established that they lack capacity.

2.2 This includes simple decisions such as what to wear or what to eat, as well as more complex decisions such as those regarding medical treatment, where to live or making a Lasting Power of Attorney.

Lack of capacity

2.3 Section 4 (1) of the Law states: 'For the purposes of this Law, a person (P) lacks capacity in relation to a matter, if at the material time –

(a) P is unable to make a decision in relation to the matter, and
(b) P's inability is due to an impairment of, or disturbance in the functioning of, the mind or brain, whether the impairment or disturbance is permanent or temporary.

2.4 An assessment of P's capacity must be based on their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general. The impairment or disturbance in the functioning or disturbance of the mind, does not have to be permanent. A person can lack capacity to make a decision at the time it needs to be made even if:

- the loss of capacity is temporary or
- P's capacity changes over time.

A person may also lack capacity to make a decision about one issue but not about others.

2.5 The person assessing P's capacity to make a decision, must never base the outcome on unjustified assumptions about the following:

P's age, gender, sexuality, disability, race or appearance
or
P's condition or their behaviour

2.6 The term 'appearance' refers to all aspects of the way people look. This includes, but is not limited to, the physical characteristics of certain conditions (for example, facial features related to Down's syndrome or muscle spasms caused by cerebral palsy), the colour of a person's skin as well as aspects of appearance like tattoos and body piercings, or the person's clothing.

2.7 The term ‘condition’ includes physical disabilities, cognitive impairment, learning difficulties and disabilities, brain injury, age related illness, as well as temporary conditions (for example, an infection, intoxication or unconsciousness).

2.8 Aspects of behaviour might include shouting or gesticulating, talking to oneself or avoiding eye contact. It may include aggressive behaviours.

Scenario: identifying whether a person may be unable to make a decision

Mr Andrew Seymour is 54 and has a mild learning disability. He lives in his own flat, within a supported accommodation service. Mr Seymour has support with shopping, preparing his meals, laundry and managing his tenancy. His support workers notice that Mr Seymour has started to have some difficulty with his sight and has some minor accidents, such as bumping into furniture and spilling drinks. They support him to see an optician who advises that Mr Seymour will need some specialist tests at the hospital.

The optician explains to Mr Seymour what tests he will need and why these have to be carried out in hospital. Mr Seymour appears quite confused by the explanation and tells the optician that he does not want to go to hospital. Although the optician and the support worker reassure Mr Seymour that this is simply an appointment for tests, he continues to appear confused. The optician decides to carry out a mental capacity assessment to establish whether Mr Seymour can make his own decision about having the recommended tests.

Evidence required by the Law in relation to lack of capacity

2.9 The first principle of the Law is the presumption of capacity. In order to state that P lacks capacity to make a specific decision, it is necessary to provide evidence to support this. A capacity assessment should show, *on the balance of probabilities,* that P lacks capacity to make the specific decision. The person, completing the capacity assessment, should demonstrate that they have a ‘**reasonable belief’** (see 2.52) that an individual lacks capacity to make the relevant decision.

When should capacity be assessed?

2.10 Assessing capacity well is important for everyone affected by the Law. A person who is assessed as lacking capacity will have specific decisions made for them. Equally, P may make a decision without understanding the consequences, and this leads to them being abused or exploited. For example, P may pay excessive amounts for repairs to their property, even though this work is not necessary. It is important therefore to carry out an assessment when P’s capacity is in doubt. It is also important that the person who undertakes the assessment can justify their conclusions.

2.11 There are a number of reasons why someone might question P's capacity to make a specific decision. These include:

- P's behaviour or their circumstances means that the decision maker has doubts about P's capacity to make their own decision.
- a situation where P demonstrates the inability to make a specific decision
- someone who knows P raises concern about their capacity and
- P has a diagnosis of a mental disorder and has already been assessed to lack capacity to make other decisions

The presumption of capacity is not a license to avoid assessing P's capacity. If there is a reason to investigate, then you should do so.

2.12 If P has previously made decisions which were based on a lack of understanding of the risks or the inability to weigh the information, these can form part of a capacity assessment, particularly if P repeatedly makes decisions that puts them at risk or results in significant harm. A capacity assessment can also consider evidence of P's actual decision making in their day-to-day life as well as the information from the assessment interview[1]. For example, P may say one thing but act differently.

2.13 Capacity is decision and time specific. It may therefore be necessary to review P's ability to make a decision if their condition changes. A person with a brain injury who is undergoing rehabilitation may regain capacity over time. Likewise, a person with a progressive condition may lose capacity as their health declines. P may lose the ability to make some complex decisions, such as admission to a care home or consent to treatment, however they may still be able to make less complex decisions, such as what to wear and what to eat.

2.14 The decision maker (see 2.15) should provide evidence to support their assessment that P lacks capacity to make a specific decision on the balance of probabilities. The core principle is the presumption of capacity.

Who should assess capacity?

2.15 The person who assesses an individual's capacity to make a particular decision will usually be the person who is involved in that decision, for example the doctor proposing treatment. This person is known as the **decision maker**. For many day-to-day decisions, the decision maker would be P's carer. For example, a care worker may need to assess whether P can consent to have help to shower or to take their medication.

[1] See NICE guidance: Decision Making and Mental Capacity 3rd October 2018 https://www.nice.org.uk/guidance/ng108

2.16 A capacity assessment does not need to be completed by a person who is professionally qualified. The same principles and processes apply to every person completing a capacity assessment. It is important to be able to demonstrate how the decision maker reached their conclusion. Some decisions may require additional support to ensure that the person has been fully supported to participate.

2.17 If a doctor or healthcare professional proposes treatment or medical tests, and P is not able to make their own decision regarding the proposed treatment, the healthcare professional must assess P's capacity to make this decision. If P is assessed to lack capacity to make the specific decision, the healthcare professional must follow the best interests process to decide whether the proposed treatment should be given.

2.18 For a legal transaction (for example, making a will or selling a house), the advocate should assess their client's capacity to make the decision to issue instructions, if there is any doubt as to whether they can make this decision.

2.19 In some situations, it may be necessary to involve a professional to support P's involvement in the assessment. This could be, for example, a psychiatrist, psychologist, speech and language therapist, occupational therapist or social worker. However, whilst such professional opinion may contribute to the assessment, the final decision about P's capacity must be made by the decision maker (the person intending to provide the care or treatment or to act on a legal matter).

2.20 If P is expressing different views to different people (perhaps they are trying to please everyone or tell people what they think they want to hear), this may indicate that they are unable to understand or to use the relevant information and the likely foreseeable consequences of deciding one way or the other. In such circumstances it may be helpful to seek the advice of a professional who has relevant expertise.

Assessing Capacity

2.21 To determine whether P has capacity to make the specific decision, the Law provides a two stage test. This requires consideration of whether

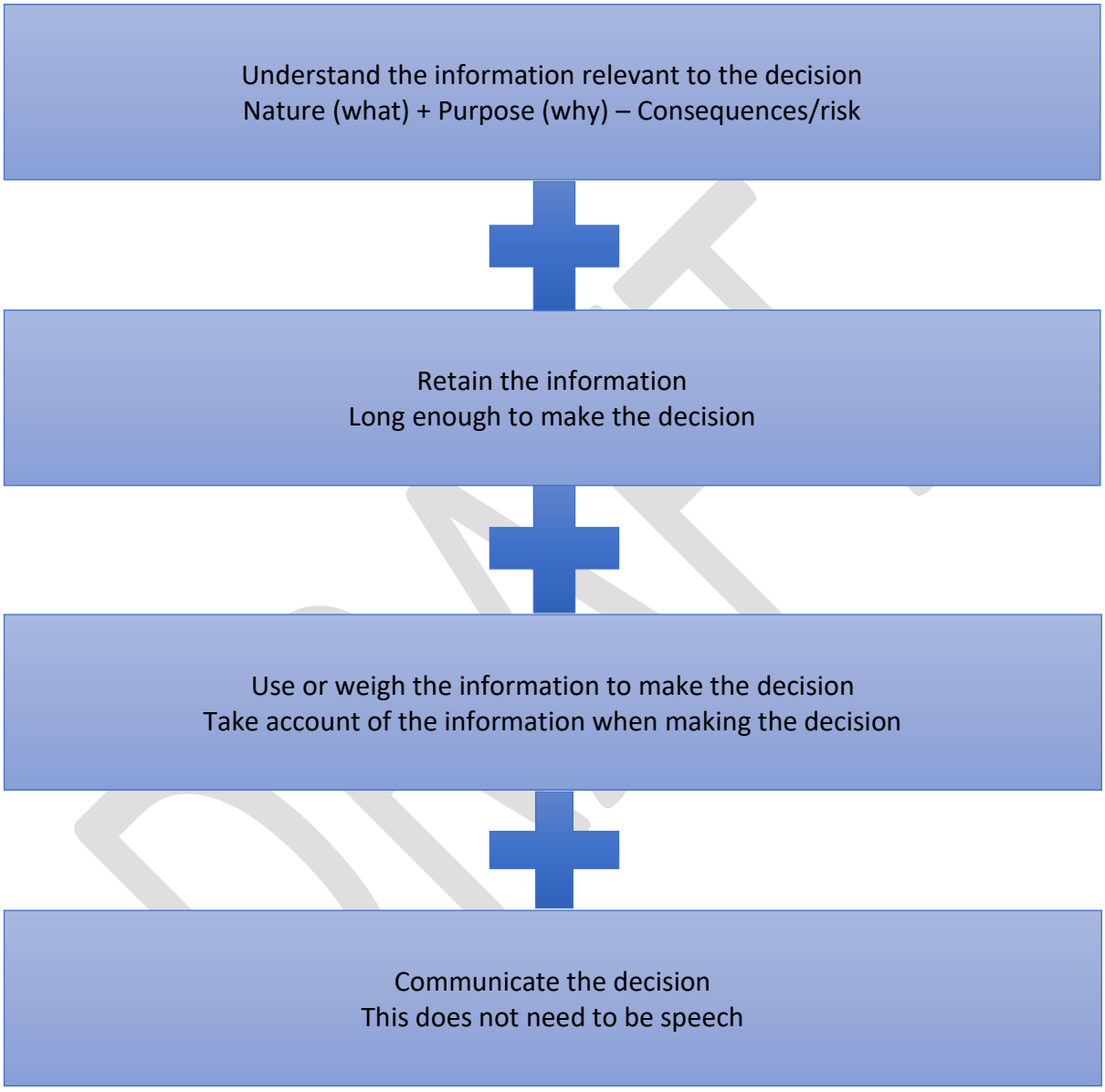
(i) P is able to make the decision (**the functional assessment**) and,
(ii) if they are unable to do so, whether this inability is due to an impairment of, or a disturbance of the functioning of the mind or the brain (**the diagnostic assessment**).

It is not for P to prove they have capacity to make the relevant decision. It is for the assessor to show that P does not have capacity.

2.22 The assumption of capacity is the first core principle. The capacity assessment should be completed due to P's inability to make the decision, before considering any disorder or impairment.

2.23 A lack of capacity can only be established if the inability to make the decision is due to an impairment of, or a disturbance in the functioning of the mind or the brain.

2.24 Functional Test
To have capacity to make a decision P must be able to do the following:



If P is not able to do <u>any one</u> of these elements, P lacks capacity to make the specific decision.

2.25 Relevant information
Before determining whether P can make the decision, the assessor must identify the relevant information. This includes the reasonably foreseeable consequences of deciding one way or another, or failing to make the decision. The assessor should make a record of the relevant information provided and which aspects of this P is unable to understand, retain and/or use or weigh to make their own decision

2.26 Understanding the relevant information
The ability to understand means that P understands the information relevant to the specific decision. In order to assess whether P understands the information they must be provided with the relevant information in a way that is appropriate to support P to understand this.

2.27 Relevant information for medical treatment.
P needs to understand:

- the nature, purpose and effects of the proposed treatment. It is not necessary for P to understand every detail of the options however, the healthcare professional must provide information about the potential risks of, (as well as those of not) having that treatment.[2]

2.28 Relevant information for residence
P needs to understand:

- the different options of where they would live, including the type of accommodation (whether this would be supported living or residential/nursing home placement, what sort of property this will be)
- where each property will be and any risks of living in that area
- the difference between living somewhere and simply visiting it
- the activities available to P in each option
- whether P will be able to see friends and family in each place
- there may be rules or restrictions, such as those of a tenancy agreement
- who P would be living with at each option
- the sort of care P would have in each place
- that P may be limited in their access to the community
- there may be set meal times with limited choices of meals
- that staff administer medication
- that P may have a loss of privacy

2.29 Relevant information for receipt of care
The person needs to understand:

- which areas P needs support with
- what sort of support P needs
- who will provide the support P needs
- what may happen to P if they do not have support or if P refuses this (such as risk of harm)

[2] *Montgomery v Lancashire Health Board [2015] UKSC 11*. Adult health and social care starts with consent. **Consent** equals understanding the **Nature** (what) plus the **Purpose** (why) plus the **Consequences** (risks) and it is **freely given** (not coerced)

2.30 Relevant information for contact with others
The person needs to understand:

- whom the contact will be with
- the relationship between P and that person
- the nature of the contact. (e.g. will this be in a private place or in the community? How long will it be for? Will a support worker be present?)
- the pros and cons of contact with the person
- any risks posed by the contact, including any criminal convictions held by them

2.31 Significant restriction of P's personal rights and freedoms
The person needs to understand the main elements of the restrictions which P will be, or is, subject to. This would need to be specific to P's situation but could include:

- P would be confined to a care home or property,
- P may not be able to go out unescorted,
- P would not be free to leave the relevant place to live elsewhere,
- Meals and drinks may be provided at set times, with limited choice,
- Staff may administer medication,
- P may be living with people they do not know,
- P may have limited privacy,
- P may have regular checks by staff or have sensors and/or CCTV in place monitoring P's whereabouts,
- P may not have the freedom to do things when they want, for example if P is dependent upon staff to help P to get out of bed or to wash

2.32 The important issue is that P has sufficient information to support their decision making. Information should be provided in a way that is appropriate to meet the individual's needs and circumstances. For example:

- a person with a learning disability may need somebody to read information to them. They might also need visual aids to support them to understand what is happening. It might also be helpful for them to discuss the information with someone who can support them, such as a family member or an Independent Capacity Representative
- a person with anxiety may find it difficult to reach a decision about proposed treatment, whilst in a meeting with professionals. They may prefer to read the relevant documents in private. This way they can come to a conclusion and ask for support if necessary
- some individuals might need to be given information several times and to check that they can understand the information. If P has difficulty understanding, it might be useful to present information in a different way (for example, different forms of words, pictures or diagrams). Written information, audio information and the use of technology can all support people to remember information.
- consider whether there is a time of day when P may be best able to understand the information.

2.33 Relevant information must include what the likely consequences of a decision would be. In some cases, it may be enough to give a general explanation using simple language. If a decision could have serious or grave consequences, a person will need more detailed information or access to advice.

Scenario - Supporting people to understand the relevant information

Ms Arabella Jackson is 50 years old and has a mild learning disability. She has no verbal communication but uses Makaton, a form of sign language used by people with learning disabilities. She lives in supported accommodation. Ms Jackson has been invited for routine breast screening, due to her age.

As this is routine screening and there are no current concerns about Ms Jackson's health, her carers know that they can spend time supporting her to make her own decision, as far as she is able. Ms Jackson's carers use Makaton and pictorial aids to explain the reasons for the test and the process for carrying this out. They explain the potential risks of not having the test at this time. Her carers provide the information over a period of time, so as not to overload Ms Jackson. Her carers are confident that Ms Jackson has understood the information provided. When she attends her appointment, Ms Jackson is accompanied by a Makaton interpreter. Ms Jackson confirms that she is in agreement to the screening test going ahead.

Retaining information

2.34 P must be able to hold the information in their mind long enough to be able to use it to make the decision. People who can only retain information for a short period cannot automatically be assumed to lack the capacity to decide. Items such as notebooks, photographs and computers can support people to record and retain information.

Scenario - Retaining Information

Mr Meadows has been diagnosed with advanced dementia. Although he can still communicate verbally, he has difficulty understanding information and his short-term memory is noted to be poor. He previously smoked for many years and has recently developed a bad cough. His GP believes that he should have a chest x-ray.

Mr Meadows attends the appointment with his wife to support him. The GP explains the reason she thinks Mr Meadows should have the X-ray and the potential risks of not doing so. She repeats the information several times and asks Mr Meadows whether he wishes to have this test. Mr Meadows appears to understand the doctor's explanations but, each time the GP asks whether he is willing to have the X-ray, Mr Meadows asks the reason for this test. Mrs Meadows tells the GP that her husband is not able to retain information for even short periods and that he had asked her several times about why he had

been coming this appointment. The GP concludes that Mr Meadows is unable to retain the relevant information for long enough to make his own decision and therefore he lacks capacity.

Using or weighing information

2.35 For a person to be deemed to have capacity to make a decision, they must be able to use or weigh the relevant information. This means that P has accepted the information provided and has taken account of this. Sometimes people can understand information but an impairment of, or disturbance in the functioning of the mind affects their ability to use this. In other cases, the impairment or disturbance leads to a person making a specific decision without using the information they have been given.

2.36 For example, a person with dementia may not understand the effect that condition has on their ability to manage their activities of daily living. As a consequence, they may not be able to weigh up the information to decide how best to meet their care needs. To be able to use information refers to the ability to apply it in practice.

2.37 P can disregard any information that they disagree with when making a decision, even if this is contrary to the views of others. Unless the basis for disregarding the information is due to an impairment or condition affecting the mind or brain, this may simply be an unwise decision and not an indication of a lack of capacity. For example, a person may choose to continue smoking cigarettes despite the evidence regarding health risks, however a person with Prader-Willi syndrome[3] may be unable to stop eating excessively, despite the impact on their weight and health. This is because their condition affects their ability to use the relevant information. P may not agree with the advice or recommendation of the professional, but this does not mean that P lacks capacity.

2.38 If P is able to use the relevant information, the weight they attach to information in the decision-making process is for P to decide. This requires care when assessing P's capacity to ensure that the decision maker does not confuse the way that P applies their own values (which may be different from those of the decision maker) with the inability to use or weigh information. The assessor should seek to find out P's values and beliefs.

[3] Prader-Willi syndrome is a rare genetic condition which causes learning difficulties and excessive appetite and overeating, which can easily lead to dangerous weight gain

2.39 If P does not believe the information provided this may indicate a lack of capacity. For example, if P does not believe that they have a particular condition, they will not be able to use or weigh that information to make the decision[4].

Scenario – using or weighing information

Mrs Jones has been diagnosed with dementia. She lives alone with the support of carers, who visit three times a day. As her condition has declined, Mrs Jones has suffered a number of falls, resulting in admission to hospital. Each time she has been insistent that she can manage and that she does not want to move to a care home. Consequently, she has been discharged back home. One day Mrs Jones' carers visit in the morning to find her lying on the floor. She is dressed in the clothes she had been wearing the previous day. Mrs Jones is admitted to hospital where she is found to be very confused and dehydrated. It is thought likely that she had fallen the previous evening and had therefore been lying on the floor all night.

The hospital social worker visits Mrs Jones on the ward to discuss whether it is safe for her to return home or whether she should be admitted to a care home. When he is talking with Mrs Jones he notes that she is quite confused and does not seem able to make her own decision, therefore he completes a capacity assessment. Mrs Jones is able to respond to the social worker's questions and he assesses her to be able to understand and retain the information. However, when he talks with her about the risk of further falls, Mrs Jones is adamant that she will be safe and denies that she has ever had any injuries from falls, even when the social worker shows her the information regarding her current hospital admission. The social worker assesses that Mrs Jones is unable to weigh or use the relevant information and therefore she lacks capacity to make her own decision regarding her accommodation.

Communicating the decision

2.40 The final stage of the capacity assessment is for P to be able to communicate the decision. Occasionally it is not possible for a person to communicate at all. This will apply to very few people, but includes:

- people who are unconscious or in a coma, or
- those with 'locked-in syndrome', who are conscious but cannot speak or move at all

[4] See *MM [2007] EWHC 2003 (Fam)* Munby J stated "if one does not believe a particular piece of information then one does not, in truth, comprehend or understand it, nor can it be said that one is able to use or weigh it." In other words, the specific requirement of belief is subsumed into the more general requirements of understanding and the ability to use and weigh information.

2.41 If P cannot communicate their decision in any way at all, the Law states they should be treated as unable to make that decision. Before deciding that P is unable to communicate their decision, it is important to make all practical and appropriate efforts to support them to do so. This could include involving a speech and language therapist or other professionals.

2.42 Communication by simple muscle movements can show that P can communicate and may have capacity to make a decision. For example, a person might be able to blink an eye or squeeze a hand to say ‘yes’ or ‘no’ however particular care should be taken in that situation.

2.43 Lack of capacity
When assessing capacity, the decision maker should document why they believe that the person lacks capacity to make the specific decision, for example, what information was provided and how the person responded to this, including which elements of the diagnostic test they were not able to do.

2.44 Diagnostic test
If P is unable to do any of the four elements of the functional test then it should be considered whether this inability is due to an impairment of, or disturbance in the functioning of the mind or brain. This is known as the diagnostic test.

2.45 This stage requires evidence that the person has a mental disorder which can be either temporary or permanent. If a person does not have an impairment of, or a disturbance in the functioning of their mind or brain, they do not lack capacity under the Law.

2.46 Examples of an impairment of, or a disturbance in the functioning of their mind or brain include the following:

- conditions associated with some forms of mental illness
- dementia
- significant learning disabilities
- brain injury
- physical or medical conditions that cause confusion, drowsiness or loss of consciousness
- delirium
- concussion following a head injury
- the symptoms of alcohol or drug use

Causative Nexus

2.47 The Law states that for a person to be assessed to lack capacity the inability to make the decision must be "due to an impairment of, or disturbance in the functioning of, the mind or brain, whether the impairment or disturbance is permanent or temporary." The decision maker must be able to demonstrate that the reason that P cannot make their own decision is as a result of a mental disorder. This is known as the **causative nexus**.

2.48 Capacity assessments must link the inability to make a decision to the impairment or disturbance in the functioning of the mind or brain. It is not sufficient to rely on the fact that there is a diagnosis or condition or that it 'may be' related to the inability to make the decision. The Law states "due to" to ensure there is an identified link between the inability to make the decision and the impairment or disturbance in the functioning of the mind or brain.

Scenario – the causative nexus

Mr Singh was diagnosed with dementia in Alzheimer's Disease seven years ago. He had previously been a University lecturer. His condition is declining and he is now having difficulty walking safely. He has been provided with a frame to support his mobility but he often forgets to use it and has had a number of falls, although thankfully he has not sustained any serious injuries. His family want him to use a wheelchair for his safety. The Occupational Therapist talks to Mr Singh but his responses are out of context with the subject. The Occupational Therapist completes a formal mental capacity assessment and notes that Mr Singh is unable to understand the information she provides as to why he would be safer using a wheelchair. She repeats the information several times but it is clear that Mr Singh is unable to understand or retain this information for even the briefest of time. She assesses Mr Singh to lack capacity to make his own decision.

The occupational therapist knows that the symptoms of Alzheimer's Disease increase over time and that a decline in mobility can come in the later stages of the disease. Communication is also affected at this stage of the disease, including memory problems. The occupational therapist knows that Mr Singh had previously been able to understand complex information and to communicate well (as a lecturer) but his family advise her that this has declined over the past two or three years. As a decline in communication and understanding information is a symptom of dementia, she is of the opinion that Mr Singh's inability to understand the relevant information is due to his diagnosis of Alzheimer's Disease.

Completing capacity assessments

2.49 Carers and family members would not usually need to follow formal processes, such as involving a professional to make an assessment. However, if somebody challenges their assessment, they should be able to describe the steps they have taken. They must also have clear reasons for believing that P lacks capacity. Paid carers may wish to make note of capacity assessments in case notes.

2.50 When assessing capacity the assessor should:

- start by assuming that P is able to make their own decision. (Is there anything to suggest otherwise?)
- consider how best to communicate with P so that they have the best possible chance to participate,
- consider whether the decision could be delayed in order to help P to make their own decision or to give time for the person to regain capacity,
- provide P with the information they need to be able to make the decision and
- be aware that simply because P agrees with you or to the proposed act, this does not necessarily mean that they have capacity. Compliance is not informed consent.

Factors to consider for capacity assessments

2.51 It is important to assess P when they are most able to engage in the process. This may be a particular time of day when P may be more alert or able to communicate well or in a particular setting where P may feel most comfortable and able to participate. This may not always be possible, depending on the nature and urgency of the decision to be made, however consideration should be given to how to support P to participate as far as they are able to do so.

2.52 Anyone assessing capacity must not assume that P lacks capacity simply because they have a particular diagnosis or condition. There must be evidence that the impairment or disturbance in the functioning of the mind or brain directly affects the ability to make the specific decision at the time it needs to be made.

What is a 'reasonable belief' of a lack of capacity

2.53 Carers (whether family carers or other carers) are not expected to be 'experts' in assessing capacity. However, to have protection from liability when providing care or treatment, they must have a 'reasonable belief' that any person they care for has, or lacks, capacity to make the relevant decisions about their care or treatment. To have a reasonable belief of a lack of capacity, the person assessing capacity must have taken appropriate steps to establish that P lacks capacity to make the decision or consent to an act, at the time the decision needs to be made. This means following the steps in the Functional Test (2.24).

Involving professionals

2.54 It may be necessary for the decision maker to seek professional support and guidance, for example if the decision is particularly complex. If P has a particular condition or disorder, it may be appropriate to involve a specialist or other professional with experience of working with people with that diagnosis. The person carrying out the act, or providing the care or treatment, is still the decision maker. When other professionals are consulted, this is to support the assessment, for example by supporting P's ability to communicate or to provide information about how P's condition may affect their cognitive abilities.

2.55 Professional involvement might be needed if:

- the decision is very complex or has serious consequences
- an assessor concludes that a person lacks capacity, but P challenges the finding
- family members, carers and/or professionals disagree about P's capacity
- there is a conflict of interest between the assessor and P
- P is assessed to have capacity but repeatedly makes decisions that put them at risk or could result in them suffering significant harm

2.56 In some cases, it will be necessary to complete a further, formal assessment of a person's capacity to make a particular decision. Such cases would include:

- if P's capacity to sign a legal document could later be challenged
- if P or their family/carers challenge a capacity assessment and the matter has been referred to the Mental Health and Capacity Review Tribunal [5]
- if there has been a referral to the Committee for Health and Social Care's Safeguarding Team[6] due to concerns about P's capacity to make a Lasting Power of Attorney

What practical steps should be taken to support P when assessing capacity?

2.57 P must be supported to participate in the assessment. The assessor should consider which steps are relevant and should:

- be clear about the decision to be made and explain the reason for the assessment,
- take all reasonable steps to minimise distress and encourage participation,
- consider whether there is a time of day when the person is more alert or able to participate,
- explain the options available to P in relation to the decision. The assessor should consider what information P needs be able to explore the options and to make a decision. To do so they may need access to certain relevant documents and/or background information to provide P with the relevant information.[7] See also 2.25-2.29.

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[5] The Mental Health and Capacity Review Tribunal will be introduced at a later date.

[6] This includes the Sark Safeguarding Officer

[7] As Theis J noted in judgment in *LBX v K and ors [2013] EWHC 3230* "In *CC v KK* [2012] EWHC 2136 in the Court of Protection Baker J. emphasised the need to present the options to the person concerned and not to start the assessment with a blank canvas. He adopted the words of Macur J. in *LBL v RYJ* [2010] EWHC 2664 that it was not necessary for a person to weigh up every detail of the options but rather to consider the salient features. He also stressed at paras.64 to 65 of the *CC v KK* decision that it was crucial to recognise that different individuals gave different weight to facts and professionals must not conflate a capacity assessment with a best interests assessment."

- consider P's communication needs. Does P needs interpreter or use communication aids or equipment? The assessor should use clear language and avoid the use of jargon.
- allow enough time for the assessment, including giving people with communication needs more time, if needed. A capacity assessment does not necessarily need to be completed in one session. Some people may need information provided over time. If a decision is not urgent, consideration should be given to conducting this in more than one session, if that would be appropriate, or delaying it until P feels less anxious and may be more able to make the decision.
- introduce the assessment and conduct it in a way that is respectful, collaborative, non-judgmental and which preserves P's dignity
- ensure, as far as is reasonably possible, that the assessment takes place at a location and in an environment where the person is comfortable
- identify the steps a person is unable to carry out even with all practicable support
- consider whether involving people, with whom the person has a trusted relationship, would help the assessment.

2.58 When preparing for an assessment, consider P's decision-making history, including the extent to which P felt involved and listened to, the possible outcomes of that assessment, and the nature and outcome of the decisions reached.

2.59 People with fluctuating or a temporary lack of capacity
Fluctuating capacity means that P has times when they can make decisions and times when they are not able to. This can be because P has an illness or condition that gets worse at times, affecting their ability to make decisions. Temporary factors that may also affect someone's ability to make decisions include acute illness, severe pain, the effect of medication, intoxication, and distress after a death or shock.

2.60 Some people's capacity can fluctuate on a reasonably predictable basis, for example a person with dementia may be able to function quite well in the morning but may be very confused in the afternoon. Other people's capacity may fluctuate unpredictably or over days or weeks.

2.61 An assessment should only examine P's capacity to make a particular decision, at the time when it needs to be made. With some, one-off non-urgent decisions, it may be possible to delay until P has the capacity to make their own decision. If P's ability to make decisions changes at different times of the day, it would be advisable to speak with P at the time when they are at their best.

2.62 It may be helpful to make a distinction between one-off decisions, such as making a will or a Lasting Power of Attorney and repeated decisions which are taken on an ongoing business, such as managing one's affairs. As Sir Mark Hedley stated

"The management of affairs relates to a continuous state of affairs whose demands may be unpredictable and may occasionally be urgent."[8] This is known as the longitudinal view. The judge noted that "When P was relaxed and in a good place he might well be regarded as having capacity. However, when he became anxious his position could be very different."

2.63 Managing a health condition involves making many decisions daily or weekly. Considering P's ability over the course of the day or week can provide a clearer picture. Is P mostly able to make decisions during the day or week or are there only limited periods when P is able to do so? If there are only very limited times when P can make the necessary decision, it would most likely be appropriate to conclude that they lack capacity. Case law has described this as consideration at a macro level, or a series of micro-decisions. In a judgment regarding capacity with regard to diabetes management, the judge concluded (Para 48):

"a) on the assessment of capacity to make decisions about diabetes management, in all its health consequences, the matter is a global decision, arising from the inter dependence of diet; testing her blood glucose and ketone levels; administration of insulin; and, admission to hospital when necessary in the light of blood glucose levels. And
b) that [the person] lacks the capacity to make those decisions, and having regard to the enduring nature of her personality disorder which is lifelong and therefore unlikely to change."[9]

2.64 It may not always be possible, or appropriate, to delay making the decision. A decision may need to be made on P's behalf, based on the balance of probabilities, that P lacks capacity to make the decision, at that time. The decision maker should explain <u>why</u> they had a reasonable belief that P has or lacks capacity.

Refusal of assessment

2.65 It is important to be aware that P could be distressed by having their capacity questioned, particularly if they strongly disagree that there is a reason to doubt their ability to make the specific decision. P may refuse to undergo an assessment of capacity or refuse to be examined by a doctor or other professional. In these circumstances, it is important to explain to P why the assessment is needed and the likely consequences of such refusal. If P continues to refuse to participate, the assessor will need to base their conclusions on the balance of probabilities. In such cases, this will require involving the person's family, friends and/or carers to provide information and consideration of previous decisions made by the person.

[8] *Cheshire West and Chester Council v PWK* [2019] EWCOP 57 para 18.
[9] *Royal Borough of Greenwich v CDM* [2019] EWCOP 32

***Scenario – assessing capacity when a person refuses to participate**.*

Mrs Pamela Brown lives alone in a second floor flat. There is no lift access. Mrs Brown is unsteady on her feet but does not use a walking stick. When she goes out, she holds on to walls and hedges to avoid falling. She was diagnosed with dementia a year ago. The police contact the social work team as Mrs Brown has repeatedly been found wandering at night, without suitable clothing for the weather. There are reports that she has stopped strangers in the street and asked for help to find her way home.

The social worker, Chris Henry, visits Mrs Brown at her flat. Mrs Brown refuses to let Chris Henry in although she agrees to speak with him at her front door. The social worker observes that the flat is very cluttered and dirty. Mrs Brown appears very unsteady and holds on to the door whilst she is talking with Chris, although she denies that she has any problems with her mobility when he asks about this. He is very concerned that she does not seem to be aware of her situation or the risks she faces. He explains that he needs to complete a capacity assessment to assess whether she has capacity to decide about the risks of remaining in her own home. When he explains this, Mrs Brown becomes angry and says that she is not prepared to have an assessment and shuts the door. She refuses to open this, even though Chris politely requests that she talk with him.

Chris returns the following day at a different time to see whether Mrs Brown is more willing to talk with him, however she refuses to talk with him. Chris has had a further report from the police that they had had to return her home the previous night and were concerned that she was finding it difficult to use the stairs safely. Chris decides that the assessment cannot wait, due to the potential risks to her safety. He consults with Mrs Brown's GP, the police officer who has brought her home and with her son, who lives in England. The GP says that she has noticed that Mrs Brown has not attended the surgery recently even though she has been invited for a regular health check. This is unusual as she has previously kept her appointments. The police officer said that Mrs Brown appeared confused and distressed. She did not seem to understand what he was saying when he spoke with her and this was why he had contacted the social work team. Mrs Brown's son advises the social worker that his mother's communication has declined significantly over the past few weeks. He had visited her three weeks ago and suggested that she should move to a care home or have carers to help her in her home, but his mother had been very angry and told him to leave. Most importantly, he tells the social worker that he does not believe that his mother understands the risks she is facing at home.

Chris takes account of all this information and gives weight to Mrs Brown's son's views as he knows his mother well. Chris also notes that Mrs Brown had demonstrated an inability to weigh information when he had spoken with her (denying that she has mobility difficulties). His opinion is that, on the balance of

probabilities, he has a reasonable belief that Mrs Brown lacks capacity to make her own decision about how to meet her care needs and to maintain her safety.

2.66 Nobody can be forced to participate in an assessment of their capacity to make a decision. The assessor should consider whether they have enough surrounding evidence to come to a reasonable belief about capacity or incapacity. If the stakes are high, for the person or others, it may be necessary to make an application to the Mental Health and Capacity Review Tribunal to decide whether the person has or lacks the capacity to make the relevant decision. If there are serious worries about the person's mental health, it may be more appropriate to consider the Mental Health (Bailiwick of Guernsey) Law 2010, but refusing a capacity assessment does not in itself justify using the Mental Health Law.

2.67 Maintaining a record of assessments

It is good practice for a professional carrying out an assessment of P's capacity to make the relevant decision, to record the findings in their relevant professional records. Assessments of P's capacity to make day-to-day decisions do not require a formal assessment or recorded documentation. It would be good practice however, for paid care workers to keep a record of the steps they have taken to consider P's capacity when caring for P.

2.68 Challenging a finding of lack of capacity

There may be occasions when P or P's friend or family member may wish to challenge the outcome of a capacity assessment. If the challenge comes from P, they might need support from family, friends or an Independent Capacity Representative[10] (for decisions relating to serious medical treatment, accommodation, safeguarding or a Protective Authorisation). P or P's representative should ask the assessor to provide evidence to support their conclusion that P lacks capacity to make the relevant decision

2.69 The assessor must show they have applied the principles of the Law and that the capacity assessment is objective.[11] All people making decisions for a person who lacks capacity will need to show that they have also followed the guidance in this chapter. This includes attorneys and family as well as all professionals.

2.70 If a disagreement cannot be resolved, the person who is challenging the assessment may refer the matter to the Mental Health and Capacity Review Tribunal

[10] Independent Capacity Representatives will be introduced at a later date.

[11] In "KK v STCC [2012] EWCOP 2136 (26 July 2012) Baker J notes "Equally, in cases of vulnerable adults, there is a risk that all professionals involved with treating and helping that person – including, of course, a judge in the Court of Protection – may feel drawn towards an outcome that is more protective of the adult and thus, in certain circumstances, fail to carry out an assessment of capacity that is detached and objective. On the other hand, the court must be equally careful not to be influenced by sympathy for a person's wholly understandable wish to return home."

(MHCRT) or the Royal Court, depending on the situation.[12] The MHCRT and the Royal Court have the authority to request a further assessment and to rule on whether P has capacity to make the specific decision.

[12] The Mental Health and Capacity Review Tribunal will be introduced at a later date.

3. Best Interests

Overview

3.1 A key principle of the Capacity Law is that any decision or any act, on behalf of a person (P), who has been assessed to lack capacity, must be made or done, in P's best interests. This principle applies to family, friends, paid workers, attorneys and guardians, and covers all decisions, simple and complex. The only exceptions to this is where P has made a relevant Advance Decision to Refuse Treatment or under the Protective Authorisation Scheme.[13]

3.2 A best interests decision is a person-centred decision, i.e. it should be based on P's wishes, feelings and values, rather than the wishes, feelings and values of the decision maker. Considering what is in P's best interests can be difficult to assess, but the Law requires decision makers to follow certain steps. The decision maker must:

- involve P as far as P is able to do so
- not to base the decision simply on P's age, appearance, condition or their behaviour
- consider all the relevant information and circumstances
- consider whether P may regain capacity to make the relevant decision (and therefore whether the decision can be delayed)
- where the decision relates to life sustaining treatment, not be motivated by a desire to bring about P's death
- consider P's past and present wishes and feelings, as well as their beliefs and values which may have influenced their decision, when they had capacity
- any other factors that P may have considered relevant
- take account of those named by P to be consulted, family or friends, carers and those interested in P's welfare.

3.3 Significant Restriction of a person's rights

The Law does not authorise a person to significantly restrict P's rights within the meaning of section 47 Capacity Law (Bailiwick of Guernsey) Law 2020. This can only be authorised under the Protective Authorisation Scheme[14] or by a decision of the Court or the Mental Health and Capacity Review Tribunal.[15]

3.4 Who is the decision maker?

Many different people may be required to make decisions or act on behalf of any P who lacks capacity to make their own decision. The person who makes the relevant decision is called the decision maker. It is the responsibility of the decision maker to work out what is in the best interests of P. If P has a relevant Lasting Power of

[13] Advanced Decisions to Refuse Treatments will be introduced at a later date.
[14] The Protective Authorisation Scheme will be introduced at a later date.
[15] To be introduced at a later date.

Attorney, the attorney will be the decision maker for decisions within the scope of their authority. The decision maker should assess P's capacity to make the specific decision (see Code of Practice section on capacity).

Decision	**Decision maker (if no relevant LPA)**
Day to day decisions such as what to wear, what to eat, activities	P's carer (formal or informal)
Medical treatment	The healthcare professional responsible for carrying out the proposed treatment
Social care decision, such as move to a care home (funded by the Committee)	The social care professional, responsible for arranging the placement
Financial decisions	Any person appointed as Guardian

Scenario: Making a decision

Mr Paul James is 80 years old and lives alone in his rented home. He has been recently diagnosed with dementia. Mr James' daughter Samantha, lives in London, so she is not able to visit often. Mr James' neighbour contacts Samantha to express concern about her father. When Samantha visits she can see that her father has lost weight and finds that there is very little food in the fridge. The property is in poor condition and there is rubbish piled up all over the floor. Mr James is unsteady on his feet and Samantha observes that he has difficulty moving safely around his house. She asks for a social worker to assess her father for a care home placement.

The social worker assesses Mr James to lack capacity to make his own decision about how best to meet his needs. He does not have a Lasting Power of Attorney for Health and Welfare decisions. Mr James does not have much money so his placement will be funded by the Committee, therefore the social worker is the decision maker. The social worker understands that she should involve Mr James, as far as possible, in making the decision about where he should live, as well as his daughter. Mr James' neighbour has been very involved as an informal carer and is also invited to participate.

The social worker arranges a best interests meeting at Mr James' house, to support his involvement. Although Mr James is quite confused, he is clear that he is happy in his house. He has previously told his daughter that he would never want to go into a care home. Despite this, Samantha wants her father to go into a care home, as she is very concerned about his safety in his own home. Mr James' neighbour says that he thinks Mr James would be very unhappy if he had

to leave his own home, particularly as he has a cat and thinks that moving to a care home would not be good for his mental wellbeing.

The social worker considers all these views, the positive and negative elements of the different options and she adds weight to Mr James' views. She notes that he has not previously had a care package to support him and that he had been managing alone, until recently. Considering the principles of the Capacity Law, the social worker decides that the less restrictive approach would be to provide support to Mr James in his own home. A package of care is consequently arranged to support Mr James to stay at home.

3.5 Available options

A best interests decision should consider the available options for P, for example, a choice about where P should live or whether P should have a particular medical treatment. Where the choice is being made on behalf of P, that choice can only be between the options which are actually available to them. The decision maker should identify the different options to be considered in the best interests process.

3.6 Support P to participate in the decision or act

It is important that P should be involved in the decision making process, as far as they are able to participate. The decision maker should ensure that all practical means are used to encourage participation. To support P to participate, consideration should be given to:

- using simple language and avoiding the use of jargon,
- using an interpreter (including signing) if required,
- what support is available from family, friends or carer,
- using communication aids, and
- the best time and place for the discussion

Scenario – supporting the person to participate

Sarah has a learning disability and has lived in foster care since early childhood, but now she is 18 she will be moving to an adult placement. Sarah has no verbal communication, but she uses Makaton. The social worker has assessed Sarah to lack capacity to make her own decision about where she should live; however, he wants to involve her and to get her views. The social worker has identified two care homes and takes Sarah to visit them both. He watches how Sarah relates to the staff in each care home and, after the visits they talk about the homes, using a Makaton interpreter to ensure participation. Sarah is able to express her views about the different placements. When the best interests meeting takes place, the social worker takes account of Sarah's view to inform the decision as to where she should live.

3.7 Avoid discrimination

The decision maker should not make assumptions based simply on the basis of P's age, appearance, condition or behaviour.

3.8 Consider whether P may regain capacity

When making a decision, consideration should be given to whether P may regain capacity. If so, can the decision be delayed? This may apply if P is receiving short term medical treatment (which has affected P's capacity to make decisions) or if P has an infection.

3.9 Consider P's past and present wishes and feelings, P's beliefs and values and any other information that P would take into account if they were making their own decision.

Has the person written an Advanced Care Plan or Advanced Decision to Refuse Treatment? Although the Advanced Care Plan is not binding, it is an expression of P's wishes and may aid the decision maker. If the decision relates to medical treatment and there is a relevant Advanced Decision, the decision maker is bound to follow this. The decision maker should also take account of P's beliefs and values which may have influenced their decision when they had capacity to make the relevant decision. This includes religious beliefs and practices. Even though P has been assessed to lack capacity to make the specific decision, P may have views, or have expressed views in the past, which should be taken into account. However, P's wishes and feelings will not necessarily be the deciding factor for working out their best interests, as the assessment will need to consider these alongside other factors.

Scenario: Taking account of the person's wishes and feelings.

Oliver Stein suffered a stroke when he was 65. He recovered well, and was able to return home but this experience has made him think about his future. Oliver writes an Advanced Care Plan which states that, in the event of a decline in his health and if he loses capacity to make his own decision, he wishes to stay in his own home and not be admitted to a care home. Oliver's only son lives in America and does not visit his father often. Oliver has not made a Lasting Power of Attorney for health and welfare decisions.

Two years later, Oliver has a second stroke and he suffers a brain injury. He is no longer able to walk and his communication is very limited. Whilst he is in hospital, he is assessed to have lost capacity to make his own decision about how to support him when he is fit for discharge. The social worker reads the Advanced Care Plan and takes account of this as an expression of Oliver's wishes. She considers whether his care and treatment needs could effectively be met in his own home however, Oliver's doctor advises that he needs 24 hour care and treatment. A best interests decision is taken that Oliver should move to a care home, to ensure that he is safe and that his needs are met.

3.10 Motivations when the decision concerns life sustaining treatment.
Anyone making a decision about whether life-sustaining treatment is in the best interests of P, should not be motivated by a desire to bring about P's death. The healthcare professional will advise whether the treatment is life sustaining. All reasonable steps, which are in P's best interests, should be taken to prolong life; however, there will be some cases where treatment may be futile or overly burdensome for P (see 3.12). In such circumstances, it may be that the best interests assessment concludes that it would not be in P's best interests to have treatment, even if this may result in P's death. The decision maker must not be motivated by a desire to bring about the person's death for whatever reason, even if this is from a sense of compassion.

3.11 Before deciding to withdraw or withhold life-sustaining treatment, the decision-maker must consider the range of treatment options available to work out what would be in P's best interests. All the relevant factors should be considered, and in particular, the decision maker should consider any statements that P has previously made about their wishes and feelings about life-sustaining treatment. P's own wishes and feeling are of critical importance in best interests decision making.

3.12 P, or P's family, cannot demand that a doctor administers treatment which the doctor does not consider is appropriate. The doctor will need to consider whether treatment would be futile or with no prospect of recovery. The UK Supreme Court [16] defined futile as "ineffective or of no benefit to the patient" (Para 40). The Court also stated that "where a patient is suffering from an incurable illness, disease or disability, it is not very helpful to talk of recovering a state of "good health". The patient's life may still be very well worth living. Resuming a quality of life which the patient would regard as worthwhile is more readily applicable, particularly in the case of a patient with permanent disabilities" (Para 44). If there is agreement between the doctor and P's family or friends, treatment can be withdrawn, however if there is disagreement about life sustaining treatment or the decision is finely balanced, this will need to be referred to the Royal Court.

3.13 Do Not Attempt Cardiopulmonary Resuscitation orders
A doctor may place a DNACPR order on P if they assess that it would be futile to attempt cardiopulmonary resuscitation, due to other health conditions. P may have other health conditions which would affect the outcome of attempts to resuscitate P. This is a clinical decision, but the doctor should consult with P's family or attorney under a relevant LPA if P lacks capacity to make this decision.

[16] Aintree University Hospitals NHS Foundation Trust v James [2013] UKSC 67 (30 October 2013)

3.14 Case law[17] has emphasised the requirement for healthcare professionals to have prior consultation with P's family, where P lacks capacity to consent to the order, before deciding to make a DNACPR. Failure to do so breaches s6 (iv) of The Capacity Law. The judge noted (para 47) that "a decision that is not taken 'in accordance with law' cannot justify an interference with the right to respect under Article 8(1)" of the European Convention on Human Rights. Article 8(1) is the right to respect for private and family life.

3.15 ReSPECT

ReSPECT [18]stands for Recommended Summary Plan for Emergency Care and Treatment. The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency where they do not have capacity to make their own decision about treatment. The process is designed to take account of the patient's views as well as clinical considerations. The document should include a recommendation by the doctor as to whether, or not, CPR should be attempted.

3.16 Consultation

Consultation is important when making a best interests decision. The decision maker should take into account the views of**:**

a) Anyone named by P as someone to be consulted. This can be a friend, as well as a family member.
b) Anyone engaged in caring for P or who is interested in their welfare. This includes paid carers, healthcare staff, GP, and Independent Capacity Representatives.
c) An attorney under a Lasting Power of Attorney (where the attorney does not have the authority to make the relevant decision).
d) Any guardian appointed for the person by a court.

3.17 The purpose of this consultation, is to consider what is in the person's best interests in relation to the specific decision. The people consulted may be able to provide information about the person's past and present wishes and feelings, their values and beliefs. This will inform the decision making process.

3.18 It is good practice for the decision maker to document the views of others and how these have been considered, as part of the decision making process. This is particularly important in the event of any disagreement about what is in P's best interests. A record of the best interests decision should be made on P's care or medical records (as appropriate). The decision should also be communicated to all those involved in the decision.

[17] Elaine Winspear v City Hospitals Sunderland NHS Foundation Trust [2015] EWHC 3250 (QB)

[18] https://www.resus.org.uk/respect

3.19 Is it necessary to have a meeting to make a best interests decision?
A best interests meeting ensures that all those involved, including P, are able to express their opinions and any disagreements can be discussed however, it may not always be possible for a meeting to be arranged, particularly when a decision needs to be made quickly. Consultation can also be via email, phone or video call. The decision maker should keep a record of all those consulted and by what method, as well as how the decision was reached and how P was supported to participate in the process. If there is a valid Lasting Power of Attorney, with authority to make the relevant decision, the attorney can make this on behalf of P without the need for a meeting. However, if the decision is particularly complex or if the attorneys have conflicting views about how to proceed, a best interests meeting can be convened to consider the options.

3.20 Is it always necessary for P to attend a best interests meeting?
It is a key principle that P should be supported to participate in all decisions made in P's best interests. To that end P should be supported to attend a meeting, if it is practical to do so. There may be exceptions to this, for example if attending a meeting is likely to cause undue distress to P. In such cases, the decision maker should consider alternative ways of gaining P's views and wishes and should ensure that these are considered when making the specific decision. P should be informed of the outcome of the best interests decision however, if this is not possible, the decision maker should record the reason for this on P's records.

3.21 Is there a less restrictive option?
It is a key principle of the Law to consider whether there is a less restrictive option available, before making the decision. For example, before deciding to admit P to a care home, consideration should be given to whether P can be supported to stay in their own home, where they would have more autonomy. If a viable less restrictive option is available, this should be taken.

Scenario – Less restrictive options

Ms Ela Stanislous is Greek. She has a diagnosis of dementia. She had been living with her partner, but they had both been very unwell with Covid-19 and spent a long period in hospital. They are eventually discharged home, but Ms Stanislous is soon re-admitted to hospital, following a fall. Her partner advises the hospital that he cannot manage her care at home, even with carers, as she keeps having falls and her sleep is very disrupted. The doctor advises that Ms Stanislous is ready for discharge, but she is assessed to lack capacity to make her own decision about where she should live. She has no insight into her needs for care and treatment. Mrs Stanislous is very wealthy and therefore can afford to pay for her own care. Her partner holds Lasting Powers of Attorney for both Property and Finances and for Health and Welfare and therefore he will decide where she should live. Ms Stanislous had always been very active and enjoyed going for long walks. She

enjoyed a good social life and had a lot of friends. She expresses her unhappiness about moving to a care home.
Her partner considers whether there is a less restrictive option which could meet Ms Stanislous' needs. He is advised that she could move to a flat in a sheltered accommodation scheme with carers on site. Ms Stanislous would have some autonomy and she would not be subject to the restrictions she might have in a care home. Her partner concludes that Ms Stanislous should move to a flat in the sheltered scheme, as this is the less restrictive option available which can meet her care and treatment needs.

3.22 What is the relevant information and circumstances?

When making a best interests decision, the decision maker should consider all the relevant information. This means that they should try to identify all the information and issues that would be relevant to P and to the specific decision, including P's values and any expressed wishes and feelings. See also sections 2.26 – 2.29 which lists relevant information.

3.23 In a recent case [19] Hayden J. stated at para 24:

"When applying the best interests tests … the focus must always be on identifying the views and feelings of P, the incapacitated individual. The objective is to reassert P's autonomy and thus restore his right to take his own decisions in the way that he would have done had he not lost capacity.

25. The weight to be attributed to P's wishes and feelings will of course differ depending on a variety of matters such as, for example, how clearly the wishes and feelings are expressed, how frequently they are (or were previously) expressed, how consistent P's views are (or have been), the complexity of the decision and how close to the borderline of capacity the person is (or was when they expressed their relevant views). In this context it is important not to conflate the concept of wishes with feelings. The two are distinct. Sometimes that which a person does not say can, in context, be every bit as articulate as wishes stated explicitly."

3.24 Consideration should also be given to the person's individual circumstances and their values, as well as their wishes and feelings. In X v MM and KM [2007] EWHC 2003 (Fam) Munby J stated that people who lack capacity should still be allowed to take risks and that it is not the Court's role to remove all possible risks, at the expense of a proportionate balance. To that end, his judgment includes the rhetorical question: "what good is it making someone safer if it merely makes them miserable?" (para. 120).

3.25 Using a balance sheet approach for a best interests decision allows for consideration of all the relevant information and circumstances.

[19] *Barnsley Hospitals NHS Foundation Trust v MSP* [2020] EWCOP 26

Scenario Considering which option is in a person's best interests

Mrs Christie is living in her own flat. She has had a number of falls, resulting in admissions to hospital. On the most recent occasion, she was found on the floor after a long lie. She had a grade three pressure ulcer and a fractured hip. Whilst in hospital, Mrs Christie makes frequent requests to go home. She tries to get out of bed, although she is unable to mobilise independently, due to the fracture. Mrs Christie's son tells staff that his mother's memory has declined over the past year and he suspects that she may have dementia. She has lost weight and he doesn't think that she has been eating well. Whilst in hospital, Mrs Christie is diagnosed with dementia. She is later assessed to lack capacity to make her own decision as to her discharge destination. A best interests meeting is arranged to consider whether she can return home or whether she needs a care home placement. The social worker, as decision maker, draws up a balance sheet, based on the information provided and on Mrs Christie's wishes. The social worker adds weight to Mrs Christie's wishes but, weighing all the risks, makes the decision that she should be admitted to the care home.

Balance sheet for Mrs Christie

Care Home Placement

Benefits: Access to 24 hour care and treatment
All meals and drinks will be provided
Activities are available in the home
All laundry is completed by staff
She will have a large room with en-suite facilities
The care home has a bus which is used to take residents out for trips
Her safety will be maintained
The environment is clutter free and staff are available at all times, reducing the risk of falls
She has been offered a ground floor room which will be easier for access, due to her restricted mobility

Burdens: Mrs Christie will be living with other people, who she does not know
The care home will have routines so she will have less autonomy than she has in her own home
Mrs Christie may have to pay to live there
She may have a limited choice of meals
She will have less privacy than in her own home
This is not where Mrs Christie wishes to live

Remain in own home

Benefits: This is Mrs Christie's strong wish
She will have autonomy and freedom
She can make her own routine
She can choose her own meals and drinks and mealtimes
She can see family and friends

Burdens: Her home is in poor condition and is cluttered
Mrs Christie is reluctant to accept carers and has previously refused to allow them to come in. Even if she accepts carers there will be periods when she is left alone.
Mrs Christie has had a number of falls. This continues to be a risk, due to the cluttered environment and she has refused to allow her son to clear the flat
The flat is upstairs and Mrs Christie's mobility is restricted currently. She will be dependent upon carers to get her out of bed and to out her to bed.
She will need to live in a micro-environment, for her own safety.
She was reported to not be eating well when she was at home previously so there is a risk of malnutrition and of dehydration.
Mrs Christie cannot currently mobilise independently therefore she will need carers to prepare her meals.

3.26 Reasonable belief about a person's best interests
A decision maker must have a reasonable belief that the decision made is in the person's best interests. They should demonstrate that they have considered all the relevant circumstances and applied the principles of the Law, including the best interest process. If the decision maker follows the principles of the Law and has a reasonable belief that the person lacks capacity and that the decision is in their best interests, they will be protected from liability.

3.27 What happens if a person has made an Advance Decision to Refuse Treatment (ADRT)?
If P has made an Advance Decision relevant to the proposed treatment, then the best interests process does not apply. The healthcare professional should not provide a treatment that P has documented (in the ADRT) that they do not wish to receive. If there is any doubt as to the validity of the ADRT, the best interests process should be followed. Even if the ADRT is not valid, it should be considered as an expression of P's wishes.

3.28 Who do these duties apply to?
These duties apply to any person who is making a decision on behalf of P. This includes a person who holds a Lasting Power of Attorney or anyone who reasonably believes that a person lacks capacity to make a specific decision. The decision maker must comply with the requirements set out in section 6(1) of the Capacity Law

if they have a reasonable belief that the decision made, or act done, is in the best interests of P.

3.29 Disagreement about the person's best interests

At times there may be differing opinions expressed about what is in P's best interests. Family member and friends, as well as carers and professionals, may have different views about the decision to be made. The decision maker should take account of these conflicting views. A best interests meeting provides an opportunity for all those involved to hear the relevant information and to express their views, but it is not the decision maker's role to resolve the disagreements. The decision maker retains the ultimate responsibility for deciding what is in the person's best interests. If the decision maker has followed the Capacity (Bailiwick of Guernsey) Law 2020 and the steps described in the Code of Practice for the Capacity Law, they will be protected from liability.

3.30 Should a best interests decision be reviewed?

What is in a person's best interests may change over time. This means that even where similar actions need to be taken repeatedly in connection with the person's care or treatment, the person's best interests should be regularly reviewed. Likewise, where a particular medical treatment has been started because it is in their best interests at that point in time, the decision should be reviewed on a regular basis to ensure that the treatment continues to be in P's best interests.

3.31 Keeping records

It is not necessary to record every simple day-to-day decision, but staff, professionals and attorneys under a Lasting Power of Attorney should keep records of how more important decisions, or those with potentially serious consequences, have been made. Such decisions may include change of accommodation, medical treatment, contact with others, financial expenditure (other than minor amounts). The decision maker should record:

- the decision that was made,
- who was consulted and the views expressed,
- how P was supported to participate,
- P's wishes and feelings, past and present (as far as these can be ascertained), and
- how the decision was reached and the reasons for that decision.

3.32 Emergency situations

In an emergency, it may not be possible to make a formal best interests decision, for example if a person requires urgent medical treatment. If the person's treatment cannot be delayed to consider their best interests, then the relevant professional will be protected from liability, as long as they are not aware of a valid and relevant ADRT (when these are introduced). The professional should document on the person's records, why the best interests process was not followed.

Making a decision in an emergency situation

Mrs Gladys Jones has a diagnosis of vascular dementia. She is able to walk with a stick, but needs support to get in and out of bed. Mrs Jones lives alone with support from carers who visit her four times a day. The final call of the day is at 8pm, to support Mrs Jones to go to bed.

At 8am one morning, carers arrive to find Mrs Jones lying on the floor. Paramedics attend and Mrs Jones is found to be severely dehydrated and she has a suspected fracture of her hip. Mrs Jones is very confused and distressed and tries to resist the ambulance staff when they tell her that she needs to go to hospital.

The ambulance staff assess that Mrs Jones' health is at high risk and make the decision to take her to hospital. The ambulance staff are acting in Mrs Jones' best interests in an emergency situation. When she goes to hospital, the doctor can provide emergency treatment, such as medication and fluids, necessary to sustain her life.

3.33 Restraint
A person (D) uses restraint if:

a) D uses or threatens to use physical, mechanical or chemical restraint, or other force on P
b) D restricts, or threatens to restrict, P's freedom of movement (including isolation, seclusion or segregation)
or if D authorises another person to do any of the above.

3.34 There are three types of restraint defined by the Law where the primary purpose is to control P's behaviour:

i) Physical restraint is the use of physical contact which prevents, restricts or subdues P's movement.
ii) Mechanical restraint is the use of a device to prevent, restrict or subdue P's movement.
iii) Chemical restraint is the use of medication to prevent, restrict or subdue P's movement

3.35 Section 9 of the Capacity Law permits the use of restraint if:

i) the individual taking the action reasonably believes it is necessary to prevent harm to P and
ii) the restraint is a necessary and proportionate response to the likelihood of harm and the seriousness of that harm.

Any restraint used should only be for as minimal a period as necessary. The use of restraint should be reviewed regularly and ceased if it no longer necessary to prevent harm or proportionate to the risks of that harm.

3.36 Examples of restraint

Situation	Response
P presents with physically challenging behaviours including aggression to others [20]	Staff are trained in physical interventions. Staff physically restrain P to prevent harm to another person. (Physical restraint)
P has periods of severe agitation. During such times P becomes very distressed and can be verbally or physically aggressive.	Trained staff, following medication protocols, administer mood altering or sedative medication to P. (Chemical restraint)
P is very physically fit and can run fast. P has previously run away from his carers, whilst out in the community, and been missing for several hours.	Two staff escort P to go out to the community. One staff hold P's arm when they are out. (Physical restraint)
P is very resistant to being supported with personal care and hits out.	Two staff attend to P with one carer holding P's hands whilst the other provides personal care. (Physical restraint)
P needs medical or dental treatment but is highly resistant to this. A best interests decision has been taken that it is in P's best interests to have the proposed treatment.	P is sedated to receive treatment, where this would not usually be required for the proposed treatment. (Chemical restraint)
P is resident in a care home and is physically mobile. P tries the doors. P has been assessed to be unsafe if able to leave the care home.	The doors are locked and P does not have access to the keycode or a key. (Mechanical restraint)

3.37 Confidentiality

Decision makers must balance the duty to consult other people with P's right to confidentiality. If confidential information is to be discussed, the decision maker should only seek the views of people who it is appropriate to consult, where their views are relevant to the decision to be made and the particular circumstances.

3.38 There may be occasions where it is necessary for personal information (for example, about P's health) to be revealed to the people consulted as part of the process of the best interests process. Health and social care staff who are trying to determine a person's best interests must follow their professional guidance, as well as other relevant guidance on confidentiality.

[20] Caution should be exercised when dealing with risks of harm to others as the Mental Health Law may apply.

4. Lasting Powers of Attorney

4.1 Overview

The Law introduces Lasting Powers of Attorney. A Lasting Power of Attorney (LPA) is a legal document which allows a person (sometimes called the Grantor but referred to as 'P' in this code of practice) who is aged 16 or over, to give another person (the attorney) authority to make decisions on their behalf. Such decisions are as valid as those made by the person. A Lasting Power of Attorney can only be made when P has capacity to make this.

4.2 There are two types of Lasting Power of Attorney: for Health and Welfare decisions and for Property and Financial decisions. P can nominate more than one person to act as the Attorney who can act jointly or severally. The Attorney must be aged 18 or over or, for property and financial affairs, holds or is deemed to hold a primary fiduciary licence[21]. The Lasting Power of Attorney for Health and Welfare decisions can only be activated and used when P has lost capacity to make relevant decisions. P can give the Attorney, under a Lasting Power of Attorney for Property and Financial Affairs, permission to use this whilst they still have capacity.

4.3 The Lasting Power of Attorney can exclude specific decisions, such as whether the Attorney can make decisions related to life sustaining treatment. The Lasting Power of Attorney cannot be used to authorise a significant restriction of a person's personal rights or freedoms. This can only be authorised by a Protective Authorisation or by the Mental Health and Capacity Review Tribunal.

4.4 What is a Lasting Power of Attorney?

A Lasting Power of Attorney is a legal document which allows the Attorney(s) to make decisions on behalf of the P. The Attorney can only make the same decisions that the Grantor would have been able to make when they had capacity to do so. The Attorney must act in P's best interests (see chapter on Best Interests in Code of Practice) and should take account of any past wishes, including those detailed in any Advanced Care Plan. This means consideration of what P would have decided, when P had capacity to do so.

[21] For the purposes of the Regulation of Fiduciaries, Administration Businesses and Company Directors, etc. (Bailiwick of Guernsey) Law, 2020.

Decision	Attorney's power (valid LPA H&W)	What Attorney cannot do
Consent to/refusal of specific medical treatment	The Attorney can consent to, or refuse treatment, when P has lost capacity to make their own decision. This should be in line with P's views and previously expressed wishes.	The Attorney can only make the same decisions as P could make when they had capacity. If there is a valid and applicable Advanced Decision to Refuse Treatment the Attorney cannot override this (unless the LPA was made after the ADRT).
Make a decision about a package of care, including move to a care home.	Attorney can make this decision.	Where the placement is made and funded by the Committee, the Attorney cannot insist upon a more expensive placement.
Decision	Valid LPA Property & Financial affairs	
Making financial decisions	Attorney can manage P's financial affairs and ensure that bills are paid.	The Attorney cannot dispose of P's real property. This needs to be referred to the Royal Court for permission.

Case example – making a decision about moving to a care home

Mr Sinclair lives with his wife. He has made Lasting Powers of Attorney for health and welfare and also for property and financial affairs, naming his son John as Attorney. Mr Sinclair suffered a stroke, which has affected his cognition, and is in hospital pending a decision about whether he can safely return home. John Sinclair contacts his father's consultant who advises that Mr Sinclair has lost capacity to make decisions about his medical treatment and also about how to manage his care needs. John Sinclair applies to activate the Lasting Powers of Attorney. Mr Sinclair's speech has been affected by his stroke and he is no longer able to express his views about where he lives, however he has always said that he would not want to live in a care home.

Mr Sinclair's wife is elderly and does not feel able to have her husband come home to live with her without 24 hour care provided so John investigates care homes and other options, such as carers in his own home. He is advised by the social worker that, as Mr Sinclair does not have a lot of money, he may be eligible for a

placement funded by the Committee. The social worker suggests a care home that may be suitable however John says that he would prefer his father to return home with 24 hour care. The cost of 24 hour care is a great deal more expensive than a care home placement. John tells the social worker that this is what he wants for his father however the social worker explains that the LPA does not give him the authority to make the Committee spend more money. If he wants his father to have care at home he will have to find a way to fund this himself.

4.5 Who can act as an Attorney (A)?
A person is eligible to act as an attorney if A is –

a) aged 18 or over for LPA
b) not bankrupt (for property and finance decisions)

A person appointed as an Attorney should be able to act in the best interests of the Grantor and to fulfil the responsibilities of the role. They should be trustworthy and competent. A person who is on the Disclosure and Barring Service barred list may not be appropriate to be appointed as an Attorney.

4.6 A paid carer, who is caring for the Grantor, should not be appointed as an attorney as there may be a conflict of interest between their role as a paid worker and as an attorney.

4.6 The Law allows for the appointment of one or more attorneys. If there is more than one attorney, P should specify whether they are to act jointly, jointly and severally, or jointly in some matters and jointly and severally in others. If P does not specify this in the document, the attorneys will act jointly.

4.7 An individual who is bankrupt is not eligible to be appointed as an attorney for a Lasting Power of Attorney for property and financial affairs, although they can act as attorney for health and welfare matters.

4.8 What happens if an attorney (for an LPA for property and financial affairs) is made bankrupt?
a) If the attorneys are to act jointly, the Lasting Power of Attorney cannot be created or activated.
b) If the attorneys are to act jointly or severally, the LPA can be created but only in respect of the other attorney(s).

If the LPA has already been registered but not activated, P should apply for an amendment (see creating an LPA) to reflect the change in Attorneys.

4.9 What happens if an attorney loses capacity?

If an attorney loses capacity to make the relevant decisions after the LPA has been registered but before it is activated, P should amend the LPA by selecting another A, unless more than one A has been appointed. P should advise HM Greffier in order that the register can be updated. If A loses capacity after the LPA has been activated, the LPA will be revoked unless more than one A has been appointed and who is eligible to act. In either case, if two or more attorneys are named and can only act jointly, the LPA will be revoked. If an attorney has concerns about another attorney's capacity to act under the LPA, they should inform HM Greffier who will update the register.

4.10 What decisions can an attorney under an LPA for property and financial affairs make?

A Lasting Power of Attorney for property and financial affairs can be used whilst P still has capacity, if P gives permission for this. The Attorney can manage P's financial affairs for a short period (such as when P is away on holiday) or for the longer term (perhaps P may need assistance to manage their affairs due to increased health needs). The Lasting Power of Attorney can specify any excluded decisions but it should be noted that the Attorney cannot dispose of P's real property. Such decisions can only be taken by the Royal Court.

4.11 What decisions can an Attorney under an LPA for health and welfare matters make?

There are a wide range of health and welfare decisions that may need to be made and therefore it is important for P to be clear, when creating the LPA, whether any decisions should be excluded (for example life sustaining treatment decisions). The Attorney should act in P's best interests and therefore it is advisable for P to discuss their wishes with A, when making the LPA. The Attorney can consent to, or refuse, medical treatment, in the same way that the person would have been able to make their own decision, when they had capacity to do so.

Examples of decisions the Attorney(s) can make	**Decisions the Attorney(s) cannot make**
Consent to, or refuse, specific treatment, in line with P's previously expressed wishes.	Insist upon treatment options that would not be available if P had capacity.
Consent to admission for P to a care home	Consent to P being subject to a significant restriction in a care home approved by the Committee to provide a Protective Authorisation.
Consent to admission to hospital	Consent to P being subject to a significant restriction in the hospital approved by the Committee to provide a Protective Authorisation.

Agreement to/ or refusal of the granting of a Protective Authorisation	The Attorney cannot refuse to allow the assessments to be completed.
Selecting the Representative for the Protective Authorisation	Changing P's will.
	An Attorney cannot refuse ECT (electroconvulsive therapy)

4.12 Treatment decisions

P can permit the attorney under an LPA for health and welfare decisions to make treatment decisions on their behalf when they no longer have capacity to make their own decision. P may exclude certain decisions (such as Life Sustaining Treatment). If treatment is proposed for P the Attorney can consent to, or refuse the treatment. Such decisions should be made in P's best interests, taking account of any previously expressed wishes or views. The healthcare professional must take account of the Attorney's decision, in the same way that they would seek consent or refusal from P, when P had capacity. If the Attorney refuses the treatment, this cannot go ahead. This is the same as if a person, who has capacity, refuses a specific treatment. This does not apply to treatment under the Mental Health Law 2010.

4.13 Lasting Power of Attorney for Health and Welfare and Advanced Decision to Refuse Treatment

An Advanced Decision to Refuse Treatment made before the Lasting Power of Attorney, will no longer be valid. It should however be considered by the Attorney when making a relevant decision about treatment. Any Advanced Decision to Refuse Treatment, made after the Lasting Power of Attorney was registered, will be legally binding if it is relevant and valid.

4.14 What happens if there is a difference of opinion?

It is important to remember that the role of the Attorney(s) is to act in the Grantor's best interests, taking account of P's wishes and views. If the difference of opinion is between two attorneys and this cannot be resolved, it may be necessary to refer the matter to the Royal Court to consider the differing opinions and to make the relevant decision.

4.15 What happens if the healthcare professional believes that an Attorney is not acting in the best interests of P?

There may be exceptional circumstances when the treating professional believes that the Attorney is not acting in P's best interests. In the first instance the professional should try to resolve the issues but, if this cannot be done, it may be appropriate to refer the matter to the Royal Court (s30 (3) (b) Capacity Law). The Court has the power to suspend the Lasting Power of Attorney, if the concerns about the Attorney are upheld. In such circumstances the healthcare professional proposing the treatment, will be the decision maker and should follow the best interests process.

Case example

Mr Albert Spencer is 92 years old. He suffered a stroke 6 months ago, since when he is no longer able to walk and he has a lot of difficulty swallowing. He has a cognitive impairment and struggles to communicate. Mr Spencer's son, Jim, holds Lasting Power of Attorney for Health and Welfare. Jim lives with his father and acts as his main carer. Mr Spencer had carers coming twice daily to support him to get up and to put him to bed, however Jim has been very critical of the care provided and the care agency has withdrawn the carers.

One morning Jim notices that his father is listless and unable to eat. An ambulance is called and Mr Spencer is admitted to hospital and he is diagnosed with aspiration pneumonia. He is prescribed antibiotics. As Mr Spencer is very unwell and has difficulty swallowing, the doctor wishes to keep him in hospital and to administer the medication intravenously. The doctor is also very concerned that Jim has been feeding his father a normal diet, rather than pureed foods as advised by the dietician after his stroke. Jim tells the doctor that he wishes to discharge his father home and that he can take oral medication. He gets very angry with the doctor when they are discussing this and threatens to take his father home. He is particularly annoyed that the hospital has granted a Protective Authorisation for Mr Spencer. Jim is later observed trying to feed his father with a burger. The doctor is concerned for Mr Spencer's safety if he is discharged home to Jim's care.

The doctor refers this matter to the Committee who can make an application to the Royal Court to revoke the Lasting Power of Attorney. If the LPA is revoked the doctor can make the decision regarding treatment, via the best interests process.

4.16 Admission to a care home

The Attorney(s) can make the decision for P to be admitted to a care home, when P no longer has capacity to make this decision. The Attorney should take account of P's wishes and views and act in P's best interests. If the arrangements in the home will included restrictions imposed on P, such that a Protective Authorisation would be required, the Attorney cannot consent to these restrictions. The Protective Authorisation process must go ahead, however, if the Attorney objects to the proposed placement in the care home, alternative arrangements will need to be made. The Attorney must act in P's best interests.

4.17 Process to create a Lasting Power of Attorney

The process to create a Lasting Power of Attorney has been designed to provide safeguards for both P and the attorney. Any person making a Lasting Power of Attorney must be 18 years of age or over and have capacity to make this.

1) The grantor should complete the relevant Lasting Power of Attorney form(s) including completing a statement to confirm that P has read and understood the

information regarding the purpose of the LPA. A separate form is required for each type of LPA (Health and Welfare decisions or Property and Finance decisions).

2) The Attorney(s) should complete a statement to confirm that A has read and understood the information regarding the duties imposed by the LPA. This includes understanding the principles of the Capacity Law (S3 The Capacity Law) and best interests (s6 The Capacity Law).
3) The Lasting Power of Attorney must be registered by P at Her Majesty's Greffier.
4) The Lasting Power of Attorney must be activated before it can be used

4.18 Registration

The Lasting Power of Attorney must be registered Her Majesty's Greffier by P who must attend in person and pay the relevant fee. Her Majesty's Greffier will confirm that P is eligible to make the Lasting Power of Attorney, including that P has capacity to do so. The Lasting Power of Attorney will be registered if all the requirements are met.

4.19 HM Greffier can refuse to register a Lasting Power of Attorney if there is evidence that P does not have capacity to make the Lasting Power of Attorney or that P has been placed under undue pressure to do so. A referral must be made to the Safeguarding Team to investigate. P and/or A can appeal this decision to the Royal Court.

4.20 Persons unable to attend HM Greffier's office.

There may be reasons why a person is unable to attend the office, for example due to ill health. In such cases, a request should be made to HM Greffier for a home visit.

4.21 Using a Lasting Power of Attorney

A Lasting Power of Attorney for Property and Financial affairs can be used by the attorney once the document is registered, provided that P has agreed that A can do so. This can be agreed at the time of registration or at a later date, using the prescribed form. HM Greffier should be notified if this agreement is granted after the LPA is registered. P can also decide that the LPA can only be used when P loses capacity to manage their affairs. A Lasting Power of Attorney for Health and Welfare cannot be used until P has lost capacity to make the relevant decision and the document has been activated.

4.22 Activating a Lasting Power of Attorney

A LPA can be activated when P has lost capacity to make the relevant decision, so that the attorney is able to make decisions for P. The attorney must request a prescribed person[22] to complete a capacity assessment to establish whether P has capacity to make the relevant decision. The prescribed person, completing the capacity assessment will complete the certificate to state that P does not have capacity to make the relevant decision. The attorney will present this to HM Greffier,

[22] For details of prescribed persons see Regulation (no)

with the request for activation of the LPA. If HM Greffier is satisfied that the prescribed person has assessed P to lack capacity, the Certificate of Activation will be issued to the attorney and the Register will be updated to show that the LPA has been activated. The attorney will be able to make relevant decisions in accordance with the LPA.

4.23 If HM Greffier believes that P still has capacity, the LPA will not be activated and the attorney cannot make decisions for P. P or A may challenge the decision of HM Greffier in the Royal Court (see section on Court).

Case scenario

Mr Paul Cox has lived alone since the death of his wife, two years ago. He had been diagnosed with dementia but has always been independent and had managed well, with only minimal support from a carer who helps with the housework. However, recently his son has been getting calls from the neighbour to say that Mr Cox has been found outside in the middle of the night, appearing confused and distressed. When he visits his father, he notes that the house is neglected and his father does not appear to be washing often. The fridge is nearly empty and large quantities of medication are found in the kitchen, suggesting that he has neither been eating well or taking his medication. The carer, when contacted, tells Mr Cox's son that he had dispensed with her services some months previously.

Mr Cox (junior) talks with his father about needing to have help in the house and with his personal care, but he does not appear to understand how bad things have got and tells his son that he is making a fuss unnecessarily. Mr Cox (junior), noting how his father has changed, thinks that he may no longer be able to make informed decisions for himself about his needs for care and support. As his father had previously made a Lasting Power of Attorney for Health and Welfare, he contacts the GP and requests a capacity assessment. If Mr Cox is assessed to lack capacity, the GP will complete the relevant certificate that can be provided to HM Greffier to activate the LPA.

4.24 What is the relevant decision for activating an LPA for property and financial affairs?

The prescribed person should assess whether P has capacity to make decisions regarding their property or financial affairs, such that the Lasting Power of Attorney should be activated. The prescribed person should consider the relevant information that P needs to understand to have capacity to make their own decision about their financial affairs or their property. The relevant information could include (but is not limited to)

- Understanding what money is and the value of money (including fair pricing for items)
- Understanding that P needs to pay bills, rent/mortgage, for food/meals
- Managing a bank account and how to withdraw or transfer money
- The risks of being financially exploited by others
- Knowledge of any financial investments, pensions etc

4.25 What is the relevant information for activating an LPA for health and welfare decisions?

The prescribed person should assess whether P has capacity to make decisions regarding their health and welfare, such that the Lasting Power of Attorney should be activated. The prescribed person should consider the relevant information that P needs to understand to have capacity to make their own decision about their health and welfare. The relevant information could include (but is not limited to)

- Can P understand about any current health condition and the treatment for this? Does P understand the risks of refusing treatment?
- Does P know what medication they have been prescribed and what this is for?
- Does P understand any risks they face due to their health or care needs?
- Does P understand that they may need assistance from others to meet their needs or to maintain their safety?

4.26 Amending a Lasting Power of Attorney

P can make changes to the LPA after this has been registered, for example changing, or adding to, the named attorneys or the permitted decisions. P will need to complete the prescribed form and pay any required fee. As with creating a LPA, P will need to attend in person at HM Greffier to make the changes. Any changes can only be made whilst P has capacity to do so. The Register will be updated to reflect the amendment.

4.27 If HM Greffier has evidence to indicate that P lacks capacity to make the amendments or that P has been put under undue pressure to do so the LPA, the changes will not be made. P or A may challenge the decision of HM Greffier in the Royal Court.

4.28 What happens is P regains capacity?

In certain circumstances P may lose capacity temporarily, for example due to an infection or injury. The Attorney can activate the LPA in order to manage P's affairs or to make treatment decisions. If P subsequently appears to have regained capacity, the attorney must request a capacity assessment. If P is assessed to have capacity the attorney must notify HM Greffier that the LPA is suspended and the Register will be updated. The attorney can no longer make decisions for P. If the capacity assessment concludes that P lacks capacity the LPA will not be suspended.

4.29 Revoking a Lasting Power of Attorney
P can make revoke the LPA after this has been registered. P will need to complete the prescribed form. As with creating a LPA, P will need to attend in person at HM Greffier to make the changes. Any changes can only be made whilst P has capacity to do so. The Register will be updated.

4.30 Register of Lasting Powers of Attorney
Her Majesty's Greffier will hold a register of Lasting Powers of Attorney. This register will include the following information:

a) Name and address of grantor
b) Type of Lasting Power of Attorney – health and welfare decisions or property and finance decisions
c) Name and address of each Attorney
d) Date of registration
e) Date of activation
f) Date of suspension (as appropriate)
g) Whether the attorneys (where there is more than one)should act jointly or jointly and severally

4.31 A professional who needs to check whether a Lasting Power of Attorney has been registered, activated or suspended, can apply to HM Greffier for this information. The attorney should provide a copy to a health or social care professional to confirm that they have authority to make decisions for P.

4.32 Fees
The fee to register or amend a lasting power of attorney must be paid before the document can be registered or amended. HM Greffier will advise of the fee.

4.33 Gifts
A lasting power of attorney for property and financial affairs can make gifts similar to how P would have made gifts when P had capacity to do so. This would include birthday presents to relatives or friends, or on the occasion of a marriage or civil partnership or for charitable donations. Such gifts should be in keeping with the size of P's estate and not of an unreasonable value. This should be in keeping with the presents that P has previously given. The purpose of any gifts should not be to dispose of P's property.

4.34 Real property
A lasting power of attorney does not permit the attorney to dispose of P's real property where the person lacks capacity to make this decision. The attorney will need to advise all other attorneys if they wish to dispose of the property and make application to the relevant court (the Court of Alderney, the Court of Seneschal or the Royal Court). If the attorney sells P's real property without the permission of the relevant court A is guilty of an offence. Disposing of P's property includes selling or

otherwise conveying the property, creating a charge over the property, granting a long lease or granting anyone a life interest in the property.

4.35 Powers of court
The Law allows for the Court to make decisions regarding the validity of a lasting power of attorney. The Court can consider whether the requirements to create a lasting power of attorney have been met, as well as whether the LPA has been revoked. The Court can rule that a lasting power of attorney should not be registered, for example if it is satisfied that fraud or undue pressure was used to force P to create the LPA or if the person lacks capacity to make this.

4.36 The Court has the power to give direction regarding decisions that the attorney has the power to make. This may apply where there are two or more attorneys and there is a conflict of opinion as to what is in P's best interests. The Court can order the attorney to produce reports or accounts, or other documents. The Court may also authorise gifts which are not agreed under S26(2) of the Capacity Law.

4.37 The Court can order that an attorney may not use the lasting power of attorney or can only make specific decisions, for a limited period to allow time for the Committee to investigate any concerns raised. This includes investigating whether fraud or pressure was used to persuade P to make a LPA or if it is believed that the attorney has acted fraudulently or applied undue pressure to P.

4.38 Bankruptcy
If P is made bankrupt, this revokes any lasting power of attorney for property and financial affairs, although this does not have any effect if the LPA is for health and welfare decisions. If the attorney is made bankrupt A can no longer act under an LPA for property and financial affairs and A's appointment will be terminated (see 8.8).

4.39 Divorce, annulment or dissolution of marriage or civil partnership
If P names P's spouse or civil partner as attorney and later they divorce, this will end the spouse or civil partner's appointment unless specifically stated otherwise in the LPA. If P names their spouse or civil partner as one of only two attorneys and they are to act jointly, divorce will revoke the Lasting Power of Attorney.

4.40 What happens if A loses capacity?
If the attorney loses capacity to make decisions for P, the LPA will be revoked unless more than one attorney has been appointed and the document allows for the A to act jointly and severally. HM Greffier should be notified that the relevant A is no longer eligible to act.

4.41 Disclaimer by an attorney
If an attorney no longer wishes to act under the Lasting Power of Attorney, they do not have to continue however, it is essential to inform the Grantor, any other attorney(s) and HM Greffier, using the prescribed form. The replacement attorney should also be informed if there is only one attorney.

4.42 Replacement attorneys
If the LPA includes a replacement attorney this person can replace an attorney who is no longer able to act under S39, 40 or 41 Code of Practice. The replacement attorney must advise HM Greffier of this change.

4.43 The Law provides powers for the Committee to investigate whether fraud or undue pressure was used, either to persuade a person to create or register a lasting power of attorney, or to activate this. If the investigation concludes that an attorney behaved, or intends behaving in a way that is not in P's best interests or that is not within A's authority, an application can be made to the Royal Court to revoke the attorney's appointment.

4.44 The Committee can require an attorney to provide information or documents as required, in order to carry out an investigation. Such documents must be provided within any period specified by the Committee.

4.45 If a person makes a false, misleading or deceptive statement or produces false, misleading or deceptive information in connection with an investigation, this is an offence under the Law. This carries a sentence of up to 2 years imprisonment or a fine. It is an offence for an attorney to fail to disclose any relevant information. Such failure will also revoke the LPA.

4.46 Expenses
An Attorney under an LPA for property and financial affairs can reimburse any reasonable expenses incurred in the course of managing P's affairs.

4.47 Keeping Accounts
It is advisable for attorneys to keep accounts of all financial transactions made on behalf of P, under a Lasting Power of Attorney for Property and Financial Affairs.

4.48 Death of P
The Lasting Power of Attorney expires upon P's death. The attorney should advise HM Greffier of P's death so that the register can be updated.

5. Protection from liability

5.0 The Law provides protection to carers and to health and social care staff providing care and treatment to P, if they are acting in P's best interests under section 8 of the Capacity Law. This includes where P cannot make their own decision about their care or treatment, or consent to another person providing care to them.

5.1 This section of the Law covers everyday tasks such as assisting P with personal care, as well as more serious matters such as medical treatment decisions or arranging for P to be admitted to a care home.

5.2 Every person has the right to a private and family life and to stop others from interfering with their body or property unless they give permission. Where P lacks capacity to make their own decision, they may still need support from another person with, for example their personal care or to eat. Section 8 of the Law provides protection from liability to carers and professionals who carry out these actions, provided that they follow the principles of the Law.

5.3 By protecting family and other carers from liability, the Law allows necessary caring acts or treatment to take place. This is the same as it would be if P had capacity to consent to the relevant care or treatment.

5.4 Section 8 does not give carers or professionals the power to make any other decisions on behalf of P. Instead, it offers protection from liability so that they can act in connection with P's care or treatment. The power to make decisions on behalf of someone who lacks capacity can be granted through other parts of the Law, for example as part of a best interests decision or by an attorney under a relevant Lasting Power of Attorney.

5.5 If people carry out actions in a way which does not comply with section 8 – for example by making a decision or performing an act which is not in the person's best interests – then they may be held liable for any consequences.

5.6 Actions which are covered by section 8 include:

- help with washing, dressing or personal hygiene
- help to eat and/or drink
- help with communication
- help with mobility
- helping P to take part in education, social or leisure activities
- going into P's home to drop off shopping or to check on their safety
- doing the shopping or buying necessary goods with P's money (this does not include access to P's bank account, which would require legal authority)
- arranging household services (for example, arranging repairs or maintenance)

- providing services that help P in the home (such as cleaning or providing meals)
- carrying out healthcare diagnostic examinations and tests
- providing professional medical, dental and similar treatment
- giving medication
- taking someone to hospital for assessment or treatment
- providing nursing care (whether in hospital or in the community)
- carrying out any other necessary medical procedures (such as taking a blood sample) or therapies (for example, physiotherapy or chiropody)
- providing care in an emergency.

5.7 A person providing care or treatment is only protected from liability if they:

- have first taken reasonable steps to establish whether P lacks capacity to make the relevant decision
- reasonably believe that P lacks capacity and
- believe that the act is in P's best interests.

5.8 What are the necessary reasonable steps?
The carer or relevant professional may need to undertake their own assessment of P's capacity or there may be a relevant capacity assessment, which can be relied upon. Some acts in connection with care or treatment may cause major life changes with significant consequences for P. Those requiring particularly careful consideration include:

- admission to a care home or nursing home
- restriction of contact with certain people
- major decisions about healthcare and medical treatment
- administration of 'covert' medication or treatment
- administration of medication or treatment against a person's known wishes

as these decisions are likely to represent a serious interference with the person's rights under the European Convention on Human Rights.

5.9 A detailed record of the decisions taken should be made to ensure that the decision maker has considered all the matters necessary to be able to rely upon the defence in section 8 of the Law.

5.10 Change of accommodation
If P cannot be safely supported to live in their own home, and they may have to move (for example to move into a care home or nursing home), steps should be taken to support P to make their own decision if they have capacity to do so. If P is assessed to lack capacity to consent to a proposed move, the decision maker must consider all the available options, to decide which of these is in the person's best interests. The decision maker must follow the principles of the Law and the guidance in chapter 3 Code of Practice, including consulting with others involved in P's care and, where appropriate, instruct an Independent Capacity Representative.

5.11 Section 9 of the Law places limits on the use of force or restraint by only permitting restraint to be used where this is necessary to protect the person from harm and is a proportionate response to the risk of harm. This includes, for example, the use of restraint to transport P from P's home to a care home. Any action taken to move the person concerned or their property could incur liability unless protected under section 9.

5.12 Restricting contact with other people

In some circumstances, it may be necessary to restrict or supervise contact between P and another person(s). If contact is to be restricted or supervised in circumstances where P wants to see the other person(s), this is likely to involve an interference with P's right to respect for their private and family life under Article 8 of the European Convention on Human Rights. Any such interference must be necessary and proportionate to the risks which P would otherwise be exposed to. This must be referred to the Mental Health and Capacity Review Tribunal to decide whether the restriction on contact is necessary and can be authorised.

5.13 Case Law example Steven Neary

Steven Neary[23] was a young man diagnosed with a learning disability and autistic spectrum disorder, who was living with his father. Steven could present with behaviour that challenged. He was also reported to be very overweight as food was often used as a reward for good behaviour. He had a support package including carers, who had known him for several years, attendance at day services and use of respite care. In 2009, Mr Neary was unwell and struggling to manage and he requested respite for a few days. Steven was admitted first to a respite unit and then to a behavioural support unit. His father never intended this to be other than a short-term arrangement however the local authority social work department refused to let Steven return home, despite his expressed wishes to do so, and in conflict with his father's wishes to have him back home.

5.14 After many delays, the case was eventually referred to the Court of Protection. The judge ruled that the local authority had breached Steven's Article 8 of the European Convention on Human Rights, to respect the right for family life. The judge, in his ruling, quotes an earlier ruling[24] which states at para 116: "*We have to be conscious of the limited ability of public authorities to improve on nature. We need to be careful not to embark upon 'social engineering'. And we should not lightly interfere with family life. If the State – typically, as here, in the guise of a local authority – is to say that it is the more appropriate person to look after a mentally incapacitated adult than her own partner or family, it assumes, as it seems to me, the burden – not the legal burden but the practical and evidential burden – of establishing that this is indeed so. And common sense surely indicates that the longer a vulnerable adult's partner, family or carer have looked after her without the State having perceived the need for its intervention, the more carefully must any*

[23] London Borough of Hillingdon v Neary & Anor [2011] EWCOP 1377 (09 June 2011)
[24] Re S (Adult Patient)(Inherent Jurisdiction: Family Life) [2002] EWHC 2278 (Fam)

proposals for intervention be scrutinised and the more cautious the court should be before accepting too readily the assertion that the State can do better than the partner, family or carer."

5.15 Steven was eventually able to return to live with his father, although this was nearly a year after he had been admitted to the support unit. There were other issues raised by this case in connection with the deprivation of his liberty. However, this also clarified that any interference with Article 8 cannot be authorised under the best interests process and must be considered by a Court or by the Tribunal.

5.16 Healthcare and treatment decisions

Section 9 allows actions to be taken to ensure that P receives necessary medical treatment, where P does not have a Lasting Power of Attorney for Health and Welfare. This includes taking P to hospital for out-patient treatment, arranging for admission to hospital for treatment and providing medication, including covert administration. If P is objecting to the proposed treatment or admission to hospital, this can be provided if -

(i) P has not made a valid and applicable Advanced Decision to Refuse Treatment, and

(ii) the best interests process and the principles of the Capacity Law have been followed and applied.

Case example – treatment against P's wishes

Ms Mary Silver was diagnosed with schizo-affective disorder when she was in her twenties. She is now 70 and has a long history of violent and public disorder offences, many of which have been committed when she has not been taking her medication. Ms Silver has served jail sentences as well as having multiple admissions to hospital under the Mental Health Law. She has constantly denied having any mental health difficulties and therefore has refused to take prescribed medication. Ms Silver has been admitted to a psychiatric nursing home, following her discharge from hospital. A Protective Authorisation has been granted prior to her admission. Whilst in hospital medication had been administered covertly to ensure compliance and it is noted that her mental health is more stable now. Ms Silver has been assessed to lack capacity to make her own decision about her medication and a decision has been taken, including the GP as decision maker, that it is in her best interests for medication to be administered covertly. This is considered to be the less restrictive option, as failure to take this may result in significant decline in her mental health, and potentially readmission to hospital under section of the Mental Health Law.

5.17 In some situations, it may be necessary to use force or restraint to provide necessary treatment. For clarification on the use of restraint please refer to Chapter 3 Code of Practice, however, any action intended to restrain P will not attract protection from liability under section 9 unless –

(i) the person taking action reasonably believes that restraint is necessary to prevent harm to P, and
(ii) the amount or type of restraint used and the amount of time it lasts is a proportionate response to the likelihood and seriousness of harm.

5.18 It should be noted that the common law allows for necessary and proportionate steps to be taken to prevent the immediate risk of serious harm to another person. Restraint for these purposes should always be used for the shortest period possible to enable the de-escalation of the situation or to provide the necessary treatment.

5.19 To comply with the Law and to provide protection from liability, consideration should always be given to P's wishes and views. If P, or P's relative, is objecting to the proposed treatment, but failure to provide the proposed treatment may result in P's death, the decision maker should refer this to the Court to make the decision.

5.20 Emergency Situations
If P requires urgent or emergency medical treatment to save their life or to prevent serious harm, this should be provided without unnecessary delay. The only exception to this is if there is a relevant and valid Advance Decision to Refuse the Treatment required. See Chapter 5.

5.21 Advance decisions and protection from liability
If healthcare staff are satisfied that an ADRT is valid and applies to the proposed treatment, they are not protected from liability if they give any treatment that goes against it. Healthcare staff are protected from liability if they did not know about an advance decision or if they are not satisfied that the advance decision is valid and applies in the current circumstances.

5.22 What limits are there on protection from liability?
The key areas where acts might not be protected from liability are where there is inappropriate use of restraint or where P is deprived of their liberty without authorisation under the Protective Authorisation Scheme. If there is a difference of opinion between family and clinicians about life sustaining treatment or where the decision is finely balanced, this must be referred to the Royal Court. The treating healthcare professional is not protected from liability in such situations as it is for the Court to rule on whether treatment continues or is withdrawn.

5.23 What is 'harm'?
The Law does not define 'harm'. This will vary depending on the situation. P may be at risk of injury from traffic due to poor road sense or be at risk of malnutrition as they are not eating well. P may no longer remember where they live or be aware of the

time of day. P may go out at night inappropriately dressed and with no awareness of potential risks. Risk assessments and care plans should take account of the risks to P and what can be done to mitigate these risks. Any responses to reduce risks should be proportionate to the risk of harm.

5.24 What is a 'proportionate response'?
The Law requires that any intervention should be the least restrictive option necessary and therefore that this is proportionate to the risk of harm. Where there are restrictions applied, these should be the least intrusive necessary to maintain P's safety. Any restraint used should only be the minimum required for the shortest possible time.

Case example

Angus Evans is 19 years old and has a severe learning disability. He has recently moved into supported accommodation and has support workers with him at all times. Angus has very limited awareness of risks and has previously burnt himself on the cooker. The kitchen in his accommodation is locked and he is only able to access this with his support workers, so that they can ensure that he does not touch the cooker when it is hot. This way the risk of harm is reduced. This is a proportionate response as a burn could be serious, but Angus is not prevented from ever going into the kitchen. It would not be proportionate to completely deny him access to the kitchen of his home.

5.25 Negligence
Section 8 of the Law does not provide a defence in cases of negligence – either in carrying out a particular act or by failing to act where necessary. For example, a doctor may be protected against a claim of assault for carrying out an operation that is in P's best interests. However, if the doctor performs the operation negligently, they would not be protected from a charge of negligence. This way any person who lacks capacity to consent to treatment has the same rights in cases of negligence as someone who has consented to treatment.

5.26 How does section 8 apply to attorneys?
Section 8 does not provide protection for actions that go against the decision of an attorney under a Lasting Power of Attorney.This means that if someone goes against the decision of an attorney acting under a valid and activated Lasting Power of Attorney, that person will not be protected under the Law.

5.27 Attorneys must only make decisions within the scope of the authority of the LPA. Sometimes carers or healthcare and social care staff might feel that an attorney is making decisions they should not be making, or that are not in a person's best interests. If this is the case, and the disagreement cannot be settled any other way, the staff should raise this as a safeguarding concern so that this can be investigated. If the dispute concerns the provision of medical treatment, this may

need to be referred to the Royal Court. Whilst this is being considered, medical staff can still give life-sustaining treatment, or treatment which stops P's condition deteriorating further.

5.28 Keeping records

Staff involved in the care of P should make sure they keep a record how they have worked out what is in P's best interests. Appropriately detailed records should be kept of decisions made. For health and treatment decisions, it is the responsibility of the professional proposing the specific treatment to decide what is in P's best interests (see chapter 3) and they should record not just the decision made but how this was reached and the reasons for this, including the views of others. This should be recorded in P's clinical notes. As long as they have recorded objective reasons to show that the decision is in P's best interests, and the other requirements of section 8 of the Act are met, all healthcare staff taking actions in connection with the particular treatment will be protected from liability.

Who is protected from liability by section 8?

5.29 Section 8 of the Law affects:

- family and other carers
- care workers
- healthcare and social care staff
- others who may occasionally be involved in the care, treatment or support for P, such as ambulance staff, housing workers, police officers

5.30 At any time, it is likely that several people will be carrying out tasks that are covered by section 8 of the Law. Section 8 does not:

- give one person more rights than another to carry out tasks
- specify who has the authority to act in a specific instance
- allow somebody to make decisions relating to subjects other than the care or treatment of the person who lacks capacity, or
- allow somebody to give consent on behalf of a person who lacks capacity to do so.

5.31 To receive protection from liability under section 8, all actions must be related to the care or treatment of the person who lacks capacity to consent. Before taking action, carers must first reasonably believe that:

- the person lacks the capacity to make that particular decision at the time it needs to be made, and
- the action is in the person's best interests

5.32 Care, support and treatment planning
The preparation of a care and support or treatment plan should always include an assessment of P's capacity to consent to the actions covered by the care and support plan. If P is assessed to lack capacity to consent to the care or treatment plan a record should also be kept of the decision that the plan is in P's best interests. Staff acting in accordance with the care and support plan will be protected from liability under section 8. P's capacity and best interests must still be reviewed and recorded regularly.

5.33 What steps should people take to be protected from liability?
To be protected from liability, staff and professionals as well as informal carers should follow the key principles set out in section 3 of the Law. They should also take all reasonable and practicable steps to establish whether P has capacity to make their own decision. The person proposing the care, treatment or action must have reasonable grounds for believing that the action is in the best interests of P. They should:

- consider whether P is likely to regain capacity to make this decision in the future, e.g. can the decision be delayed?
- consider whether a less restrictive option is available and
- have objective reasons for thinking an action is in the best interests of the person who lacks capacity to consent to it.

5.34 What is a reasonable belief?
Carers are not expected to be experts in assessing capacity, however they must be able to show that they have taken reasonable steps to find out if P has capacity to make the specific decision and that they have a reasonable belief that P lacks capacity in relation to that matter. Formal assessments may not always be required, but in some circumstances, these should be carried out (for example, where consent to medical treatment is required, the doctor will need to assess and record P's capacity to consent). Under section 8, carers and professionals will be protected from liability as long as they are able to provide objective reasons that explain why they believe that P lacks capacity to consent to the proposed care or treatment.

5.35 Carers, relatives and others involved in caring for someone who lacks capacity must have reasonable grounds for believing that their action is in the P's best interests. They must not simply impose their own views. They must be able to show that they considered all relevant circumstances and have followed the Law. This includes showing that they have tried to involve the person who lacks capacity, and find out their wishes and feelings, beliefs and values. They must also have asked other people's opinions, where practicable and appropriate. If somebody challenges their decision, they will be protected from liability if they can show that it was reasonable for them to believe that their action was in P's best interests.

5.36 If healthcare and social care staff are involved, their skills and knowledge will affect what is classed as ‘reasonable’. For example, assessing capacity is a core clinical skill, so doctors will be expected to show a better understanding of how to assess capacity to consent to care and treatment than someone without medical training. They should also record in P’s healthcare record the steps they took and the reasons for their conclusions. Healthcare and social care staff should apply clinical and professional standards when deciding what treatments to offer. They must then decide whether the proposed treatment is in the best interests of P. This includes considering all relevant circumstances following section 6 of the Law.

6. Payment for goods and services

6.0 The Capacity Law allows for expenditure on behalf of a person who lacks capacity. If P has money in their possession, this can be used to cover the costs. This includes a carer using P's money for the purchase of food or other day to day items, which are necessary for P. A person who lacks capacity to manage their financial affairs may still be able to withdraw money from their bank account to cover necessary expenditure. Records should be kept of such expenditure. This section does not apply where there is a Lasting Power of Attorney with authority to manage P's financial affairs.

6.1 Who can pay for goods and services?

Whenever a person agrees to buy goods or services, a contract is formed. Such contracts can cover everyday matters, such as buying clothes in a shop or arranging for take-away food order to be delivered. In general, a contract that is entered into by a person who lacks capacity to make the contract cannot be enforced if the other person knows, or should have known, that P lacks capacity. Section 10 of the Law states that where 'necessary' goods or services are supplied to a P who lacks capacity to enter into the contract, they must be charged a reasonable price for these items.

6.2 What are necessary goods and services?

Necessary means something that is suitable to P's condition in life (P's place in society, rather than any mental or physical condition) and P's actual requirements when the goods or services are provided. The aim is to make sure that P can continue to enjoy a similar standard of living and way of life to that which they had before they lost capacity. This section of the Law covers accommodation costs as well as the purchase of items for P.

6.3 Payment for permitted acts

If it is necessary to make payment for an act, allowed under the Law, then the person doing this act (D) can either pay for this using money that P has in their possession or to authorise that this payment will be made. If D has made the relevant payment from their own money, they can be reimbursed out of money held by P or repaid by a person who manages P's financial affairs.

6.4 How should payments be made?

Where P has entered into a contract for the supply of necessary goods and services, their attorney under a Lasting Power of Attorney for property and affairs will be required to pay any money that is owed under the contract on P's behalf, for example payment of rent. If P does not have an attorney for property and affairs, it may be necessary to apply for a Guardian to manage P's finances and to make the necessary payments.

6.5 Expenditure in connection with care and treatment

Sometimes an act in relation to the care or treatment of P may involve a cost. For example, a carer might buy food for P, if P is unable to go to the shops. The carer must take reasonable steps to decide whether P lacks capacity to make the decision or do the act for themselves. If so, the carer must decide whether the decision or the act in question relates to P's care or treatment and whether it is in their best interests.

6.6 Paid carers may need to check with their employer as to whether there are any restrictions on handling service users' money. The carer does not have any right to access a bank or building society account belonging to P. Carers should keep bills, receipts and other proof of payment when incurring expenditure on P's behalf. They will need these documents when requesting reimbursement.

6.7 Access to a person's assets

The Law does not give a carer or care worker, or P's family, access to P's income or assets. Nor does it allow them to sell P's property. Anyone wanting access to money in P's bank will need formal legal authority. Such authority can be given by P in a Lasting Power of Attorney whilst P still had capacity or by the Court under Guardianship.

7. Powers of the Court and the Tribunal

7.0 This chapter covers the role of the Court and the Mental Health and Capacity Review Tribunal ("the Tribunal") in relation to people who lack capacity. It covers who can make an application to the Court or the Tribunal and when such applications should be made.

7.1 What decisions can the Court and the Tribunal make?
The Court or the Tribunal can be asked to rule whether a person has capacity to make a specific decision. This would apply where there is a dispute as to whether P has capacity to make a specific decision. It would be particularly relevant where the outcome would have a significant impact on P or P's life. The role of the Court in such cases would be to decide whether P has, or whether P lacks capacity to make their own decision on the matter. If it is decided that P lacks capacity, the Court can make the relevant decision on behalf of P. The Court can consider matters relating to P's health and welfare and to P's property and financial affairs.

7.2 The Court and the Tribunal can rule on the following matters:

- where P should live
- whether P has contact with specific individuals
- whether to prevent a person or persons having contact with P
- whether a specific treatment should be carried out or continued for P
- a Protective Authorisation
- transferring responsibility for P's health care to another person
- dealing with P's property, including the management and sale of this
- the purchase or rent of property for P
- managing P's business, including dissolving a legal partnership
- dealing with P's debts
- the conduct of legal proceedings for or on behalf of P

Additionally, the Court can make decisions regarding:

- the execution of a will for a P aged 18 or over
- whether an advanced decision to refuse treatment is valid and relevant to proposed treatment
- any other matters related to P's health welfare

The Tribunal can also make decisions regarding:

- any other matters related to P's health and welfare.

7.3 The Mental Health and Capacity Review Tribunal can refer matters to the Court if the members believe that it is in the interests of justice to do so.

7.4 Making an application to the Court or the Tribunal
The following can apply to the Court or Tribunal under the Law without requiring any further permission from the Court or Tribunal:

- A person who lacks or is believed to lack capacity
- A parent or person with parental responsibility for a person aged 16 or 17, who lacks capacity
- A grantor or attorney under a lasting power of attorney
- A guardian appointed by a court
- A person named in an order by the court or the Tribunal, where that order is relevant to the application
- P's representative under a Protective Authorisation
- An ICR appointed as P's representative under a Protective Authorisation

Any other person wishing to apply to the Court or Tribunal for the exercise of its powers under the Law will need permission from the Court or the Tribunal to do so. Permission may be granted on the basis of factors including the applicant's connection with the person to whom the application relates, and the benefit to that person if the application is granted.

7.5 How to make an application to the Court or Tribunal
Applications must be made in accordance with rules of court made by the Court under section 83 of the Capacity Law.

7.6 Is legal aid available?
For most cases legal aid will not be available. The exception is for an application under section 69 of the Capacity Law to challenge a Protective Authorisation or for decisions about withdrawal of life sustaining treatment.

7.7 What kind of cases cases can be referred to the Tribunal or the Court?
It is advisable to seek legal advice as to whether a case should be brought; however, there are some cases where it is likely to be necessary to apply to the Court or Tribunal. These include, for example, complex decisions about the person's treatment where there is no agreement between family and clinicians, or where P is subject to a Protective Authorisation, but is objecting to the arrangements for their care. Any decision to restrict contact between P and another person or persons must always be brought before the Tribunal or Court, as this constitutes interference with Article 8 of the European Convention on Human Rights.

7.8 Before an application is made consideration should be given as to whether there is any other way that the matter can be resolved:

- Can the matter can wait until the person recovers capacity and is able to take the decision for themselves?

- Is this the simplest and most appropriate legal way to address this person's needs?
- Can the purpose which the applicant has in mind be as effectively achieved in another way, which is less restrictive of the person's rights and freedom of action?
- if relevant, does the person still have capacity to complete an LPA or advance decision?
- can what is proposed be lawfully and appropriately be done in the person's best interests under section 6 of the Law?
- is there anyone such as an attorney or guardian who already has authority to make this decision for the person?
- is there another legal route which could be used, such as the Mental Health Law or guardianship?
- is this the only way to resolve the matter. Is there a possibility of mediation? Would the appointment of an Independent Capacity Representative help?

7.9 Examples of cases

Type of case	**Dispute over place of residence**	**Suitability of attorney**	**Dispute over contact with another person(s)**
Can the Court or Tribunal deal with the matter?	The Tribunal may decide where P should live.	The Court may revoke the appointment of an attorney.	The Court may decide contact issues with another person (Y)
The Committee's submission	It is in P's best interests to reside in a particular care home rather than in P's own home.	It is in P's best interests for the attorney (A) to no longer act on P's behalf under the LPA.	It is in P's best interests not to have unsupervised contact with Y
The Committee is seeking to alleging or seeking to prove	P was at high risk of harm at home and would not be safe to return there.	A has been misusing P's money (not acting in P's best interests).	Y has physically abused P.
The evidence to support the allegations	P has had several hospital admissions due to injury from falls, dehydration and unintentional overdose of prescribed medication.	Bank statements and failure to explain financial transactions.	P has sustained bruising when Y has been visiting. Carers observe that P appears afraid of Y.

Possible alternative explanation	P's carers have not been visiting or carrying out their duties. P could manage at home with appropriate support.	P owed A the money. P gave A the money.	P's skin bruises easily. There is no evidence that Y is the only person that could have caused the injury. P appears fearful of many people, not only Y.
Evidence of any less restrictive options.	Arrange alternative carers.	Allow A to continue as A as there is no evidence of dishonesty.	The relationship is important to P and in P's best interests to continue to have contact.

7.10 When should an application be made to the Tribunal to challenge a Protective Authorisation under section 69?

Although some people are quite happy to move to a care home, or to live with restrictions in their own home, others will object to the relevant arrangements. In such cases, it is the role of P's representative to consider whether an application should be made to the Tribunal to challenge the arrangements which have resulted in the Protective Authorisation being granted. The following guidance applies:

a) The representative must consider whether P wishes, or would wish to apply to the Tribunal. This involves the following steps:

- Consider whether P has capacity to ask to issue proceedings. This simply requires P to understand that they should not be subject to the current care arrangements. It is a lower threshold than the capacity to conduct proceedings.
- If P does not have such capacity, consider whether P is objecting to the arrangements for their care, either verbally or by behaviour, or both, in a way that indicates that P would wish to apply to the Tribunal if P had the capacity to ask.

b) In considering P's stated preferences, regard should be had to:

- any statements made by P about their wishes and feelings in relation to issuing proceedings,
- any statements made by P about their residence in care,
- P's expressions of their emotional state,
- the frequency with which P objects to the placement or asks to leave,
- the consistency of P's express wishes or emotional state; and
- the potential alternative reasons for P's express wishes or emotional state.

c) In considering whether P's behaviour constitutes an objection, regard should be had to:

- the possible reasons for P's behaviour,
- whether P is being medicated for depression or being sedated,
- whether P actively tries to leave the care home,
- whether P takes preparatory steps to leave, e.g. packing bags,
- P's demeanour and relationship with staff,
- any records of challenging behaviour and the triggers for such behaviour.
- whether P's behaviour is a response to particular aspects of the care arrangements or to the entirety of those arrangements.

d) When considering whether to make an application, it is important to recognise that:

- there could be reason to think that P would wish to make an application even if P says that they do not wish to do so or,
- alternatively, reason to think that P would not wish to make an application even though P says that they do wish to,

since P's understanding of the purpose of an application may be very poor.

e) If P does not express a wish to challenge the Protective Authorisation, the representative can still apply to the Tribunal to determine:

- whether P continues to meet all of the requirements for a Protective Authorisation
- whether the period of the authorisation or the conditions subject to which the authorisation is given are contrary to P's best interests;
- whether the purpose of the authorisation could be as effectively achieved in a way that is less restrictive of P's rights and freedom of action.

f) The consideration of P's circumstances must consider all aspects of P's situation and should be based on more than one meeting with P, as well as discussions with P's carer(s), P's family and friends.

g) An alternative to applying to the Tribunal may be to request a review by the Capacity Professional under section 68 of the Law, or to work collaboratively with the Committee to see whether alternate arrangements can be put in place to meet P's needs. Such measures should not, however, prevent an application to the Tribunal being made where it appears that P would wish to do so under section 69 of the Law.

Scenario – challenging a Protective Authorisation

Mr Alfred Bluett was living in his own home quite independently however, he had a fire in the house, rendering it uninhabitable. He was admitted to a care home on a temporary basis to keep him safe, whilst repairs are completed to his house. Mr

Bluett has been diagnosed with dementia although this is not very advanced and he can make some basic decisions for himself. He accepts initially that he cannot live in his house until the repairs are completed. Mr Bluett's nephew is his attorney and decides that it would be in his uncle's best interests to stay in the care home, rather than returning home. He thinks that it would be better to sell his uncle's home to pay the care home fees rather than spending money on the repairs. The social worker allocated to Mr Bluett submits the relevant assessments for a Protective Authorisation as part of the application to place him in the care home. As Mr Bluett's nephew does not live in Guernsey, an Independent Capacity Representative is appointed as his representative.

The ICR appointed as representative visits Mr Bluett who is very distressed that there has been no progress on him returning home. He is adamant that he does not wish to stay in the care home. The ICR contacts Mr Bluett's nephew and attorney who advises that he is planning on selling the house and for his uncle to stay in the care home.

The ICR speaks with Mr Bluett who says that he wishes to make a legal challenge to the Protective Authorisation. The ICR agrees that the application should be made, given how strongly Mr Bluett feels about his situation and because potentially there is a less restrictive option available, which would be for him to return home. The ICR, as representative, makes the relevant application to the Tribunal.

7.11 What decisions cannot be made by the Court or the Tribunal?

The Court and the Tribunal cannot make any decisions on behalf of a person who has the capacity to make that decision. It can, however, declare that the person has that capacity, which can be important if there is a dispute. If there is concern about the welfare or interests of a person who has capacity to make the relevant decisions, but reasonably appears to be vulnerable, then an application may need to be made to the Royal Court under the inherent jurisdiction (see 7.19 below)

7.12 Neither the Court nor the Tribunal can decide on behalf of a person whether to accept or refuse medical treatment for mental disorder using the Capacity Law, where that person is detained under the Mental Law 2010.

7.13 The Court and the Tribunal can only decide on the options actually available to P. They cannot create options that are not available, for instance where the Committee has decided that it cannot provide a particular care package the Tribunal cannot order the Committee to do so. Similarly, where clinicians consider that a particular treatment is not on offer (whether because it is not clinically appropriate or for some other reason) neither the Court nor the Tribunal can require them to provide that treatment. However, in both situations the judge can test the reasons that the treatment or care package are not on offer to P.

7.14 Medical treatment decisions

In some cases, the Court or the Tribunal must be asked to make the relevant decision in order to secure P's rights under the European Convention on Human Rights. In particular, the Court must be asked to make the decision on behalf of the person as to whether or not to agree to life-sustaining medical treatment where:

- the decision is finely balanced
- there is a difference of medical opinion; or
- there is a lack of agreement as to the proposed course of action from those with an interest in the person's welfare.

7.15 Where the treatment is to be carried out against the patient's known wishes, feelings, beliefs or values, medical professionals should consider and document:

- on what basis they can properly say that they reasonably believe the treatment is in the person's best interests,
- whether they have considered all other options which are less restrictive,
- whether delivery of the treatment will require the use of physical force, and, if so, whether this will require the authority of the Court.

7.16 Other cases

In any other case where there is doubt or disagreement between those interested in P's welfare which cannot be resolved, the Court should be asked to make the decision on P's behalf if it is believed that they do not have capacity to make the decision. Key decisions include where P should live and who P should see, but this principle applies to any significant issue involving P's welfare.

7.17 What powers does the court have in relation to Lasting Powers of Attorney?

The Court can determine the validity of an LPA and can give directions as to how an attorney should use their powers under an LPA. In particular, the court can revoke an LPA and end the attorney's appointment. The Court might do this if the attorney is not carrying out their duties properly or not acting in the best interests of the grantor.

7.18 Where can people get legal advice?

You do not need an Advocate to make application to the Court or the Tribunal, but it might be helpful for you to take legal advice before you do so. Legal advice may be given by Advocates in relation to any application under the Capacity Law, although legal aid may not be available. It may also be possible to discuss your situation with the Citizens' Advice Bureau or a charity (e.g. MIND), although they will not be able to give you legal advice.

7.19 What happens to vulnerable adults when the Capacity Law does not apply?

The Capacity Law only applies to people who lack capacity to make their own decision due to an impairment of, or a disturbance in the functioning of the mind or

the brain. If there are concerns raised about a vulnerable adult, who has been assessed to have capacity to make their own decision, the Capacity Law cannot be used to make the relevant decision. In such cases, the inherent jurisdiction may be used by the Royal Court, if it is considered necessary to intervene.

7.20 What is the inherent jurisdiction?
The inherent jurisdiction is the ability of the Royal Court to make declarations and orders to protect adults who have capacity to make their own decisions, but who are considered to be vulnerable and at risk, due to the actions, or lack of action, of other people.

7.21 Who is a vulnerable adult?
A vulnerable adult is a person *"who is or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation."*[25] *(Para 81)* It is important to note that the person is subject to undue influence and control by another person, rather than simply vulnerable due to any disability on its own.

7.22 In the same case decided in the English High Court[26] the judge commented "…*the inherent jurisdiction can be exercised in relation to vulnerable adult who, even if not incapacitated by mental disorder or mental illness, is or is reasonably believed to be, either (i) under constraint or (ii) subject to coercion or undue influence or (iii) for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent."(Para 77)*

7.23 When using the inherent jurisdiction to intervene in the life of a vulnerable adult who has capacity, the court must only impose orders that are necessary and proportionate. The Court must have proper regard to the personal autonomy of the individual, in accordance with the European Convention on Human Rights. In certain circumstances, it may be appropriate for the court to take or maintain interim protective measures while carrying out all necessary investigations.

7.24 An example of the use of the inherent jurisdiction is the case of BF, who was 97 years old and who had been living with his son, KF, in squalid conditions. KF suffered with drug and alcohol addiction and prevented professionals from entering the property to provide care or treatment to his father. There had been a long history of social work involvement and court hearings. In 2018, BF was admitted to a respite unit due to concerns for his welfare, although he wished to return home. This was referred to the court. He was assessed to have capacity to decide where he should live but his case was heard under the inherent jurisdiction, due to the concerns for Mr BF's welfare. The Judge stated that (Para 31) "*On any view, BF is a*

[25] A Local Authority v MA & Ors [2005] EWHC 2942 (Fam) (15 December 2005)
[26] A Local Authority v MA & Ors [2005] EWHC 2942 (Fam) (15 December 2005)

vulnerable adult. His age, blindness and other infirmities, combined with his traumatic experiences living in squalid and dangerous conditions at home, render him particularly vulnerable. He has an extremely complex relationship with his son, which, on the evidence which I have read, seems to me at least to have elements of the insidious, persuasive undue influence … He is, without question, a person who falls in the category of vulnerable adults for whom this expanded role of the inherent jurisdiction is intended." [27]

7.25 The case returned to Court in 2019 when the local authority sought a declaration that they had discharged their obligations to BF. The judge noted that BF had capacity to decide where to live, that he was not vulnerable merely by being blind and that he was not of unsound mind. This would ordinarily indicate that there were no grounds for the court to intervene and any choices made, including unwise decisions, would have to be respected however the judge stated (Para 41) *"KF's influence on his father is insidious and pervasive. It triggers [BF's] sense of duty, guilt, love and responsibility... In reality, KF exerts an influence over his father which is malign in its effect if not in its intention. The consequence is to disable [BF] from making a truly informed decision which impacts directly on his health and survival."*

7.26 He added *"Here [BF's] life requires to be protected and I consider that, ultimately, the State has an obligation to do so. Additionally, it is important to recognise that the treatment of [BF] has not merely been neglectful but abusive and corrosive of his dignity. To the extent that the Court's decision encroaches on [BF's] personal autonomy it is, I believe, a justified and proportionate intervention. The preservation of a human life will always weigh heavily when evaluating issues of this kind."*[28]

7.27 This judgment gives some clarity about the safeguarding obligations of public bodies and the need to comply with the positive duty under Article 2 of the European Convention on Human Rights 'the right to life'[29]. If life is at risk, there is an obligation not just to investigate, but also to take action, which may include seeking the authority of the court to intervene. Essentially the inherent jurisdiction provides the "great safety net"[30] which can support a vulnerable adult whilst ensuring that any such intervention is both necessary and proportionate.

7.28 The inherent jurisdiction can be used on an interim basis whilst further investigations are made as to whether the person's situation is such that the court should intervene.

[27] A Local Authority v BF [2018] EWCA Civ 2962 (21 December 2018
[28] https://www.bailii.org/ew/cases/EWHC/Fam/2019/399.html
[29] https://www.echr.coe.int/Documents/Guide_Art_2_ENG.pdf
[30] Re F (Mental Patient: sterilisation) [1990] 2 AAC 1

7.29 How should health and social care professionals act if there are concerns about a vulnerable adult?
It is important to follow the principles and sections 4 and 5 of the Capacity Law and to respect the right of a person, who has capacity, to make unwise decisions. As a starting point the relevant professional should assess the person's capacity to make their own decision. Consideration should be given to the 'causative nexus' (see chapter 2 Code of Practice). Is the reason that the person is unable to make their own decision to protect themselves because they have an impairment of, or disturbance in the functioning of the mind or brain, or is it because another person is exerting influence over them? If the inability to make the relevant decision is due to a mental disorder, then the Capacity Law applies. If it is due to the influence of another person, it may be possible to use the inherent jurisdiction.

7.30 If the person has been assessed to have capacity to make the relevant decision but they appear to be vulnerable, such that intervention may be required to protect them from harm, legal advice should be sought as to whether the inherent jurisdiction can be used. Consideration needs to be given to what order the court will be asked to make, to protect the person.

7.31 In these circumstances, the inherent jurisdiction will only be used where the Capacity Law does not apply. However, consideration should always be given to whether any other legislation can be used to resolve the particular situation.

7.32 Interference with the person's rights under Article 8, ECHR.
It is likely that an order made under the inherent jurisdiction will interfere with the person's rights to respect for private and family life. Consideration should therefore be given as to whether this is both necessary and proportionate and whether there is a less restrictive option that could maintain the person's safety.The Court will need to show that the aim of the order is to secure the person's right to life, their health or to free them from inhuman or degrading treatment

8. Disclosure of Information and confidentiality

What laws and regulations affect access to information?
8.1 People caring for, or managing the finances of, someone who lacks capacity may need information to:

- assess the person's capacity to make a specific decision
- determine the person's best interests, and
- make appropriate decisions on the person's behalf.

8.2 The information they need varies depending on the circumstances. For example:

- a daughter providing full-time care for an elderly parent will make decisions based on her own experience and knowledge of her parent
- an attorney under a Lasting Power of Attorney (LPA) may need information from other people. For instance, if they were deciding whether a person needs to move into a care home or whether they should sell the person's home, they might need information from family members, the family doctor, the person's bank and their solicitor to make sure they are making the decision in the person's best interests.

8.3 Much of the information needed to make decisions under the Act is sensitive or confidential. It is regulated by:

- the Data Protection (Bailiwick of Guernsey) Law, 2017
- the common law duty of confidentiality
- professional codes of conduct on confidentiality, and
- the Human Rights Act 1998 and European Convention on Human Rights, in particular Article 8 (the right to respect for private and family life), which means that it is only lawful to reveal someone's personal information if:
    - there is a legitimate aim in doing so
    - a democratic society would think it necessary to do so, and
    - the kind and amount of information disclosed is in relation to the need.

What information do people generally have a right to see?
8.4 Section 15 of the Data Protection (Bailiwick of Guernsey) Law, 2017 gives everyone the right to see personal information that an organisation holds about them. They may also authorise someone else to access their information on their behalf. The person holding the information has a legal duty to release it. So, where possible, it is important to try to get a person's consent before requesting to see information about them.

8.5 A person may have the capacity to agree to someone seeing their personal information, even if they do not have the capacity to make other decisions. In some situations, a person may have previously given consent (while they still had capacity) for someone to see their personal information in the future.

8.6 Doctors and lawyers cannot share information about their clients, or that clients have given them, without the client's consent. Sometimes it is fair to assume that a doctor or lawyer already has someone's consent (for example, patients do not usually expect healthcare staff or legal professionals to get consent every time they share information with a colleague – but staff may choose to get clients' consent in writing when they begin treating or acting for that person). But in other circumstances, doctors and lawyers must get specific consent to 'disclose' information (share it with someone else).

8.7 If someone's capacity changes from time to time, the person needing the information may want to wait until that person can give their consent. Or they may decide that it is not necessary to get access to information at all, if the person will be able to make a decision on their own in the future.

8.8 If someone lacks the capacity to give consent, someone else might still be able to see their personal information. This will depend on:

- whether the person requesting the information is acting as an agent (a representative recognised by the law, such as an attorney) for the person who lacks capacity
- whether disclosure is in the best interests of the person who lacks capacity, and
- what type of information has been requested.

When can attorneys ask to see personal information?

8.9 An attorney acting under a valid LPA can ask to see information concerning the person they are representing, as long as the information applies to decisions the attorney has the legal right to make.

8.10 In practice, an attorney may only require limited information and may not need to make a formal request. In such circumstances, they can approach the information holder informally. Once satisfied that the request comes from an attorney (having seen appropriate authority), the person holding information should be able to release it. The attorney can still make a formal request for information in the future.

8.11 The attorney must treat the information confidentially. They should be extremely careful to protect it. If they fail to do so, the court can cancel the LPA.

8.12 Requests for personal information must be in writing, and there might be a fee. Information holders should release it. Fees may be particularly high for getting copies of healthcare records – particularly where information may be in unusual formats (for example, x-rays). Complaints about a failure to comply with the Data Protection (Bailiwick of Guernsey Law, 2017 should be directed to the Data Protection Authority.

What limitations are there?

8.13 Attorneys should only ask for information that will help them make a decision they need to make on behalf of the person who lacks capacity. For example, if the attorney needs to know when the person should take medication, they should not ask to see the entire healthcare record. The person who releases information must make sure that an attorney has official authority (they may ask for proof of identity and appointment).

8.14 When asking to see personal information, attorneys should bear in mind that their decision must always be in the best interests of the person who lacks capacity to make that decision.

8.15 The attorney may not know the kind of information that someone holds about the person they are representing. So sometimes it might be difficult for them to make a specific request. They might even need to see all the information to make a decision. However, the 'best interests' principle still applies.

8.16 The attorney may also find that some information is held back (for example, when this contains references to people other than the person who lacks capacity). This might be to protect another person's privacy, if that person is mentioned in the records. It is unlikely that information relating to another person would help an attorney make a decision on behalf of the person who lacks capacity. The information holder might also be obliged to keep information about the other person confidential. There might be another reason why the person does not want information about them to be released. Under these circumstances, the attorney does not have the right to see that information.

8.17 An information holder should not release information if doing so would cause serious physical or mental harm to anyone – including the person the information is about. This applies to information on health, social care and education records.

8.18 The Data Protection Authority can give further details on:

- how to request personal information
- restrictions on accessing information, and
- how to appeal against a decision not to release information.

8.19 When can someone see information about healthcare or social care?
Healthcare and social care staff may disclose information about somebody who lacks capacity only when it is in the best interests of the person concerned to do so, or when there is some other, lawful reason for them to do so.

8.20 The Capacity Law's requirement to consult relevant people when working out the best interests of a person who lacks capacity will encourage people to share the information that makes a consultation meaningful. But people who release information should be sure that they are acting lawfully and that they can justify releasing the information. They need to balance the person's right to privacy with what is in their best interests or the wider public interest (see paragraphs 8.24–8.25 below).

8.21 Sometimes it will be fairly obvious that staff should disclose information. For example, a doctor would need to tell a new care worker about what drugs a person needs or what allergies the person has. This is clearly in the person's best interests.

8.22 Other information may need to be disclosed as part of the process of working out someone's best interests. A social worker might decide to reveal information about someone's past when discussing their best interests with a close family member. But staff should always bear in mind that the Capacity Law requires them to consider the wishes and feelings of the person who lacks capacity.

8.23 In both these cases, staff should only disclose as much information as is relevant to the decision to be made.

8.24 Sometimes a person's right to confidentiality will conflict with broader public concerns. Information can be released if it is in the public interest, even if it is not in the best interests of the person who lacks capacity. It can be difficult to decide in these cases, and information holders should consider each case on its merits. These include situations where disclosing information could prevent, or aid investigation of, serious crimes, or to prevent serious harm, such as spread of an infectious disease. It is then necessary to judge whether the public good that would be achieved by the disclosure outweighs both the obligation of confidentiality to the individual concerned and the broader public interest in the provision of a confidential service.

8.25 For disclosure to be in the public interest, it must be proportionate and limited to the relevant details. Healthcare or social care staff faced with this decision should seek advice from their legal advisers. It is not just things for 'the public's benefit' that are in the public interest – disclosure for the benefit of the person who lacks capacity can also be in the public interest (for example, to stop a person who lacks capacity suffering physical or mental harm).

8.26 What financial information can carers ask to see?
It is often more difficult to get financial information than it is to get information on a person's welfare. A bank manager, for example, is less likely to:

- know the individual concerned
- be able to make an assessment of the person's capacity to consent to disclosure, and
- be aware of the carer's relationship to the person.

So they are less likely than a doctor or social worker to be able to judge what is in a person's best interests and are bound by duties to keep clients' affairs confidential. It is likely that someone wanting financial information will need to apply to the Court for access to that information. This clearly does not apply to an attorney appointed to manage the person's property and affairs, who will generally have the authority (because of their appointment) to obtain all relevant information about the person's property and affairs.

8.27 Is information still confidential after someone shares it?
Whenever a carer gets information, they should treat the information in confidence, and they should not share it with anyone else (unless there is a lawful basis for doing so). In some circumstances, the information holder might ask the carer to give a formal confirmation that they will keep information confidential.

8.28 Where the information is in written form, carers should store it carefully and not keep it for longer than necessary. In many cases, the need to keep the information will be temporary. So the carer should be able to reassure the information holder that they will not keep a permanent record of the information.

8.29 What is the best way to settle a disagreement about personal information?
A carer should always start by trying to get consent from the person whose information they are trying to access. If the person lacks capacity to consent, the carer should ask the information holder for the relevant information and explain why they need it. They may need to remind the information holder that they have to make a decision in the person's best interests and cannot do so without the relevant information.

8.30 This can be a sensitive area and disputes will inevitably arise. Healthcare and social care staff have a difficult judgement to make. They might feel strongly that disclosing the information would not be in the best interests of the person who lacks capacity and would amount to an invasion of their privacy. This may be upsetting for the carer who will probably have good motives for wanting the information. In all cases, an assessment of the interests and needs of the person who lacks capacity should determine whether staff should disclose information.

8.31 If a discussion fails to settle the matter, and the carer still is not happy, there are other ways to settle the disagreement. The carer may need to use the appropriate complaints procedure. Since the complaint involves elements of data protection and

confidentiality, as well as best interests, relevant experts should help deal with the complaint.

8.32 In cases where carers and staff cannot settle their disagreement, the carer can apply to the Court for the right to access to the specific information. The Court would then need to decide if this was in the best interests of the person who lacks capacity to consent. In urgent cases, it might be necessary for the carer to apply directly to the Court without going through the earlier stages.

9. Advanced Care Planning

Advance Decisions to Refuse Treatment

9.1 Overview

A fundamental principle of the Capacity Law is to support people to make their own decisions about care and treatment. This includes making an advance decision to refuse a specified medical treatment (ADRT) whilst the person has capacity to make this. The ADRT will only take effect if they lose capacity to consent to, or refuse the relevant treatment. A valid ADRT will have the same effect as a decision made by a person with capacity and it must be followed by healthcare professionals.

9.2 A person (P) may decide to make an ADRT after they have received a diagnosis or simply because they want to plan ahead, in case something happens. An ADRT must always be in writing to avoid any doubts as to its validity and applicability to the relevant treatment. If the ADRT relates to life sustaining treatment, it must be discussed with and countersigned by P's doctor, and it must be witnessed.

Scenario – advance decision to refuse treatment

Mr Albert is 86 years old and has previously had treatment for cancer. This included chemotherapy and he had suffered very bad side effects from this. Mr Albert has now been diagnosed with dementia. He is concerned that, if the cancer returns, he may no longer have capacity to make his own decision about treatment however he is very clear that he would not want to have chemotherapy again. He writes an ADRT specifying that, if he is diagnosed with cancer again, he would not want to have chemotherapy treatment. He includes a statement that the ADRT is to apply, even if his life is at risk. As the consequence of the ADRT could potentially result in his death, Mr Albert speaks with his doctor about this decision. The GP advises Mr Albert about the consequences of the decision but accepts that he has capacity to make his ADRT. The GP signs the ADRT.

9.3 What is an advance decision to refuse treatment?

People have the right to consent to or refuse medical treatment, if they have capacity to do so. An ADRT allows P to make a formal, written decision to refuse a specified treatment, whilst they have capacity to do so. This will only take effect if P loses capacity to make their own decision.

9.4 Who can make an ADRT?

An ADRT can be made by P who:

- aged 16 or over and
- has capacity to make this decision

9.5 What is a valid ADRT?
An advance decision is valid only if:

- it is in writing
- P had capacity at the time they made the ADRT
- P is aged 16 or over
- it details the specific treatment P is refusing
- it has not been revoked by P
- P has not been put under undue pressure to make the ADRT
- P has not made an LPA for health or welfare after making the ADRT or the LPA does not give authority to the attorney(s) to consent to, or to refuse, the specific treatment
- since making the ADRT, P has not acted in a way that is clearly inconsistent with the ADRT.

In addition, if the ADRT relates to life sustaining treatment decisions:

- the document includes an explicit statement by P that the ADRT is to apply even if P's life is at risk, and
- P's doctor or other healthcare professional has signed the ADRT to confirm that P has been given advice about the specific treatment, the consequences of P making the decision to refuse the treatment, and
  all other possible treatment options and
- it has been signed by P in the presence of a witness, and the witness has also signed the ADRT.

9.6 Capacity to make an ADRT
P must have capacity to make an ADRT. This means that P can understand, retain, use and weigh the relevant information for this decision as well as communicate their decision. The relevant information for this decision includes:

- the nature of the treatment that is to be covered by the ADRT
- the circumstances under which the treatment is not to be started or continued
- the consequences of refusing the start or the continuation of that treatment, including for life sustaining treatment, that this may result in P's death
- that the ADRT can be withdrawn or changed at any time while P still has capacity to do so
- that, unless the ADRT is withdrawn or changed, if P loses capacity to consent to the identified treatment, the ADRT will be legally binding on medical professionals.

9.7 Healthcare professionals and others should be aware that a person with capacity can make decisions which others may consider to be unwise, including refusing treatment. Professionals cannot override an ADRT if P had capacity to make this, even if they disagree with P's decision. However, if there is any evidence to suggest

that P may not have had capacity at the time of making the ADRT, the relevant healthcare professional should seek legal advice.

9.8 ADRT and Lasting Powers of Attorney

A valid ADRT must be followed; however, if P has created a Lasting Power of Attorney for Health and Welfare **after** the ADRT was made, this will override the ADRT. The attorney will make the decision to consent to, or refuse the proposed treatment for P. The only exception to this is if P has specifically excluded this decision in their LPA, in which case, the ADRT will apply.

9.9 When does an ADRT apply?

An ADRT will apply only if P loses capacity to consent to, or to refuse the specific treatment, at the time when that decision needs to be made. If, at the time the specific treatment is proposed, P has capacity to make their own decision, the advance decision will not apply. It is good practice for the decision maker to keep a record of the capacity assessment (for this treatment).

Scenario

Mrs Roxanne Holmes has a diagnosis of Huntington's Chorea, which is an inherited progressive disease. Over time it is likely that she will lose her ability to swallow. She has been advised that, at that time, she will need a PEG tube to be fitted to provide nutrition, hydration and her medication. Mrs Holmes has watched her mother die from Huntington's disease and is very clear that she does not want to have a PEG tube fitted to prolong her life. She is also aware that, at the time she may require such treatment, she may also have lost the capacity to consent to or to refuse this. After a discussion with her doctor, she writes an ADRT to refuse to have a PEG tube fitted. She signs this in the presence of a witness, as it relates to life-sustaining treatment. Mrs Holmes passes a copy of her Advance Decision to her doctor and also gives a copy to her son. By doing this she ensures that, at the time this decision needs to be made, if she has lost capacity her doctor must abide by her decision and not fit a PEG tube. If she still has capacity at that time, she can make her own decision.

Mrs Holmes' physical condition declines over time and she is admitted to a specialist nursing home for people with Huntington's disease. She has a good quality of life in the home and enjoys many of the activities there. As her ability to swallow deteriorates her doctor speaks with Mrs Holmes about a PEG tube. He assesses her to have capacity to make her own decision therefore the advance decision does not apply and Mrs Holmes can decide whether to consent to or to refuse the PEG tube.

9.10 An ADRT can only be made to refuse a specific treatment; it cannot be used to request a treatment. Nobody has a legal right to insist on being given a specific treatment. It is the decision of the treating healthcare professional as to whether a treatment is appropriate for the person.

9.11 An ADRT cannot be used to ask for, or to receive, procedures that are against the law, such as assistance to commit suicide.

9.12 Consultation with medical professionals before completing an ADRT for life sustaining treatment decisions.

If P wishes to make an ADRT which relates to life sustaining treatment, this must be discussed with P's doctor, who must sign this to confirm that P has been given appropriate advice. The purpose of this consultation is to provide P with information about the specific treatment, any treatment options and the consequences of this advanced decision. It is not the purpose of the consultation to change P's views but simply to provide P with the information to allow them to make an informed decision. The doctor should sign the ADRT, as well as keeping a copy of the ADRT on P's notes.

9.13 Consultation with medical professionals before completing an ADRT which does not include life sustaining treatment decisions.
There is no requirement to speak with a healthcare professional before making an ADRT **unless** the decision relates to life sustaining treatment, but it is advisable to do so. In many cases a person may make the decision at a time when they are not receiving active medical treatment. A discussion about an ADRT with a healthcare professional should ensure that P has all the relevant information and also that the document is valid. It is important that the ADRT is clear and specific so that it can be easily understood and implemented, at the time it is needed. The healthcare professional should support P to clarify what their wishes are, as well as to help P to understand the treatment options and the implications of refusing a treatment. Healthcare professionals consulted by P should make a note on P's health records that P has made an ADRT as well as taking a copy of the ADRT.

9.14 Format for an advance decision

To be valid, an ADRT must be made in writing. It can be on the prescribed form or in another document if it includes the following information:

- P's name, date of birth, address and any distinguishing features
- name and address of P's GP and whether the GP has a copy of the ADRT
- a statement that the document should be used if P loses capacity to make their own decision about the specified treatment
- details of the specific treatment to be refused and the circumstances in which the ADRT will apply. This should include as much detail as possible to avoid any doubt

- if the decision relates to life sustaining treatment the document must include a statement that the decision applies even if the person's life is at risk
- if the decision relates to life sustaining treatment the document must be signed by a prescribed person to confirm that advice has been provided in relation to the specified treatment, the consequences of the decision and other treatment options
- the date the decision was made
- the document must be signed by P and it must be witnessed if it relates to life sustaining treatment

Although not a legal requirement, P may explain the reasons for refusing the specific treatment, so that P's wishes are clear if, for any reason, the ADRT is not valid or applicable and therefore a decision-maker has to decide whether the treatment is in P's best interests (see 3.26).

9.15 What happens if P makes a verbal decision, but has not written it?
A verbal decision does not have legal standing as an ADRT but can be considered as an expression of the person's wishes. If P has lost capacity and a treatment decision needs to be made, this will be made via the best interests process (see Chapter 3) or, where relevant, by a person who holds a Lasting Power of Attorney for Health and Welfare. P's wishes, as stated verbally, should be considered as part of the decision making process.

9.16 What happens if P cannot write the ADRT?
P can be assisted to write the ADRT if they are no longer able to do so without such support. This would apply, for example, if P has a physical disability, which prevents them from writing. The ADRT would need to be provided in the prescribed form. If P is unable to sign the form, a witness will be required to confirm that the document has been signed by another person but at the direction, and in the presence, of P.

Scenario

Mr Cambridge has been involved in a road traffic accident in which he suffered a spinal injury. Although he has had extensive rehabilitation he is now quadriplegic. Mr Cambridge's cognition has not been affected and he can still communicate well. He now wishes to make an advance decision to refuse specific treatment as a result of his current condition, however he can no longer write or use a computer. He is also unable to sign or make a mark in place of a signature. Mr Cambridge asks his wife to write the ADRT for him. When this has been completed they arrange for a friend to witness that Mr Cambridge is in agreement to the contents of the document. Mrs Cambridge signs the ADRT on behalf of her husband. Their friend signs the document including a statement to confirm that, to the best of his belief, this is Mr Cambridge's ADRT and that he has not been forced to write this.

9.17 Can an ADRT be made to refuse artificial nutrition and hydration?
An ADRT can specify that P refuses artificial nutrition and hydration, provided that this has been discussed with a medical professional who has signed the prescribed form. The ADRT form must also be witnessed. It should be noted however that an ADRT cannot refuse actions that are needed to keep a person comfortable, such as warmth, shelter, maintaining personal care and offering food and water.

Legal case example – withdrawing life sustaining treatment
NHS Cumbria CCG v Rushton [2018] EWCOP 41 (21 December 2018)

This case came before the Court of Protection in England in December 2018 to consider whether clinically-assisted nutrition and hydration (CANH) could be withdrawn from Mrs Rushton, an 85 year old former nurse. In 2014 she had written an advance decision to refuse treatment which stated "*on collapse, I do not wish to be resuscitated by any means,*" that "*I am refusing all treatment. Even if my life is at risk as a result,*" and that *"in all circumstances of collapse that put my life at risk, this direction is to be applied."* A year after writing this she fell and sustained a serious head injury. At that time she was not expected to live. A naso-gastric tube was inserted to feed her. Mrs Rushton's condition improved and a percutaneous endoscopic gastrostomy inserted in 2016. Prior to inserting this the hospital contacted her GP as they had been advised of the ADRT, however the GP said that there was only a 'Do not resuscitate' document in place. The PEG was inserted however Mrs Rushton was in a "persistent vegetative state" with no prospect of recovery. Her sons brought the case to court on the basis that the treatment received was against their mother's wishes, as expressed in her ADRT. CANH was subsequently withdrawn and Mrs Rushton died.

9.18 What happens if there are doubts about the validity of an ADRT?
It is the responsibility of the doctor treating P to decide whether the ADRT is valid and applicable. If there is disagreement, either between the healthcare professionals treating P, or between the doctor and P's family or friends, the senior medical professional must consider all the available evidence. All staff involved in P's care as well as family members or friends should be given the opportunity to express their views. The purpose of such discussions is to seek evidence concerning the validity of the ADRT and to confirm its applicability to the proposed treatment.

9.19 What happens if a member of P's family disagrees with the ADRT?
A family member cannot override P's ADRT, anymore than they can force a person, who has capacity, to have a treatment if they do not consent to this. The only exception is if the relative holds a Lasting Power of Attorney for Health and Welfare granted **after** the ADRT was made and the decision falls within the scope of the LPA (see 4.13).

9.20 Role of the Court

If there are doubts or disagreement about the existence, validity or applicability of an ADRT which cannot be resolved the matter must be referred to the relevant Court for a decision. The Court cannot overturn a valid and relevant ADRT, however it can decide:

i) whether P does or does not have capacity to consent to or refuse treatment at the time that the treatment is required;
ii) whether an ADRT is valid; and
iii) whether an ADRT is applicable to the proposed treatment.

9.21 Reviewing an ADRT

Although there is no requirement in the Law to review an ADRT, it would be advisable to do so. Medical treatments may change over time, which may make it appropriate to review and update the ADRT. Where any change is made, the ADRT must still be in the required format and contain the required information, in order to remain valid.

9.22 Revoking an ADRT

An ADRT can be revoked by P but they can only do so if they still have capacity. P can destroy the ADRT document but they should also advise their family and relevant healthcare professionals of the decision to revoke the ADRT. If the ADRT related to life sustaining treatment decisions P should advise their doctor that they have revoked the ADRT. The ADRT only takes effect when P loses capacity to make their own decision about the specific treatment.

9.23 What happens if P has lost capacity but appears to have changed their mind about the advance decision?

An ADRT can only be made at a time when P has capacity to do so. It comes into effect at the time that the specified treatment is proposed *and* if P has lost capacity to consent to, or to refuse that treatment. If P has lost capacity but appears to have changed their mind about the specified treatment the ADRT would still apply. However, such a situation may be very difficult for the treating professionals, particularly if the ADRT applies to life sustaining treatment. It would be advisable to consider, in such situations, whether P made any statements, prior to losing capacity, to indicate that they may have changed their mind even if they did not revoke the ADRT. If there is evidence to suggest that P may have changed their mind, it would be advisable to refer to the Court to rule on the validity of the ADRT.

9.24 In a court case in 2021[31] a judge ruled that a woman who was a Jehovah's Witness and who had made an ADRT to refuse blood products, should be given a blood transfusion. The ADRT had been made in 2001. In 2020 she made a LPA for health and welfare, naming her adult children as her attorneys. She did not give her

[31] *Re PW (Jehovah's Witness: Validity of Advance Decision)* [2021] EWCOP 52,

attorneys the authority to make life sustaining treatment decisions but told them that she would wish to be resuscitated if the need arose. It was argued that she had done and said things that were incompatible with the ADRT.

9.25 In his ruling the judge noted at paras 57 and 58 “She granted to her children, whom she surely knew were hostile to the Jehovah’s Witnesses denomination, authority to make decisions about all medical treatment, other than life-sustaining treatment, on her behalf should she lose capacity to make such decisions for herself, without mentioning to them or including in the written LPA any preference or requirement not to receive blood transfusion or blood products. The advance decision was widely drawn and did not restrict the refusal of consent to blood transfusion or blood products by way of life-sustaining treatment. Her actions at the time of granting the LPA were in my judgment clearly inconsistent with the advance decision remaining her fixed decision. For the reasons stated earlier, I must presume that she had capacity at that time. Likewise, Ms W’s actions earlier this year on requesting the removal of the DNR notice, without qualification and without telling her children or, to their knowledge, her clinicians, about the advance decision or that she would refuse a blood transfusion or blood products is, in my judgment inconsistent with the advance decision remaining her fixed decision.”

9.26 What should healthcare professionals do if an ADRT is not valid or applicable to the proposed treatment?

If the ADRT is not valid or does not apply to the proposed treatment and P lacks capacity to make their own decision, the healthcare professional must decide whether to provide the proposed treatment under the best interests process. If the ADRT is not valid (perhaps because it has not been signed) but refers to the planned treatment then this should be considered as a statement of P’s wishes, as part of the decision-making process.

9.27 What happens if a healthcare professional has a conscientious objection to ceasing or not providing life sustaining treatment?

The Law applies even if a healthcare professional disagrees with P’s decision however, healthcare professionals do not have to do something which conflicts with their beliefs. In such a case a different healthcare professional must take over to ensure that the advance decision is respected. Treating a person against their expressed wishes could constitute assault.

9.28 How does this relate to emergency treatment?

In an emergency, treatment should not be delayed unless there is a valid and applicable ADRT or a clear indication that there may be one. The Law states at s37(5)

“Nothing in an apparent advance decision stops a person –

(a) providing life-sustaining treatment, or

(b) doing any act that the person reasonably believes to be necessary to prevent a serious deterioration in P's condition,

while a declaration as respects any relevant issue is sought from the relevant court."

9.29 Protection from liability

It is the responsibility of P to provide their ADRT to medical professionals and they should also ensure that their family members are aware of the ADRT and its contents. A medical professional can only comply with an ADRT if they are aware of this and of its contents, however, if they are not aware of the existence of an ADRT they will be protected from liability. A medical professional treating a P who lacks capacity to make their own decision about the proposed treatment should, as part of the best interests process, check whether there is a valid and relevant ADRT. A healthcare professional who follows a valid and applicable ADRT, even if this results in P's death, will be protected from liability.

Advanced Care Plans

9.30 Overview

An advanced care plan (ACP) is a document written by a person, whilst they have capacity, to express their wishes about their future care and treatment, in case they lose capacity to make their own decisions. It is not legally binding although it should be considered when making a best interests decision for the person. It can be used to express wishes about future care options, such as a preference to move to residential care or to remain at home with carers. This can only relate to the decisions the person could make if they had capacity.

Scenario – Advanced care plan

Mr Spencer has recently been diagnosed with dementia. His wife has been living with dementia for the past 6 years and, following his diagnosis and an increase in her care needs, Mrs Spencer's social worker has assessed her to need a care home placement. She moves to Sunview Care Home. Mr Spencer sees how well his wife is cared for and writes an advanced care plan stating that, when his needs increase to the level that he cannot manage in his own home, he would like to go to a care home, preferably the same one as his wife. He also says that, if that is not possible, he would like to be living close to his wife so that he can visit her.

Mr Spencer understands that, at the time that he needs full time care, it may not be possible for him to move to Sunview care home, however his views (as expressed in the ACP) should be considered when a decision is made.

9.31 Who can make an ACP?
An ACP can be written by any person aged 16 and over, who has capacity to make the specific decisions in the plan. For example, if the decision is about where the person wishes to live (at a time when they have lost capacity) they must have capacity to make their own decision regarding their accommodation at the time the advanced care plan is written.

9.32 How can an ACP be made?
An ACP must be made in writing and must be signed by the person making the plan. It should be in the prescribed form or contain the same information. It does not need to be witnessed.

9.33 Is the ACP legally binding?
An ACP is not legally binding however, as an expression of a person's wishes, it should be taken into account by a decision maker who is making a relevant best interests decision. For example, an ACP could specify that the person wishes to be cared for at home, in the event that they need care. This may not be possible as the person may suffer an injury or other health condition which means that their needs cannot be met in their own home. In such a situation, it is still important that the decision maker considers the ACP and is able to explain why the person's wishes cannot be met.

9.34 How should the ACP be used?
It is important that a person making an ACP provides this to members of their family and to social care professionals. If no one is aware of the document it cannot be considered. If the person loses capacity the document should be provided to any decision maker, who should consider whether the ACP relates to the specific decision. The decision maker should ensure that the ACP has been considered as a representation of the person's wishes. The best interests decision should record how the ACP has been considered and, as appropriate, why the person's wishes could not be met.

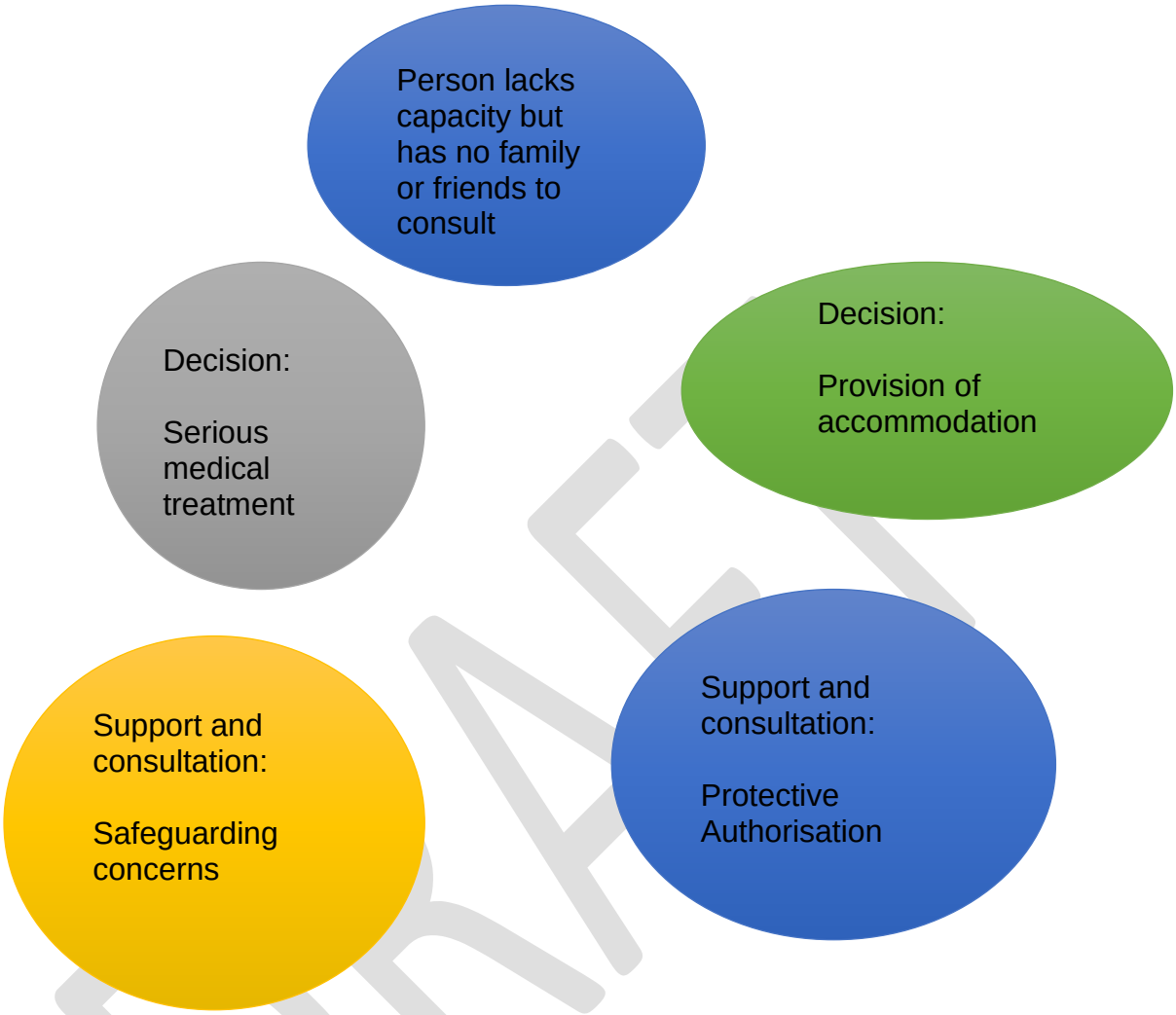
9.35 What happens if a family member disagrees with the ACP?
The ACP is not legally binding however it is an expression of wishes which should be considered as part of any decisions made in the person's best interests. The person's wishes, as documented in the ACP, should be considered, as well as the views of any family members, as part of the best interests process (see Chapter 3).

9.36 What happens if the person cannot write?
A person can be assisted to write the ACP if they are no longer able to do so without such support. This would apply, for example, if a person has a physical disability which prevents them from writing. The ACP would need to be provided in the prescribed form. If the person is unable to sign the form, a witness will be required to confirm that the document has been signed by another person but at the direction of, and in the presence of the person making the ACP.

9.37 Reviewing an ACP.
Although there is no requirement in the Law to review an ACP, it would be advisable to do so periodically.

9.38 Withdrawing an ACP
An ACP can be withdrawn by the person whilst they still have capacity to do so. The document (and any copies) can be destroyed.

10. Independent Capacity Representatives



10.1 Overview

The fundamental principle underpinning the Capacity Law is to uphold the rights of people who lack capacity (P). To that end, before any decision is taken, P must be represented and supported by someone who is independent of the decision maker. In most cases P, will have family or friends who can provide support and representation. However, if P has no friends or family to consult, or whom it would not be appropriate to consult for specific decisions, then an Independent Capacity Representative (ICR) **must** be appointed. There are also some decisions and additional roles where the ICR **can** be appointed to support the person or to support their representative.

10.2 An ICR is a person who has been specially trained to support people who are not able to make certain decisions for themselves and do not have family or friends who are able to speak for them. The ICR does not make decisions and is independent of the decision maker.

10.3 An ICR can support anyone who is over 16 years old and who has been assessed as lacking capacity to make their own decision, at the time that this decision needs to be made. P may have dementia, a learning disability, mental health problems, a brain injury or a temporary condition affecting P's ability to make their own decision.

10.4 When should ICR be instructed?
An ICR must be instructed if a relevant decision needs to be made and there is no one appropriate to consult, other than professionals and people who are paid to provide care or treatment to P. The Law requires that the decision maker must instruct and consult an ICR for the following decisions or roles:

a) Serious Medical Treatment
b) Protective Authorisation Scheme

The decision maker can also instruct an ICR for the following decisions and roles:

c) Provision or change of accommodation for more than 28 days
d) For a safeguarding investigation

10.5 An ICR can also be appointed to support or represent P if it is decided that this would be in P's best interests. P may have relatives with whom there has been no contact for many years and therefore it may not be appropriate to consult with them about what is in P's best interests. ICR can also be instructed if it is not possible to consult with P's family or representative and the decision cannot be delayed.

10.6 Serious medical treatment decisions
Serious medical treatment is treatment which involves giving new treatment, stopping treatment which has started or withholding treatment that could be offered where P lacks capacity to make their own decision about the proposed treatment and in circumstances where

i) if a single treatment is proposed, there is a fine balance between the likely benefits and the risks it is likely to entail for P,
ii) if there is a choice of treatments the decision as to which one to use is finely balanced or
iii) the proposed treatment is likely to involve serious consequences for P including
    a) causing distress or prolonged pain or side effects,
    b) having serious consequences for P (for example stopping life-sustaining treatment or having major surgery)

c) having a serious impact on P's future life choices, such as treatments which may affect P's fertility

Note: This does not include treatment which would be provided under the Mental Health Law.

10.7 It is not possible to provide a list of all medical procedures that may amount to serious medical treatment however the following are examples of serious treatments.

- chemotherapy, radiotherapy and/or surgery for cancer
- sterilisation
- major surgery
- amputation of a limb
- treatment which will result in loss of sight or hearing
- withholding or stopping artificial nutrition and hydration
- termination of pregnancy

An ICR should be involved in such cases, where the decision is whether to provide or not to offer, the particular treatment. The ICR can request a second medical opinion, just as a person with capacity has the right to request a second opinion.

Scenario: serious medical treatment decision

Mr Oliver Wilcox is 66 years old and he has been admitted to hospital following a cardiac arrest and hypoxic brain injury. He had been living alone with carers visiting three times a day, as he has a physical care needs. Mr Wilcox is no longer able to communicate meaningfully. The doctor has assessed him to lack capacity to make his own decision about treatment. As he has difficulty swallowing, it is proposed that a PEG tube should be fitted to provide nutrition and hydration. Mr Wilcox has no family or friends that can be contacted therefore an ICR is instructed. The ICR meets Mr Wilcox and consults with his doctors before completing their report. The ICR attends the best interests meeting to represent Mr Wilcox. It is agreed that it is in his best interests to have the PEG tube fitted.

10.8 If an urgent decision is needed for the proposed treatment (for example for emergency life saving treatment) and this cannot be delayed, it is not necessary to instruct an ICR. The reason that an ICR was not instructed should be recorded on the patient's notes. An ICR will still need to be instructed for any further serious medical treatment that P may require subsequently.

10.9 Protective Authorisation
An ICR must be instructed under the Protective Authorisation scheme if

i) P's care arrangements or proposed arrangements amount to a significant restriction and an assessment for a Protective Authorisation is required
ii) P has a Protective Authorisation in place

and there is no person to available to consult with or to act as P's representative, other than one engaged in providing care or treatment in a professional capacity.

10.10 Change or provision of accommodation
If a change of accommodation is proposed for P, for a period of at least 28 days and there is no one suitable to consult, the decision maker may request the appointment of an ICR. This includes accommodation in hospital, a care home or supported accommodation, but does not include accommodation in any place, including approved establishments for treatment under the Mental Health Law. An ICR does not need to be appointed if P has capacity to decide whether an ICR should represent P and does not want an ICR to be involved in the decision making process.

10.11 Safeguarding and other cases
An ICR may be appointed if:

i) a safeguarding investigation is being carried out or
ii) a safeguarding allegation has been made against P's family or friend

and there is no one suitable to support P for the safeguarding process. The Law allows for an ICR to be appointed to support P at such time. Furthermore, if a safeguarding allegation has been made against P's family or friend, it would not be appropriate for them to support P or to act as P's representative until this has been resolved. An ICR can therefore be appointed to support P whilst the matter is investigated. The ICR's role is to uphold P's rights.

10.12 The Law allows for an ICR to be appointed for other cases at the discretion of the Committee, if this is thought to be in P's best interests.

10.13 Persons detained under the Mental Health Law
For any treatment provided to P under the Mental Health Law, an ICR does not need to be instructed. However, if the detained patient requires treatment which is not for their mental disorder, (for example if treatment is proposed for cancer or a heart condition) P has a right to an ICR, if they do not have family or friends who could be consulted.

10.14 The role of the Independent Capacity Representation: Support and consultation for decision making.

The ICR must act in accordance with the Law, in particular ss.3 to 6 and chapters 2 and 3 of the Code of Practice. The ICR

- should find out as much as possible about P's past and present wishes, views and beliefs
- has the right to meet P privately
- has the right to see P's health and care records
- should consider all the relevant information about P
- should consult with the professionals and paid workers involved in P's care and treatment, including discussion of all possible options for P
- write a report for the decision maker which should be considered as part of the decision making process
- can consider other options which were not suggested by the health or social care professional
- can ask for a second medical opinion
- has the right to challenge any decision made
- must respect P's confidentiality
- should discuss with the decision maker whether the decision can be delayed, if there is evidence to suggest that P may regain capacity, the ICR

Scenario: Change of accommodation

Mr Davies is a widower. He and his wife did not have any children. He lives alone but has suffered a severe stroke, which has resulted in a cognitive impairment. He has been admitted to hospital for treatment and rehabilitation but is now fit for discharge. The healthcare professionals treating do not feel that he would be able to manage in his own home and believe that he should move to a care home. Although Mr Davies is still able to communicate verbally, he is confused and his communication is not reliable as he contradicts himself often. The social worker assesses him to lack capacity to make his own decision as to his discharge destination. As Mr Davies has no family to consult, the social worker makes a referral for ICR.

The ICR talks with Mr Davies about the different options and his views on these. The ICR attends the best interests meeting and ensures that Mr Davies' views are included, to uphold his rights. The decision maker must take account of ICR's report and views (to represent Mr Davies) when making the decision about whether he is discharged home or to a care home.

10.15 What happens if the ICR disagrees with the decision maker?
It is the role of the ICR to represent and support P and to ensure that P's views are taken into account by the decision maker. There may be times when the decision maker makes a decision that conflicts with P's wishes, for example P may wish to stay at home but there are serious concerns about P's safety or how to meet P's needs effectively and therefore the decision is taken to admit P to a care home. In such cases, where an ICR is involved, they can challenge the decision if they consider that the decision maker has not taken account of their report or of other relevant information. The ICR should discuss the issues with the decision maker as a first step to see if their concerns can be resolved. If there is no resolution, then ICR can use the decision maker's agency's complaints process. In urgent or serious cases, ICR should consider referring this to the Tribunal for a decision about P's best interests.

10.16 The role of the Independent Capacity Representative:
Support and consultation for a Protective Authorisation pre-authorisation
Before a Protective Authorisation can be granted the Capacity Professional or social worker completing the best interests assessment must consult with P's family or friend. If P has no friends or family who can be consulted an ICR **must** be instructed. The role of the ICR is to establish P's views about the actual, or proposed accommodation to receive care and/or treatment, including the restrictions which will be in place. The ICR's role is to consider whether the proposed care arrangements are in P's best interests, taking account of the available options and P's views. The ICR must provide a written report to the Capacity Professional which should be considered as part of the Protective Authorisation process. This needs to be provided before the Protective Authorisation can be granted (if appropriate).

To carry out their role the ICR:

- should find out as much as possible about P's past and present wishes, views and beliefs
- has the right to meet P privately
- has the right to view or take copies of any relevant assessments (relating to the request for a Protective Authorisation)
- should consider all the relevant information about P
- should consult with the professionals and paid workers involved in P's care and treatment, including discussion of all possible options for P
- consider other options which may be available to meet P's needs
- must respect P's confidentiality
- should discuss with the decision maker whether the decision can be delayed, if there is evidence to suggest that P may regain capacity to make the relevant decision.

10.18 The role of the Independent Capacity Representative.
Support and consultation for a Protective Authorisation post-authorisation
All those persons subject to a standard authorisation have the right to a representative, whose role is to uphold P's rights. In most cases P will have a member of their family or a friend who can act as the representative. However, if P does not have anyone who is suitable or eligible to act an ICR must be appointed to uphold. ICR can also be appointed as P's representative if P's friends or family are unable to visit P in line with the requirements for the representative (see 10.17 and 12.98).

10.19 An Independent Capacity Representative appointed as P's Representative for a Protective Authorisation has the same role as any other person named as a representative. The representative should:

i) maintain regular contact with P. Where possible, this should be face to face however, there may be times when this is not possible and therefore other methods to maintain contact can be used, if P is able to engage with these. The Law does not specify how often contact should be made but it would be reasonable to expect this to be at least every 6-8 weeks
ii) try to establish what P's wishes and feelings are, or would be likely to be if they had capacity, regarding the arrangements for P's care and treatment
iii) provide support to P so that they are fully involved in decisions regarding the Protective Authorisation. The ICR should help P to understand about the Protective Authorisation and the restrictions in place.
iv) represent P's wishes or feelings including requesting a review of any of the qualifying requirements or supporting an appeal to the Mental Health and Capacity Review Tribunal to challenge the Protective Authorisation and
v) do anything reasonably practicable to support P under the Protective Authorisation

In order to fulfil the role of the representative, the ICR has the right to see P's care plans and records.

10.20 A capacity professional can also request that an ICR is appointed for P under a Protective Authorisation as follows:

i. P (subject to the Protective Authorisation) requests the appointment of an ICR. If P has capacity to select their representative they may wish to select an ICR, if they do not think that a family member would provide appropriate support

Scenario: Person subject to a Protective Authorisation requests an ICR as Representative

Mr Sam Barry is diagnosed with schizophrenia and has a history of suicide attempts and admissions to hospital under the Mental Health Law. He has now been discharged from hospital and admitted to a care home under a Protective Authorisation, as it has been agreed that he needs full time care and treatment which cannot safely or effectively be provided in his own home. Mr Barry has expressed his objection to staying in the care home and blames his wife for his admission, claiming that she is refusing to let him go home. Mr Barry tells the Capacity Professional that he objects to staying in the care home and that he wishes to take his case to the Mental Health and Capacity Review Tribunal. He tells the Capacity Professional that he does not believe that his wife will support him to make the Tribunal application and therefore he does not wish her to be named as his Representative. Mrs Barry has advised the Capacity Professional that she wishes her husband to remain in the care home. ICR is appointed to uphold his rights.

ii. P's Representative (for the Protective Authorisation) requests the appointment of an ICR to support them to carry out their role *or* the Capacity Professional believes that the representative requires support of an ICR to carry out the relevant functions. For example, if P is objecting to their care arrangements and the representative is required to take an application to the Mental Health and Capacity Review Tribunal. The ICR's role is to support the Representative to ensure that the person's rights are upheld.

Scenario – supporting the Representative

Mr Richard Adkin has recently moved to a care home. He had suffered a head injury in a road traffic accident and, despite rehabilitation his communication is quite impaired and he has difficulty expressing himself verbally, although he can make choices using communication aids. He has lost his mobility and has been assessed to need 24 hour care and treatment which can only be provided in a care home. Mr Adkin has always been a fiercely independent person and he expresses his unhappiness about living in a care home, rather than in his own home. His partner, Jeff James would also like Mr Adkin to come home and is willing to act as his Representative, but he is finding it difficult to deal with everything since Mr Adkin's accident. The Capacity Professional believes that Mr James is eligible to act as the Representative but that he would benefit from the support of an ICR.

The ICR meets with Mr James and discusses the role of the Representative and explains how to make an application to the Mental Health and Capacity Review Tribunal. Mr James makes the application but maintains contact with the ICR who

is able to provide advice and information about the process and ensure that Mr Adkin's rights are upheld.

Scenario: Requesting a reassessment of a qualifying requirement
Alfred Biggs is 22 and has a learning disability. He has been living in a care home since he was 18 and is subject to a Protective Authorisation. The support workers have assisted him to develop his independent living skills and Mr Biggs is now able to prepare his meals and drinks with minimal support. He has developed his road safety awareness and can now manage to go to the local shop to buy snacks on his own. He still has difficult understanding money, but his support workers help him to manage his finances. Mr Biggs is fully independent with his personal care and only requires prompting with his laundry. He starts to talk with his brother, who is his representative about living in a more independent setting.

Mr Biggs' brother and representative has the support of an ICR and discusses this with the ICR for advice about what he should do. The ICR advises Mr Briggs' brother to request a reassessment of the Capacity and Best Interests' requirements. This is because Mr Biggs may now have capacity to make his own decision about his accommodation in the care home and also because it may no longer be in his best interests to be living in the care home if there is a less restrictive option which could meet his needs.

10.21 Role of ICR where P's representative for a Protective Authorisation is the subject of a safeguarding investigation or allegation.

If P has an appointed representative for a Protective Authorisation but a safeguarding allegation has been made against the representative, it may not be appropriate for that person to continue to represent P. In such circumstances, the Capacity Professional can appoint an ICR to represent P. At the conclusion of the safeguarding investigation, the Capacity Professional should decide, dependent on the outcome, whether the person can be reinstated as the representative.

Scenario - Role of ICR where there are safeguarding concerns

Ms Agatha Lawrie has never married nor had children and lives alone. She has two nephews, John and Christopher. John has always been very involved in her life and has previously lived with his aunt. Ms Lawrie has a diagnosis of dementia, made several years ago. Her condition has declined recently and she now needs a high level of care. John contacts the social work team and it is eventually decided under a best interests process that she should be admitted to a care home, as she needs 24 hour support. As his aunt has been assessed to lack capacity to consent to this admission, a Protective Authorisation application is granted and John is appointed as his aunt's representative. Although Ms Lawrie is initially quite settled in the home, after a few weeks she is noted to be very unhappy and keeps packing her bags. She is often found sitting by the door with her bags. She tells staff that

John had told her she would only be staying for a couple of weeks for a break and now she wants to go back to her own home.

A few weeks after Ms Lawrie is admitted to the care home, Christopher contacts the safeguarding team to say he is concerned that his brother may not be acting in Ms Lawrie's best interests. He reports that John has moved into her house and is withdrawing money from her bank account. Christopher says that his aunt is objecting to staying in the care home but that John is not representing her wishes by making an application to the MHCRT and he thinks this is because John wants to stay living in her house.

A safeguarding investigation is opened and the Capacity Professional is advised of the allegations. Due to these concerns and the potential conflict of interest, John is removed as his aunt's representative and an ICR appointed whilst the safeguarding allegations are investigated. The ICR will represent Ms Lawrie as her appointed representative, including supporting an application to the Tribunal.

10.22 Can P refuse the involvement of an ICR?
If P has capacity to decide whether they wish an ICR to be instructed under s42 Capacity Law and they do not wish an ICR to be involved, there is no obligation for an ICR to be appointed to represent P. It is important to understand that P's refusal of an ICR's involvement does not necessarily mean that P has capacity to make this decision. The ICR's support is to ensure P's involvement and to represent P in complex decisions. A capacity assessment should be completed and documented on P's notes to consider whether P has capacity to decide whether an ICR should be appointed. If P lacks capacity a best interests decision will need to be made regarding the involvement of an ICR, against P's wishes.

10.23 Who can act as an ICR?
A person can act as an ICR if they have successfully completed the relevant training approved by the Committee. The person should be able to act independently and with integrity. The ICR must follow the Law and the relevant guidance in the Code of Practice.

10.24 Independence of ICR
An ICR cannot support a particular P if the ICR is already engaged in caring for, or treating P in a paid or professional capacity (other than if they are already instructed as an ICR for P). The ICR should not have any links to the person instructing them, the decision maker or to other individuals involved in P's care or treatment, which could affect the ICR's independence.

10.25 If P has friends or family able to support and represent them but they do not agree with a best interests decision, this is not a reason to instruct ICR. See Chapter 3.

11. Protective Authorisation Scheme

Protective Authorisation Scheme Overview

Who does it cover?
Any person aged 16 or over who has a mental disorder and who has been assessed to lack capacity to make the relevant decision about their accommodation to receive care and/or treatment.

Where?
Care homes registered with CHSC
Hospitals
Supported accommodation
Own home, if provided with CHSC funded package of care

How is it authorised?
Different processes apply to different settings with oversight provided by a Capacity Professional.

What does it mean?
P is subject to a significant restriction of P's personal rights:

- P is confined to a particular place
- P has not consented to the confinement
- Arrangements made by, or due to an action of an Island authority
- Includes a deprivation of liberty within meaning of Article 5 ECHR

Rights
A person subject to a Protective Authorisation has the right to:
1.make an appeal
2.the support of a representative

Qualifying requirements

1. Age
2. Capacity (functional)
3. Significant Restriction
4. Cognitive impairment (diagnostic)
5. Contrary Decisions
6. Best Interests

Why?
The Protective Authorisation Scheme provides legal authorisation for care and health providers where the arrangements for a person's care amounts to depriving that person of their liberty, contrary to Article 5(1) European Convention of Human Rights. The Scheme provides the person with the right to challenge this in compliance with Article 5(4).

11.0 The Protective Authorisation Scheme provides safeguards and upholds the rights of persons who lack capacity to make their own decisions regarding being accommodated in a specific place to receive care and/or treatment, where those arrangements comprise **significant restrictions** on their personal rights and freedoms, amounting to a **deprivation of their liberty**. This chapter uses P to refer to a person who lacks capacity to make their own decision about being accommodated to receive care and treatment.

11.1 European Convention on Human Rights

The Protective Authorisation Scheme, complies with the right to liberty and security under Article 5 of the ECHR, which states: “Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law"[32] and "Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful." The Protective Authorisation scheme complies with Article 5 ECHR. Although a best interests decision can decide that P should be accommodated in a particular place to receive care and treatment, where these arrangements comprise a significant restriction of P’s rights, this must be authorised under the Protective Authorisation scheme. A best interests decision cannot authorise a significant restriction (deprivation of liberty).

11.2 Article 5 protects individuals from unlawful deprivation of liberty but also recognises that sometimes it is necessary to detain a person of "unsound mind". It does not apply to someone who can give informed consent to the arrangements for their care and treatment (i.e. a person who has capacity to make the relevant decision).

11.3 Article 5(4) states “Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.” Under the Protective Authorisation scheme P, or P’s representative, can make an application to the Mental Health and Capacity Review Tribunal to challenge their detention.

11.4 The main features of the Protective Authorisation scheme are as follows:

- applies to all persons aged 16 and over, who have a mental disorder (whether this is temporary or permanent) who are assessed to lack capacity to make their own decision about their accommodation in the specific place.
- applies to all settings, including hospitals, care homes approved by the Committee, supported accommodation and the person’s own home.

[32] Article 5(1) ECHR

- the Protective Authorisation should be requested in advance of the arrangements, which amount to a significant restriction, being made. The only exception to this is in an emergency situation. The Protective Authorisation should be granted as part of the process of arranging a care package/placement, where such arrangements would deprive a person of their liberty.
- includes provision for short term authorisations (up to 28 days) to be granted by hospital wards, without the need for a full assessment to take place (subject to certain requirements).
- creates the role of the Capacity Professional, to act as an independent reviewer of cases, as well as assessing certain cases.
- the Mental Health Review Tribunal becomes the Mental Health and Capacity Review Tribunal. The Tribunal will hear most cases where a person or their representative objects to the proposed or actual arrangements.
- requires care homes to be approved by CHSC before a resident can be accommodated under a Protective Authorisation.
- allows for a Protective Authorisation to be transferrable, provided that the key features remain the same and provided that there is no evidence that there has been a change in the person's capacity.
- a Protective Authorisation can be granted for a maximum period of 11 months.
- covers the person's accommodation arrangements in order to provide them with care and treatment but does not authorise the provision of care or treatment (any decisions to provide care or treatment should be made under s6 Best Interests).

11.5 Significant Restriction

The Protective Authorisation Scheme defines "a significant restriction of P's personal rights" which has three elements:

(a) **The objective element**: a person (P) is confined in a particular restricted space for a not negligible time,

(b) **The subjective element**: P has not validly consented to that confinement, and

(c) **Involvement of the state:** The arrangements which include the confinement are made by, or are due to an action of, a person or body responsible to, or regulated by, an island authority,

For the avoidance of doubt, this includes a deprivation of liberty within the meaning of Article 5 of the European Convention on Human Rights ("the ECHR").

11.6 What constitutes a deprivation of liberty?

There are several key legal judgments, which have sought to identify what constitutes a deprivation of liberty. These are summarised below.

11.7 HL v the United Kingdom 45508/99 [2004] ECHR 471

This case concerned a man (HL) diagnosed with autistic spectrum disorder and a severe learning disability. HL was living with carers in the community, having previously spent 32 years in Bournewood Hospital. He attended a day service, but

became agitated one day and was readmitted to Bournewood Hospital on an informal basis. He was not permitted to leave, nor was he permitted to have visitors. HL's carers, Mr and Mrs E, challenged this admission in court and he was eventually discharged back to their care. This case was ultimately appealed to the European Court for Human Rights and in 2004 the Court held that this hospital admission constituted the deprivation of HL's liberty and had breached Article 5(1) as it had not been in accordance with "a procedure prescribed by law." HL's Article 5(4) rights had also been breached because he had no means "to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful."

11.8 P v. Cheshire West and Chester Council [2014] UKSC 19
Two cases, P v Cheshire West and Chester Council and P&Q v Surrey County Council, were heard at the Supreme Court in London in 2014 and the relevant persons found to be deprived of their liberty. The ruling set out the "acid test" for a deprivation of liberty: the person who lacks capacity to consent to their accommodation in order to receive care and/or treatment is (a) subject to both continuous supervision and control, and (b) not free to leave.

11.9 JE v DE & Ors [2006] EWHC 3459 (Fam)
DE was diagnosed with dementia, but he had also sustained a stroke, which had affected his sight and his short term memory. He was married to JE, however she was finding it difficult to manage and placed him on a chair outside their home and called the police. The local authority placed him in a care home before later moving him to a different home. DE repeatedly expressed his wish to return home. JE also requested that he be able to live with her; however, the local authority refused.

11.10 Munby J stated: "The fundamental issue in this case, in my judgment, is whether DE was deprived of his liberty to leave the X home and whether DE has been and is deprived of his liberty to leave the Y home. And when I refer to leaving the X home and the Y home, I do not mean leaving for the purpose of some trip or outing approved by SCC or by those managing the institution; I mean leaving in the sense of removing himself permanently in order to live where and with whom he chooses, specifically removing himself to live at home with JE." (Para 115).

11.11 The judge added: "DE was not and is not 'free to leave', and was and is, in that sense, completely under the control of SCC [the local authority], because, as [counsel] put it, it was and is SCC who decides the essential matters of where DE can live, whether he can leave and whether he can be with JE." (para 117)

11.12 Storck v. Germany 61603/00 [2005] ECHR 406
This was the case of a young woman who had been placed in a psychiatric institution by her father. She was placed in a locked ward but when she tried to leave she was brought back by the police. The judgment states: "… the notion of deprivation of liberty within the meaning of Article 5(1) does not only comprise the objective element of a person's confinement to a certain limited place for a not

negligible length of time. A person can only be considered as being deprived of his or her liberty if, as an additional subjective element, he has not validly consented to the confinement in question." (Para 74)

11.13 Guzzardi v. Italy (1981) 3 E. H. R. R. 333
Mr Guzzardi was an Italian citizen, who was arrested on 8 February 1973, placed in detention on remand in Milan and then charged with conspiracy and being an accomplice to the abduction of a businessman. Mr Guzzardi was remanded pending trial, during which time he married his fiancée by whom he shortly afterwards had a son. After two years, Mr. Guzzardi was removed from Milan jail and taken under police escort to the island of Asinara, which lies off Sardinia. He challenged the deprivation of his liberty.

11.14 The judgment says: "in order to determine whether someone has been "deprived of his liberty" within the meaning of Article 5, the starting point must be his concrete situation and account must be taken of a whole range of criteria such as the type, duration, effects and manner of implementation of the measure in question." (Para 92)

11.15 In the matter of D (A Child) [2019] UKSC 42
This long running case was heard by the UK Supreme Court where the ruling was finally handed down in September 2019. D was 15 years old when the case first came to the court. He has diagnoses of ADHD, Asperger's syndrome and Tourette's Syndrome as well as a mild learning disability. At the age of 14 he was admitted to a psychiatric hospital for assessment and treatment, due to difficulty managing his behaviour at home. The hospital trust applied for authority from the High Court (under the inherent jurisdiction) as they recognised that D was confined to the hospital. At the hearing the judge held that D's parents were consenting to the confinement and therefore he was not deprived of his liberty. When D was discharged from the hospital to a residential placement, his parents provided consent to the arrangements under the Children Act 1989. Again, he was confined and was subject to restrictions, including locked doors, no unescorted access out of the home and one to one support during the day. The local authority brought the case to court on the basis that his parents could provide consent once D turned 16, which would therefore prevent his circumstances from being seen as a deprivation of liberty for the purposes of Article 5 of the ECHR. This view was originally upheld in 2016, but overturned by the Court of Appeal in 2017. In 2019, the Supreme Court ruled that D was deprived of his liberty. Lady Hale stated: "the degree of supervision and control to which D was subject while in Placement B and Placement C was not normal for a child of 16 or 17 years old. It would have amounted to a deprivation of liberty in the case of a child of that age who did not lack capacity."

11.16 On the subject of parental responsibility, she addressed the question of whether there was any scope to authorise what would otherwise be a deprivation of liberty. She said: "in both Nielsen and Storck it was recognised that the state has a

positive obligation to protect individuals from being deprived of their liberty by private persons, which would be engaged in such circumstances."

11.17 Lady Hale concluded that it was: "… not within the scope of parental responsibility for D's parents to consent to a placement which deprived him of his liberty. Although there is no doubt that they, and indeed everyone else involved, had D's best interests at heart, we cannot ignore the possibility, nay even the probability, that this will not always be the case. That is why there are safeguards required by article 5. Without such safeguards, there is no way of ensuring that those with parental responsibility exercise it in the best interests of the child." (Para 49)

11.18 London Borough of Hillingdon v Neary & Anor [2011] EWCOP 1377
Steven Neary was a 20 year old man who was diagnosed with autistic spectrum disorder and severe learning disability. He had been living with his father with a package of care including attending a day service and regular respite care. Mr Neary requested respite care for his son in December 2009, for a few days. Subsequently there was disagreement between Mr Neary and the local authority about Steven returning home and he remained in the unit until December 2010.

11.19 This case highlighted that the DOLS process (and, by extension, is relevant to the Protective Authorisation Scheme) cannot authorise an interference with a person's Article 8 rights, for example by preventing P from living with their family or to restrict contact with family. This is reflected in the Law at s49(2) "a Protective Authorisation does not authorise an arrangement or act which would only be a restriction with P's rights under Article 8 of the Human Rights Convention."

11.20 AG v BMBC & SNH [2016] EWCOP 37
This case concerned the covert administration of medication to a woman with dementia living in a care home. The Court of Protection found that: "Medication without consent and covert medication are aspects of continuous supervision and control that are relevant to the existence of a deprivation of liberty." The judge stated that this should therefore have been recorded as a restriction and that a condition should be imposed to ensure frequent review of the covert administration of the medication.

11.21 Re: Ferreira v HM Senior Coroner for Inner South London [2017] EWCA Civ 31
Maria Ferreira was diagnosed with Down's Syndrome. She died in an intensive care unit. An inquest was to take place, but a jury would only be required if she had died in "state detention" under ss7 and 48 of the Coroners and Justice Act 2009 (CJA 2009). A key issue therefore was whether "state detention" equated to "deprivation of liberty" under Article 5(1) of the ECHR and the relevance of the Supreme Court's decision in *Cheshire West*.

11.22 The Court of Appeal concluded Ms Ferreira was not in state detention for three reasons: (1) *Cheshire West* did not apply; (2) if it did apply, she was free to leave;

and (3) unlike MCA s 64(5), the CJA 2009 does not expressly require consideration of Article 5 and ICU is not state detention.

11.23 The Court ruled that Ms Ferreira was: "… not deprived of her liberty at the date of her death because she was being treated for a physical illness and her treatment was that which it appeared to all intents would have been administered to a person who did not have her mental impairment. She was physically restricted in her movements by her physical infirmities and by the treatment she received (which for example included sedation) but the root cause of any loss of liberty was her physical condition, not any restrictions imposed by the hospital." (para 10)

11.24 The judge concluded that: "… There is in general no need in the case of physical illness for a person of unsound mind to have the benefit of safeguards against the deprivation of liberty where the treatment is given in good faith and is materially the same treatment as would be given to a person of sound mind with the same physical illness. The treatment is neither arbitrary nor the consequence of her impairment… In the case of a patient in intensive care, the true cause of their not being free to leave is their underlying illness, which was the reason why they were taken into intensive care." (para 93 and 99)

11.25 This ruling means that where a patient is so ill that they would be at risk of dying if they were not in hospital (ie they have to be in hospital in order to receive treatment) they are not subject to a significant restriction (deprived of their liberty). However, if as treatment progresses and the patient's condition improves, their ongoing care could become a significant restriction. If life-saving treatment is being provided in care homes or hospitals, including for the treatment of COVID-19, it does not amount to a or significant restriction, provided that the treatment is the same as would normally be given to any patient without a mental disorder.

Identifying a significant restriction

11.26 The Objective Element:
Section 47 of the Law states that P is subject to a significant restriction if P is confined in a particular place, for a not negligible time, P has not validly consented to the confinement and the relevant arrangements are made by, or due to an action of, a person responsible to or regulated by an Island authority.

11.27 To identify a significant restriction, it is important to consider the **concrete** situation of the relevant person, including the type, duration, effects and manner of implementation of the restrictions in place, in order to determine whether (a) P is not free to leave, AND (b) the restrictions constitute continuous (or complete) supervision and control

11.28 P is prevented from moving from the place in which P is required to reside
If P would be prevented from leaving the place where they are residing, to live elsewhere or with whom they choose, this is a restriction of the person's personal rights and freedoms, even if P has not requested to leave or would be unable to do so without support (ie P is nursed in bed). The important consideration is what would happen if P wishes to leave.

11.29 P is subject to continuous supervision and control.
The cumulative effect of the restrictions in place should be considered to see whether these amount to continuous supervision and control. One or two restrictions alone may not amount to a significant restriction. It is the **cumulative effect**, and the degree and intensity of the restrictions, which needs to be assessed. The difference between confinement and restriction of P's liberty is "merely one of degree or intensity, and not one of nature or substance".[33] To consider whether P is subject to continuous supervision, consideration should be given to whether the care plan ensures that carers

- know where the person is, and
- know what the person is doing, and
- would intervene to protect the person if they were at risk of harm.

11.30 Restraint
Section 9 of the Law provides that the use of restraint is permitted only if the individual taking the action reasonably believes it is necessary to do so in order to prevent harm to the person and that the restraint is a proportionate response to the likelihood of harm and the seriousness of that harm.

11.31 Restrictions

Examples of restrictions which may amount cumulatively to continuous supervision and control:

- one to one (or higher) staffing for long periods of time;
- doors are locked and P does not have access to a key or the door code. This includes locked areas (such as the kitchen) of the home or restrictions on entering areas (for example only being able to use the bathroom or the kitchen with staff support);
- use of technology to monitor the person, including CCTV, sensor mats to alert staff when the person moves around, door alarms, room monitors;
- staff escort the person to attend activities outside of the care home and P cannot go out without an escort;
- the use of covert medication, particularly if the medication is used to alter P's mood or is antipsychotic. This could constitute chemical restraint.;
- the use of physical restraint;

[33] Guzzardi v Italy 7367/76 [1980] ECHR 5

- the use of bedrails or lap belts in wheelchairs;
- decisions are made on behalf of the person (loss of autonomy);
- the use of 'seclusion areas' where the person is removed from others in the home;
- restriction on certain foods or drinks such as alcohol or caffeine;
- restriction on smoking, staff storing cigarettes/lighter etc;
- restriction on the use of technology (for example staff removing mobile phone or tablet and the person does not have free unrestricted access);
- a person is prevented from having or maintaining a sexual relationship where there are no safeguarding concerns;
- restrictions on contact with family or friends (this constitutes an interference with Article 8 and cannot in itself be covered by a Protective Authorisation);
- the person does not have access to their glasses, hearing aids, false teeth as and when they need these;
- the decision to admit P to the care home was made by a social care professional;
- P would be prevented from leaving the home to live elsewhere. If the carers would prevent P from leaving, including by distracting them, this is a restriction. It includes those people who are physically unable to leave the home. It is not necessary for the person to ask to leave in order for that person to be subject to a significant restriction.

11.32 Carers or staff operate continuous supervision and control over P
The following table sets out examples which suggest situations where there is likely or unlikely to be continuous supervision and control in relation to P.

Likely to be continuous supervision and control	**Unlikely to be continuous supervision and control**
Carers/staff know where P is or monitor P's whereabouts	P has freedom to go out or move around without monitoring
Carers decide when or if P can go out. This includes assessing P's mood, placing restrictions on how long P goes out for, calling the police if P does not return at the designated time.	P can come and go without restrictions.
Carers wake P and/or put P to bed at times decided by the carers.	P has freedom to decide what time to get up and to go to bed.
P is escorted to go out at times decided by the staff.	P is escorted by staff but has flexibility as to when they go out.
Meals are provided at set times, with a limited choice.	P can choose when and what to eat and/or is able to prepare their own meals.
Staff anticipate P's needs	P makes own decision about what support they receive and when

11.33 The restrictions should be necessary and proportionate to the risks of the harm that they are designed to prevent. However, when considering whether there is a significant restriction, it is necessary to consider only the concrete situation of the person and the restrictions they are subject to, not whether these are necessary to

maintain their safety or wellbeing. These matters are considered when looking at the person's best interests.

11.34 Restrictions should be regularly reviewed. A sensor mat may no longer be necessary if P loses the ability to walk. The use of mood altering medication and physical restraint should be reviewed regularly. In AG v BMBC & SNH[34], the Court of Protection noted: "*Although it is not an issue for me to determine I accept that treatment without consent (covert medication in this case) is an interference with the right to respect for private life under Article 8 of the ECHR and such treatment must be administered in accordance with a law that guarantees proper safeguards against arbitrariness. Treatment without consent is also potentially a restriction contributing to the objective factors creating a DOL within the meaning of Article 5 of the Convention. Medication without consent and covert medication are aspects of continuous supervision and control that are relevant to the existence of a DOL. It must therefore attract the application of Section 1(6) of the Act and a consideration of the principle of less restriction and how that is to be achieved." (para 25)*

11.35 Not negligible time.
The Law does not specify what constitutes "a not negligible time", therefore consideration should be given to the intensity of the restrictions and the potential impact on the person. It is likely that a period of two to three days would be considered a "not negligible" period of time. In one case a 2 hour journey to a residential school was held to be a deprivation of liberty.[35] In deciding whether a confinement for a short period of time will amount to a significant restriction (deprivation of liberty), the following factors should be considered. The presence of any of these will make it more likely that a deprivation of liberty will be, or is, occurring: the use or threat of force or coercion; particularly severe or serious forms of restraint, and the consequences of the restrictions for the person.

11.36 The Supreme Court judgment Cheshire West [UKSC] 2014 confirmed that the following are not relevant to the question of whether P is deprived of their liberty (subject to a significant restriction):

- P's compliance or lack of objection to the arrangements for their care
- the relative normality of the placement
- the reason for, or purpose of a particular placement

11.37 The Subjective Element: Consent
If P has been assessed to lack capacity to make P's own decision about being accommodated in a specific place, to receive care and treatment, including all the restrictions in place, P has not validly consented.

[34] See AG v BMBC & SNH [2016] EWCOP 37.
[35] Re Z (A child: deprivation of liberty: transition plan) [2020] EWHC 3038 (Fam) a

11.38 It is important to consider what the relevant information is when making an assessment of P's capacity to make a decision as to their place of residence. This has been set out in case law[36] and provides clear guidance to assessors.
These are:

a) the different options, to include the type and nature of the options and how the person will be supported. P must understand the kind of property they would be living in and the facilities available.
b) Information about the area where they would be living.
c) The difference between living in a place and visiting it.
d) The activities available to the person in each option.
e) Whether P would be able to see friends and family in each option.
f) Payment for the accommodation. It would only be necessary for the person to understand that there is a payment required but not the actual cost.
g) Any rules or obligations, for example if there is a tenancy agreement involved but not the legal nature of the tenancy.
h) Who P would be living with at each option.
i) The care they would have in each option – for example in a care home they may have 24 hour care but in sheltered accommodation they may have periods without carers/support.

11.39 The relevant arrangements for care or treatment are provided by, or are due to an action of, a person or body responsible to, or regulated by, an Island authority
A Protective Authorisation will be required for all significant restrictions where the State has some responsibility for P's confinement. This includes care packages or placements funded by CHSC, but also where a health or social care worker has been involved in arranging the care or treatment, even if P or P's family funds P's care.

11.40 Under Article 5 there is a positive obligation on the State to protect all of its citizens against interferences with their liberty, whether by public bodies or by private individuals. Public authorities are therefore obliged to take action to protect individuals, including reasonable steps to prevent a significant restriction of which the authorities have or ought to have knowledge. Therefore, if the CHSC (including those employed or otherwise instructed by the Committee) knows, or ought to know that P is subject to a significant restriction, the positive obligation is triggered. This includes if a care home makes an application for a Protective Authorisation or if a safeguarding alert is raised. At that time a CP must investigate the situation and determine whether there is, a significant restriction. If so assessments should be completed under the PA scheme Process A.

[36] LBX v K. L & M [2013] EWHC 3230 (Fam)

Examples where Protective Authorisation required	Examples where Protective Authorisation not required
P is resident in a care home which has been approved by or on behalf of the Committee.	A person who **has** capacity is accommodated in a care home or hospital.
P is staying in hospital to receive care and/or treatment.	A person who lacks capacity is receiving care and treatment in their own home arranged and paid for by the person or their family and where there has been no involvement by health or social care professionals.
P has a package of care in their own home, which amounts to a significant restriction with their rights and freedoms, and where such care has been arranged by, or funded by the CHSC.	A person who lacks capacity is resident in a care home but is not subject to a significant restriction on their personal rights and freedoms.
P spends periods in respite care, in a home approved by the Committee.	P had validly appointed a family member or friend as their attorney under a lasting power of attorney. The attorney arranges the placement in the care home. The attorney, or P, pays for the placement.
P had validly appointed a lawyer as their attorney under a Lasting Power of Attorney. The attorney arranges the placement in the care home.	A person is detained in an approved establishment in accordance with the Mental Health Law.

11.41 Significant restriction and 16/17 year olds

The safeguards provided by the Protective Authorisation Scheme apply to 16 and 17 year olds, who lack capacity to consent to their accommodation in order to receive care and/or treatment, whether they are accommodated in hospital, a residential placement, educational facility or in their own home. A parent (or person with parental responsibility) cannot consent to the significant restriction on behalf of a 16 or 17 year old person (see In the matter of D (A child) [2019] UKSC 42).

11.42 Capacity Professionals

The Law creates the role of the Capacity Professional, who will have responsibility for overseeing and, in some cases completing, the assessments to meet the requirements for a Protective Authorisation. The following professionals are eligible to undertake training as a Capacity Professional:

- registered social worker,
- approved social worker,
- occupational therapist,
- nurse,
- psychologist,
- Speech and Language Therapist.

11.43 The Capacity Professional must:

- complete training approved by the Committee before being qualified to act,
- attend further relevant training every 11 months to include legal updates and practice issues,
- have the skills necessary to obtain, evaluate and analyse complex evidence and differing views and to be able to weigh that information as part of the process, and
- act with fairness, impartiality and independence. The Capacity Professional's role is to act in the best interests of the relevant person.

11.44 The Capacity Professional has the right to enter a place where the person is, or may be, subject to a Protective Authorisation and to have access to all relevant documentation.

11.45 The role of the Capacity Professional
The Capacity Professional (CP) has responsibility for the granting of the Protective Authorisation. The CP must scrutinise the assessments to ensure that all the requirements are met for a Protective Authorisation. If a CP has completed the best interests and/or significant restriction assessments, a different CP must provide the final authorisation, to provide adequate scrutiny and independence.

11.46 Process A (see 11.61 for detail of Process A).
The CP ensures that the relevant assessments are completed to meet the requirements for an authorisation. This includes instructing a doctor to complete the Cognitive Impairment assessment or ensuring that any existing assessment is valid and relevant.

Note: If P is objecting to the proposed arrangements the CP must complete the significant restriction and best interests requirements.

Assessment	Completed by:
Age requirement	Health or social care professional arranging placement or equivalent assessment
Capacity (functional) requirement	Health or social care professional arranging placement or equivalent assessment
Significant restriction requirement	Health or social care professional arranging placement
Cognitive impairment requirement	Doctor or equivalent assessment

Contrary decisions requirement	Health or social care professional arranging placement
Best interests requirement	Health or social care professional arranging placement

11.47 Process B (see 11.57). The prescribed person in the care home grants an initial 28 days authorisation and submits an application for an assessment by the CP. Assessments are completed as follows. A different CP must scrutinise the assessments to confirm that these meet the requirements and grant the authorisation.

Assessment	Completed by:
Age requirement	CP or equivalent assessment
Capacity (functional) requirement	CP or equivalent assessment
Significant restriction requirement	CP
Cognitive impairment requirement	Doctor or equivalent assessment
Contrary decisions requirement	CP
Best interests requirement	CP

11.48 Process C (see 11.61). The prescribed person in the hospital grants an initial 28 days' authorisation. If the person is to remain in hospital for longer than 28 days, the prescribed person must submit an application for an assessment by a CP. A different CP must scrutinise the assessments to confirm that these meet the requirements and grant the authorisation.

Assessment	Completed by:
Age requirement	CP or equivalent assessment
Capacity (functional) requirement	CP or equivalent assessment
Significant restriction requirement	CP
Cognitive impairment requirement	Doctor or equivalent assessment
Contrary decisions requirement	CP
Best interests requirement	CP

11.49 How can a significant restriction of a person's personal rights be authorised?

The Law provides for a Protective Authorisation to be granted for any P who is accommodated in a care home, hospital or in P's own home, where P lacks capacity to consent to their accommodation to receive care and/or treatment and where the arrangements amount to a significant restriction of P's personal rights. The process for authorisation is dependent upon the setting where P is accommodated.

11.50 Processes for authorisation

There are three processes to grant a Protective Authorisation. These apply where P is to be confined in order to receive care and/or treatment and these arrangements amount to a **significant restriction** and where P **lacks capacity to consent** to those arrangements.

11.51 Which process applies?

P has a CHSC commissioned placement in a care home, supported accommodation or in P's own home The placement is arranged by a health or social care professional and the funding is provided by arrangement of the CHSC. The person, the person's representative or ICR do **not** object to the proposed arrangements	**Process A applies**	The professional making the arrangements completes the Significant Restriction assessment, Best Interests Assessment and other assessments, as required by the Capacity Professional, prior to the arrangements commencing. The Capacity Professional **oversees** the Protective Authorisation process, including arranging for the completion of assessments, as necessary.
P has a CHSC commissioned placement in a care home, supported accommodation or in P's own home The placement or package of support is arranged by a health or social care professional and funding provided by arrangement of the CHSC. The person, the person's representative or ICR **object** to the proposed arrangements		The Capacity Professional must **complete** the significant restrictions and Best Interests Assessments and **oversees** the process, including completing or arranging the completion of the other assessments.
P is self-funding a placement in a CHSC approved home. The person is resident in, or will be resident in a care home, which is approved by CHSC to take residents under a Protective Authorisation. The person's care is, or will be paid for by the P or P's representative, or by the Chief Pleas of	**Process B applies**	The prescribed person grants an initial Protective Authorisation for a period of 28 days **and** applies to a Capacity Professional to oversee the completion of the assessments. If the requirements are met the CP will issue a Protective Authorisation.

Sark but the arrangements have been made by, or due to an action of a person or body regulated by an island authority.		
Hospital admission (not including detention under the Mental Health Law) The person is admitted to hospital for treatment (other than for life sustaining treatment).	**Process C applies**	The prescribed person in the hospital grants an initial Protective Authorisation for a period of 28 days. If the person is likely to remain admitted to hospital for longer than 28 days, the prescribed person applies to a Capacity Professional to oversee the completion of the other assessments. The Capacity Professional can extend the initial Protective Authorisation for a period of up to 7 days, if this is in the person's best interests.
The Capacity Professional is informed that P may be subject to a significant restriction (see 11.5)	Process A applies	The Capacity Professional must **complete** the significant restrictions and Best Interests Assessments and **oversees** the process, including completing or arranging the completion of the other assessments

Process A

11.52 Process A applies if:

a) P is, or will be accommodated in a care home, in sheltered accommodation or in P's own home in order to receive care and treatment,
b) the proposed arrangements amount to a significant restriction of P's personal rights and freedoms,
c) the placement or package of care will be commissioned by CHSC, **and**
d) the person lacks capacity to consent to the relevant arrangements.

11.53 It is expected that the Protective Authorisation will be granted, before the proposed arrangements go ahead. The responsible health or social care professional should complete the Significant Restriction and Best Interests Assessments, unless the person is objecting to the proposed care arrangements (see S 11.42).

11.54 The process is overseen by a Capacity Professional who arranges for completion of the other assessments or identifies whether there are suitable equivalent assessments which can be used. For example, if the person has recently seen a medical professional who has diagnosed the person with dementia, this assessment can be used for the Cognitive Impairment Requirement. The capacity professional is responsible for deciding whether an equivalent assessment is relevant and valid.

11.55 If P, or their representative is objecting to the proposed arrangements, a Capacity Professional must complete the best interests assessment and oversee the completion of the other assessments.

11.56 If P has no family or friends available to be consulted, the Capacity Professional will appoint an Independent Capacity Professional to ensure that P has representation under this process. The role of the ICR is to establish P's views about the proposed arrangements. The ICR will provide a written report to the prescribed person completing the Best Interests Assessment, within 14 days of being instructed.

The Capacity Professional will grant the Protective Authorisation if all the requirements are met. This should be for the minimum period necessary but no longer than 11 months

11.57 Process B
Process B applies if:

a) P is resident in, or will be accommodated in, a care home approved by the Committee to take residents under a Protective Authorisation, and
b) the proposed arrangements amount to a significant restriction of P's personal rights and freedoms,
c)the placement is self-funded by P or P's representative but have been arranged by, or due to action of a person or body employed by, or regulated by an island authority, **and**
d) P lacks capacity to consent to the relevant arrangements.

Case example -admission to care home Process B

Mrs Christie lives alone. She has been diagnosed with dementia and also has other physical health care needs. Mrs Christie has the support of carers twice a day. One day her carers arrive and find her on the floor. It is not clear how long she has been there. The ambulance is called and Mrs Christie is admitted to

hospital. She is dehydrated and has a pressure ulcer. Her daughter, Tracey, lives in the USA. She tells the hospital doctor that she is concerned about how her mother is managing at home, as she appears to have had several falls. Tracey is not able to travel to Guernsey. The doctor makes a referral to the hospital social worker. The social worker assesses that Mrs Christie would be at high risk at home without 24 hour care however her property is not suitable for her, increasing her risks of harm, particularly from falling.

A best interests meeting is arranged after the social worker assesses Mrs Christie to lack capacity to make her own decision about her accommodation. The best interests meeting concludes that it is in her best interests to move to a care home where she will have 24 hour support. Mrs Christie is quite wealthy and able to pay for her own care. Tracey arranges for her mother to be admitted to a care home.

The care home manager will need to complete the relevant form to grant an initial authorisation and to request an assessment by the CP.

11.58 If the prescribed person in the care home believes that P's accommodation in the home constitutes a significant restriction of P's personal rights and freedoms and that the person lacks capacity to consent to this, a Protective Authorisation should be issued for a period not exceeding 28 days. The prescribed person will be responsible for referring to the CP who will oversee the completion of the assessments to meet the requirements for an authorisation. This process can also be used to authorise short admissions for self-funded respite care.

11.59 The Capacity Professional must grant the Protective Authorisation if all the requirements are met. This should be for the minimum period necessary but no longer than 12 months.

11.60 If P has no family or friends available to be consulted, the Capacity Professional must instruct an Independent Capacity Professional to ensure that P has representation under this process. The role of the ICR is to establish P's views about being accommodated in the care home to receive care and/or treatment. The ICR should provide a written report to the CP.

11.61 Process C
Process C applies if:

a) P has been admitted to hospital for medical treatment,
b) the proposed or actual arrangements amount to a significant restriction of P's personal rights and freedoms, **and**
c) P lacks capacity to consent to the relevant arrangements.

11.62 If the prescribed person believes that P's accommodation in the hospital amounts to a significant restriction of P's personal rights and freedoms and that P's

lacks capacity to consent to stay there, a Protective Authorisation should be issued, for a period not exceeding 28 days. The responsible person in the hospital must advise the CP that a Protective Authorisation has been granted.

11.63 If P will need to stay in hospital for longer than 28 days, the prescribed person should make a referral to the Capacity Professional who will oversee the completion of the assessments to meet the requirements for an authorisation.

11.64 If P has no family or friends available to be consulted, an Independent Capacity Representative (ICR) must be appointed to ensure that the person is represented during this process. The role of the ICR is to establish the person's views about being accommodated in hospital to receive care and/or treatment. The ICR will provide a written report to the CP.

11.65 The Capacity Professional will grant the Protective Authorisation if all the requirements are met. It should only be granted for the minimum period necessary, but no longer than 12 months.

11.66 Mental Health Law
If P is detained under the Mental Health Law (2010), the Protective Authorisation Scheme does not apply. If P is already subject to the Mental Health Law, but later requires treatment in hospital for a physical health condition, this is covered by s37 Mental Health Law and does not require a Protective Authorisation.

11.67 Protective Authorisation in P's own home (including supported accommodation)
The Protective Authorisation scheme applies to arrangements which amount to a significant restriction of P's personal rights and freedoms in P's own home only if the care or treatment is provided by, or are due to an action of a person or body responsible to, or regulated by an Island authority. This applies if a health or social care professional has arranged the support package or if this is funded by the CHSC.

11.68 Respite care
Self-funded stays in care homes (approved by the Committee) for respite care can be authorised under the Protective Authorisation scheme. One-off short term visits (for example when carers are on holiday) can be authorised under Process B. If the stay is for 28 days or less this is authorised by the responsible person in the care home, without the need for further assessments. If P has a CHSC funded package of care in P's own home, which includes respite care, all the care arrangements will be authorised.

11.69 Protective Authorisation and transportation
If P is to be transported, for example to a new placement, and the arrangements involve a high level of restrictions, this should be authorised under the PA scheme. This would be required where P has (for example) a high level of staff support (at

least 1:1), where other restrictions are in place, such as additional seat straps, if medication is used to calm P before travel. If P is to be transported to a placement away from the Bailiwick, this should be referred to the Tribunal for authorisation. The Protective Authorisation scheme only applies within the Bailiwick of Guernsey.

11.70 The Protective Authorisation process comprises six assessments or requirements. All six requirements need to be met for a Protective Authorisation to be granted. These are:

1. **Age requirement** (See para. 11.73)
2. **Capacity (functional) requirement** (See para. 11.74)
3. **Significant Restriction requirement (**See para. 11.75)
4. **Cognitive Impairment (diagnostic) requirement** (See para. 11.76)
5. **Contrary decisions requirement** (See para. 11.77)
6. **Best interests requirement** (See para. 11.79)

11.71 Who can complete the assessments?
The Capacity Professional has responsibility for overseeing the completion of assessments, as well as completing some assessments, in specific cases. Certain assessments will need to be completed by a medical professional. Where relevant and valid, the Law allows for the use of equivalent assessments.

Assessment	**Who completes?**	**Can an equivalent assessment be used?**
1. Age	A Capacity Professional or other prescribed person (see below) should complete this assessment	Yes
2. Capacity	A Capacity Professional, psychiatrist, GP or other prescribed person should complete this assessment	Yes, however capacity is time and decision specific. An equivalent assessment can only be used if this is for the specific decision, has been completed within the previous 11 months and there is no evidence to indicate that P's capacity to make the relevant decision has changed.
3. Significant Restriction	A Capacity Professional or other prescribed person should complete this assessment	Yes, if the assessment has been completed within the previous 11 months and P's care arrangements are the same. For example, if a person is moving to a different care home, an

		equivalent assessment can only be used if P will be subject to the same restrictions in the new placement.
4. Cognitive impairment (diagnostic)	A GP or a psychiatrist must complete this assessment	Yes, provided that there is no evidence that there has been any change in P's condition (diagnosis). This would apply where P is diagnosed with a long-term or progressive condition, such as a learning disability or dementia. It would not be appropriate to use an equivalent assessment if this had been completed when P had a temporary mental disorder, such as an infection.
5. Contrary Decisions	A Capacity Professional or other prescribed person should complete this assessment	No. It is necessary to establish whether P's attorney has an objection to the arrangements for P's care (if within the scope of their authority).
6. Best Interests	A Capacity Professional or other prescribed person should complete this assessment	No. It is necessary to have an up to date consultation with P, P's representative and any person(s) engaged in caring for P or interested in their welfare.

11.72 Who is a prescribed person?

The Law refers to "prescribed persons". These are people who have specific roles under the Law as explained below.

Role	**Prescribed person**
Completing the age, capacity, significant restriction or best interests assessments for a Protective Authorisation	Capacity Professional, social worker, nurse, doctor or other health or social care professional
Authorising an initial (28 day) Protective Authorisation in a care home or hospital	Designated member of staff who has undergone appropriate training approved by the Committee.

Requirements

11.73 Age Requirement

The purpose of this requirement is to confirm that P is aged 16 or over. If P is under the age of 16, the Capacity Law does not apply. The Children (Guernsey and Alderney) Law 2008 and the Children (Sark) Law, 2016 (as appropriate) should be considered for any child under the age of 16. Any prescribed person can complete this assessment and an equivalent assessment (such as medical records) can be used.

11.74 Capacity Requirement

The purpose of this requirement is to assess whether P has capacity to make their own decision about being accommodated in the specific place in order to receive care and/or treatment and under arrangements which amount to a significant restriction of P's personal rights and freedoms. A person is not subject to a significant restriction if they are able to consent to be accommodated in a particular place. If P is assessed to have capacity, the Protective Authorisation scheme does not apply. A Capacity Professional, or a health or social care professional can complete this assessment; however, if the person is objecting or if the case is particularly complex, it may be appropriate for a psychiatrist to complete this assessment.

11.75 Significant Restriction Requirement

This is to assess whether the arrangements, or proposed arrangements, amount to a significant restriction of P's personal rights and freedoms. The assessor will need to specify all the restrictions that P will be subject to, to provide evidence that the cumulative effect of the arrangements go beyond mere restrictions to amount to a significant restriction of P's personal rights (to include deprivation of P's liberty). A Capacity Professional or a prescribed person should complete this assessment.

11.76 Cognitive Impairment (diagnostic) Requirement

The purpose of this assessment is to provide evidence of a mental disorder or cognitive impairment, whether this is permanent or temporary. A doctor or psychiatrist must complete this assessment. The Protective Authorisation Scheme does not apply to people who do not have a cognitive impairment. It is designed to protect those people who need the safeguards provided by the Law. A person may have a temporary condition, causing a cognitive impairment (such as a delirium or urinary tract infection). In such circumstances, and in the absence of other diagnoses, it is likely that they will only meet the cognitive impairment requirement for a limited time and this should be reflected in the period agreed for the Protective Authorisation.

11.77 Contrary Decision Requirement
The purpose of this assessment is to establish whether P has made a valid advanced decision to refuse treatment (ADRT), which could conflict with the request for a Protective Authorisation or whether P's guardian or attorney objects to the arrangements. A Capacity Professional or a prescribed person should complete this assessment. If P has made an ADRT to refuse specific treatment, P cannot be accommodated in a place, in conditions that amount to a significant restriction, in order to receive that treatment. A Protective Authorisation does not authorise treatment, only the accommodation in the relevant place, and all decisions to provide treatment should be considered under s6 (best interests). P's attorney can object to the actual or proposed arrangements, if they do not believe that these are in P's best interests.

11.78 An attorney under a Lasting Power of Attorney cannot provide consent to a significant restriction and a Protective Authorisation will still be required. However, if the attorney objects to the planned placement or package of care, which amounts to a significant restriction, and this is within the scope of their authority, alternative arrangements will need to be made which are less restrictive. The attorney must act in the best interests of the person (See Chapter 4). Such cases must be referred to the Capacity Professional. If alternative arrangements for P's care cannot be made, the Capacity Professional must refer this matter to the Mental Health and Capacity Review Tribunal.

11.79 Best Interests Requirement
The purpose of this assessment is to consider whether the arrangements for P's care and treatment, are in P's best interests. The report should explain why it is necessary to impose restrictions on P to the extent that this amounts to a significant restriction of P's personal rights and freedoms (and therefore depriving P of their liberty). All restrictions should be proportionate to the risks of harm that P would face if not accommodated in the specific place to receive care and treatment. The assessor should consider the harm that P would face without the specified arrangements and why there is no less restrictive option available which could safely and effectively meet P's needs.

11.80 The assessor should consider whether there are risk assessments to support the restrictions. Importantly, the assessment should take account of the person's views and any objections by P, or P's representative, to the actual or proposed arrangements. A Capacity Professional or other prescribed person should complete this assessment, unless there are any objections (to the actual or proposed arrangements) in which case a Capacity Professional must complete this assessment.

11.81 What happens if an assessment concludes that one of the requirements are not met?

If any of the assessments conclude that one of the requirements is not met, then the process for a Protective Authorisation should cease and an authorisation cannot be granted. The Capacity Professional will inform P and all those involved or consulted during the assessment process. A significant restriction of a person's personal rights and freedoms must comply with Article 5 ECHR.

Requirement failed	**Action necessary**
Age requirement	If the person is under the age of 16 the Law does not apply. The prescribed person will need to consider whether there are other legal processes which would apply.
Capacity requirement	If P has been assessed to have capacity to make P's own decision about being accommodated in the relevant place, a Protective Authorisation cannot be granted. If P consents to be accommodated at the actual or proposed accommodation to receive care and/or treatment, no further action is necessary. If P is refusing the actual, or proposed arrangements, then these cannot proceed and the person has the right to decide their own care arrangements.
Significant Restriction	If the person is not subject to a significant restriction, there is no need for a Protective Authorisation.
Cognitive impairment (diagnostic) requirement	If there is no evidence that the person has a cognitive impairment, either temporary or permanent, the Capacity Law does not apply
Contrary decision	If the person has made a relevant and valid Advanced Decision to Refuse Treatment regarding the proposed treatment or an Attorney under a Lasting Power of Attorney objects to the proposed placement or treatment then the proposed arrangements cannot go ahead.
Best Interests Decision	If the Capacity Professional or prescribed person concludes that the proposed or actual arrangements are not in the person's best interests, then these cannot proceed. The person proposing the arrangements should consider alternative arrangements, including adjusting the care plan to reduce the restrictions on the person.

11.82 Restrictions

All restrictions imposed on P should be necessary and proportionate to the risks of harm that P would face, if these were not in place. Before restrictions are imposed the staff responsible for the care plan, should complete relevant risk assessments with consideration to less restrictive options. A capacity assessment should be completed for each restriction. If P is assessed to lack capacity, the best interests process should be followed. All restrictions should be reviewed regularly to ensure that these continue to be necessary and proportionate to the risks of harm (see Best Interests Requirement).

Examples of restrictions

Restrictions	**Harm P may face**
Bedrails are in place. Chairs have lap belts in place.	P is at risk of falling from bed or chair. P has a history of falls
Doors are locked and P does not have access to a key/fob/code	P makes attempts to leave the care home or has a previous history of wandering. P has poor road safety awareness. P would be vulnerable if able to go out of the property without an escort.
Staff escort person in the community	P is at risk of getting lost. P is very vulnerable to abuse. P has a history of wandering
Medication is administered covertly	P refuses to take medication and is at risk of decline in their health without this.
1:1 or 2:1 support (or more)	P presents with behaviour that challenges or P is very vulnerable. P needs constant support and supervision to maintain P's safety, to attend activities and/or meet care needs. P's needs cannot be met without this level of support.
Use of physical and/or chemical restraint	Staff use physical restraint or medication to reduce P's behaviours. This should only be used when absolutely necessary to protect P, for example if P is at risk of self harm or physical retaliation by others, due to P's behaviour. NB If restraint is being used to protect others, the Mental Health Law may need to be used.
The decision to admit P to the care home or hospital has been made by a health or social care professional in P's best interests	P would be at risk of injury, physical or emotional decline or self neglect if not accommodated in the care home/hospital to receive care and treatment.
A DNACPR is in place and P lacks capacity to consent to this.	Resuscitation is likely to be futile or to cause P harm.
A sensor mat is in place to alert staff if P gets up from bed or chair.	P is at risk of falls and/or has a history of falls

Staff restrict certain foods	P has a diagnosis of diabetes and requires a suitable diet to reduce the risks from high blood sugar. P is not able to understand the risks. P's health would be at risk if staff do not control P's diet.
Staff restrict access to alcohol	P has health problems due to history of alcohol misuse. P's health would be at further risk if P were able to consume alcohol.
Staff control P's access to cigarettes/hold P's lighter	P's health and safety would be at risk if P had free access to cigarettes. Risk of fire.
Staff check P every half an hour	P is unable to use the call bell or to summon assistance, if needed
The kitchen door (in a care home) is locked.	P is at risk of burns or injury from knives if able to access the kitchen unattended.
CCTV is installed which monitors P (and other residents)	Risk assessment has identified that P's safety would be at risk without constant monitoring

11.83 What should happen if the assessor concludes that the restrictions are not proportionate to the risks of harm?

Any restrictions imposed on P should be necessary and proportionate to the risks of harm that P would otherwise face (see above for examples). The assessor should consider whether the restrictions are proportionate to the risks that P would face if not accommodated in the relevant place, to receive care and/or treatment. If these are overly restrictive it may not be in the person's best interests and consideration should be given to less restrictive options. If the assessor identifies restrictions that are not necessary or proportionate there should be a discussion with the person responsible for providing the care and treatment (for example the manager in the care home) and P's family/friends to see whether these can be reduced or removed. If this is not possible the assessor should refer this matter to the Capacity Professional who should consider whether a safeguarding referral may be required and who should also make a referral to the MHCR Tribunal. At this stage the Protective Authorisation cannot be granted as the Best Interests Requirement has not been met.

11.84 Examples of restrictions which may not be proportionate to the risks of harm to P

Restrictions	**Comments**
Bedrails are in place, chairs have lap belts	P is fully mobile and not at risk of falls. Such measures are not necessary to keep P safe.
	P is unable to move around the home or never tries to leave. Locked doors may therefore not be necessary to keep P safe. Or

Doors are locked, P does not have access to a key/fob/code or staff control whether P is able to go out.	P has been assessed to be safe in the community, without staff support. If there are reasons why the doors need to be locked (security, other vulnerable residents) can P be given a key? What can be done to mitigate the risks and reduce the restrictions?
Staff escort P in the community	P does not require such support to be safe to to go out. Staff should only escort persons if it is necessary to prevent harm to P or if such support is necessary to enable P to access the community (for example if P needs support due to mobility needs).
Medication is administered covertly	This should only happen if P is not refusing prescribed medication, which is required to maintain P's health. A risk assessment, mental capacity assessment and best interests decision, with the prescribing doctor as decision maker, should be completed before medication is administered covertly. The decision to do so should be reviewed regularly by the prescribing doctor.
1:1 or 2:1 support	If there is no documented risk assessment to demonstrate that this level of support is necessary to keep P safe from harm or to participate in activities, such a level of support may not be proportionate to the risks to P.
Use of physical and/or chemical restraint	If there is no documentary risk assessment to indicate that this is absolutely necessary to protect P. A Protective Authorisation cannot be granted to protect others (this is covered by the Mental Health Law). Inappropriate use of restraint is a safeguarding issue.
The decision to admit P to the care home or hospital has been made by another person without following the Best Interests Process.	There is a less restrictive option available which could meet P's needs. The Best Interests Process should be followed before P is admitted to the specific place, to allow consideration of all alternative options and P's views
A DNACPR is in place and P lacks capacity to consent to this.	This should only be made following a discussion with P's Attorney or relative to consider whether this is required.
P is kept in incontinence pads even though P is continent.	It is likely that this is for the convenience of staff as P may need support to use the toilet. This would not be proportionate or in P's best interests as no risk of harm.

Staff restrict contact with family or friends	During the coronavirus pandemic restrictions were imposed on everyone to reduce the spread of infection. Outside of emergency public health restrictions, preventing contact with others is an interference with P's Article 8 rights and would need to be referred to the MHCR Tribunal.
CCTV is in place	There is no evidence (risk assessments) to support the need for this. NB: The use of CCTV in a bedroom should only be used if absolutely essential to keep P safe.

11.85 Examples of less restrictive alternatives

Restriction	**Less restrictive options**
Bedrails are in place	Bed is lowered with crash mat in place
The kitchen door in a care home is locked restricting access to residents	P is supported by staff to use the kitchen safely and to be more independent
P is continent but staff put P in incontinence pads	Staff support P to use the toilet as needed
CCTV is in use, monitoring P	P is supported to have time alone for privacy
Medication is used to control P's behaviour.	Staff explore other ways of supporting P, for example involving other professionals.
P is unable to leave their accommodation for brief trips to the shop or to the cinema (for example), which is their wish.	Staff risk assess whether P would be safe to go out alone, or support P to participate in the particular activity.

11.86 Who should be consulted before a Protective Authorisation can be granted?

Consultation is a key element of the process for a Protective Authorisation. The following people should be consulted:

a. P who will be subject to the Protective Authorisation
b. P's representative, (including an attorney, under a valid Lasting Power of Attorney, or a guardian appointed by a court), or any person named by P as someone to be consulted about the proposed arrangements. This can be a friend as well as a family member.
c. a person engaged in caring for P or interested in P's welfare,

11.87 If P has no family or friends whom it is appropriate to consult, an Independent Capacity Representative must be appointed to uphold P's rights under this process. If it is not possible to make contact with any of P's family or friends or an Attorney (under a Lasting Power of Attorney) and the only people available for consultation

are paid carers or professionals, an Independent Capacity Representative must be instructed to uphold P's rights.

11.88 The purpose of consultation is to establish P's wishes and feelings about the proposed (or actual) arrangements, including the restrictions of their personal rights and freedoms. The consultation should include (where possible) P's past and present wishes. The assessor should consider any relevant information in an Advanced Care Plan created by P. It should include the views of family, friends and carers involved in P's life.

Scenario – Authorising a Significant Restriction of a person's personal rights

Mr Turner is 60 years old and has a diagnosis of Down's Syndrome. He lives in his own flat in supported accommodation. He has support from staff to help with his financial management, meal preparation and shopping but is able to come and go as he pleases, with no restrictions. Mr Turner is an independent man with a good social life, however recently he has started to refuse to go to the activities he had previously enjoyed. The staff notice that he is increasingly forgetful and, at times, he has been found in the street late at night and very disorientated. On occasion the police have had to return him home. He visits the doctor and is referred for memory tests. Mr Turner is subsequently diagnosed with dementia at the memory clinic. A care assessment indicates that he has increased needs for support.

Due to concern about Mr Turner's safety the social worker completes mental capacity assessments regarding his safety to go out without support and whether he has capacity to manage his finances. These conclude that Mr Turner lacks capacity to make these decisions. A best interests decision is made that he cannot go out independently, due to the risks of harm. As he has also been assessed to lack capacity to manage his finances, due to his cognitive decline, a guardian is appointed to manage these. A best interests decision is taken to fit a door alarm to alert staff if he leaves his flat. Mr Turner's care package is increased to provide extra support each day and he is escorted by staff to go out at set times.

The social worker concludes that the increased support coupled with the restrictions on Mr Turner's access to the community, amount to a significant restriction of his personal rights and freedoms. As part of the process of arranging the care package, the social worker completes the Significant Restriction and Best Interests Assessments and advises the Capacity Professional of the need for a Protective Authorisation. The Capacity Professional accepts the social worker's Capacity assessment (completed regarding his safety) and the memory clinic doctor's report, which includes details of Mr Turner's diagnoses of dementia and Down's Syndrome as equivalent assessments for the Protective Authorisation. The doctor's report is also accepted for the Age Requirement, as it confirms Mr Turner's date of birth. The social worker completes the Contrary

Decisions, Significant Restriction and Best Interests assessments. Following completion of the assessments, the Capacity Professional scrutinises these to ensure that these meet the requirements for a Protective Authorisation and then grants the Protective Authorisation.

11.89 What happens if P cannot communicate or express their views?
A key element of the Law is to involve P in decisions made, or actions taken, for P. The assessor should take all possible steps to involve P, in line with S6 Capacity Law. If P is unable to express their views, the assessor should consider whether P has made an Advanced Care Plan, relevant to this decision. Has P previously expressed their views to friends or family? Is P showing signs of objecting, for example by trying the doors of the care home or refusing care and/or treatment?

11.90 What happens if P is objecting to the actual or proposed arrangements?
If P is objecting to being accommodated in the relevant place in order to receive care and/or treatment or to the restrictions, the Capacity Professional must complete the Significant Restriction and Best Interests Assessments, rather than the health or social care professional involved. The Capacity Professional also oversees the completion of all the other assessments to meet the requirements for an authorisation. The Capacity Professional will grant the Protective Authorisation if all the requirements are met however, to comply with Article 5 ECHR, a person who is subject to a significant restriction of their personal rights and freedoms (deprived of their liberty) must have the right to make a legal appeal.

11.91 Making a challenge to a Protective Authorisation
The Law provides for the right to challenge the Protective Authorisation. As soon as the Protective Authorisation has been granted it is possible to make an application to the Mental Health and Capacity Review Tribunal to hear the challenge. The following can make an application to the Tribunal:

a) P who is subject to the Protective Authorisation,
b) P's representative,
c) an Independent Capacity Representative (appointed as P's representative for the Protective Authorisation), and
d) any person with parental responsibility (under the Children (Guernsey and Alderney) Law, 2008 or Children (Sark) Law 2016) where P is under the age of 18.

11.92 When should an application be made to the Tribunal to challenge a Protective Authorisation under section 69?
Although some people are quite happy to move to a care home, or to live with restrictions in their own home, others will object to the relevant arrangements. In such cases, it is the role of P's representative to consider whether an application should be made to the Tribunal to challenge the arrangements which have resulted in the Protective Authorisation being granted. The following guidance applies:

a) The representative must consider whether P wishes, or would wish to apply to the Tribunal. This involves the following steps:

Consider whether P has capacity to ask to issue proceedings. This simply requires P to understand that they should not be subject to the current care arrangements. It is a lower threshold than the capacity to conduct proceedings.

If P does not have such capacity, consider whether P is objecting to the arrangements for their care, either verbally or by behaviour, or both, in a way that indicates that P would wish to apply to the Tribunal if P had the capacity to ask.

b) In considering P's stated preferences, regard should be had to:

- any statements made by P about their wishes and feelings in relation to issuing proceedings,
- any statements made by P about their residence in care,
- P's expressions of their emotional state,
- the frequency with which P objects to the placement or asks to leave,
- the consistency of P's express wishes or emotional state; and
- the potential alternative reasons for P's express wishes or emotional state.

c) In considering whether P's behaviour constitutes an objection, regard should be had to:

- the possible reasons for P's behaviour,
- whether P is being medicated for depression or being sedated,
- whether P actively tries to leave the care home,
- whether P takes preparatory steps to leave, e.g. packing bags,
- P's demeanour and relationship with staff,
- any records of challenging behaviour and the triggers for such behaviour.
- whether P's behaviour is a response to particular aspects of the care arrangements or to the entirety of those arrangements.

d) When considering whether to make an application, it is important to recognise that:

- there could be reason to think that P would wish to make an application even if P says that they do not wish to do so or,
- alternatively, reason to think that P would not wish to make an application even though P says that they do wish to, since P's understanding of the purpose of an application may be very poor.

e) If P does not express a wish to challenge the PA, the representative can still apply to the Tribunal to determine:

- whether P continues to meet all of the requirements for a Protective Authorisation
- whether the period of the authorisation or the conditions subject to which the authorisation is given are contrary to P's best interests;
- whether the purpose of the authorisation could be as effectively achieved in a way that is less restrictive of P's rights and freedom of action.

f) The consideration of P's circumstances must consider all aspects of P's situation and should be based on more than one meeting with P, as well as discussions with P's carer(s), P's family and friends.

g) An alternative to applying to the Tribunal may be to request a review by the Capacity Professional under section 68 of the Law, or to work collaboratively with the Committee to see whether alternate arrangements can be put in place to meet P's needs. Such measures should not, however, prevent an application to the Tribunal being made where it appears that P would wish to do so under section 69 of the Law.11.93 Referral to the Tribunal by the Capacity Professional

The Capacity Professional has the power to refer a matter to the Tribunal unless an application has already been made and this has not been withdrawn or concluded.

11.94 The Law allows for P (if they have capacity to do so) or P's Representative, to instruct an Advocate to make the application to the Tribunal. P can apply for Legal Aid to cover the legal costs. The Tribunal will rule as to whether it is in P's best interests to be, or to continue to be accommodated at the relevant place in order to receive care and/or treatment. The Tribunal may reserve the right to refer to the Royal Court under s20(1) of the Capacity Law 2020

11.95 What is the process for granting the Protective Authorisation?
The Capacity Professional is responsible for overseeing the process for a Protective Authorisation. If all the requirements are met, the Capacity Professional may grant the Protective Authorisation for a period of up to 11 months. P must be informed that the Protective Authorisation has been granted, of any conditions attached to it and of their legal rights, as soon as is reasonably practicable. This information should be provided in the prescribed form in an appropriate format for the person. The named Representative should also be informed that the Protective Authorisation has been granted and advised of any conditions attached. See role of the representative.

11.96 What information should be provided?

Documents	**To be provided to:**
Protective Authorisation Granted	Person subject to the authorisation Care home manager or ward manager

	Family members or friends consulted by the assessor P's Representative under the Protective Authorisation Attorney under a LPA for Health and Welfare Any Independent Capacity Representative involved
Age, capacity, significant restriction, cognitive impairment, contrary decisions, best interests assessments	Person subject to the authorisation
Age, capacity, significant restriction, cognitive impairment, contrary decisions, best interests assessments	P's Representative under the Protective Authorisation. P's attorney under a LPA for health and welfare

11.97 Role of the representative

Where a Protective Authorisation has been granted the Capacity Professional must appoint a representative for P, as soon as reasonably practicable. The person appointed must be 18 years or over, willing and able to carry out the functions of Representative and must be able to represent P's views and wishes in relation to the Protective Authorisation. If P has no family or friends able to take on the role, then the Capacity Professional will appoint an Independent Capacity Representative as P's representative.

11.98 The functions of P's representative are:

a) to maintain contact with P. It is expected that this will be face to face contact however, there may be times when this is not possible and therefore other methods to maintain contact can be used, if P is able to engage with these,
b) to provide support to P so that P is involved in decisions regarding the Protective Authorisation, as far as practicable,
c) to obtain and evaluate any relevant information. This includes access to care plan documentation and records,
d) to ascertain what P's wishes and feelings are, or would be likely to be if they had capacity, regarding the actual or proposed arrangements for P's care,
e) to represent P's wishes or feelings regarding a reassessment or challenge to the significant restriction,
f) to do, or arrange to do, anything reasonably practicable to support P, and
g) to monitor any conditions on the Protective Authorisation to ensure these are complied with.

11.9 The representative has the right to:

a) see P in private,
b) read and take copies of health or social care records relevant to the role as P's representative,
c) make an application to the Mental Health and Capacity Review Tribunal to challenge the Protective Authorisation, if they believe that P is objecting to the care arrangements or if the representative believes that the actual or proposed arrangements are not in P's best interests, and
d) request a review of the Protective Authorisation if there is reason to believe that any of the requirements are no longer met.

11.100 If, at any time, the representative is no longer willing or able to act as P's representative, the Capacity Professional should appoint another person as Representative. This should happen if concerns are raised that the Representative is not maintaining contact or there is evidence that the representative is not acting in P's best interests.

11.101 What should happen if there is a safeguarding allegation or investigation against the Representative?

Where P has a Representative in relation to a Protective Authorisation and a safeguarding allegation has been made against the Representative, this may affect the appropriateness of the Representative to act in that role. In such circumstances, the Capacity Professional can appoint an ICR to represent the person. At the conclusion of the investigation, the Capacity Professional should decide, dependent on the outcome, whether the Representative can be reinstated. The Capacity Professional should provide a written copy of the decision to the Representative.

11.102 Maintaining records

The committee will keep a record of all applications made for a Protective Authorisation. This record must include the following information:

a) P's name, date of birth, address, religion, gender and diagnosis/es
b) Address where P is, or will be subject to a significant restriction. This should specify whether it is a care home, hospital or P's own home.
c) Name and contact details for any individual named by P to be consulted (including an attorney under a Lasting Power of Attorney for health and welfare).
d) Name and contact details of any person involved in their care or interested in their welfare. This should include carers (paid and unpaid), health and social care professionals.
e) Details of any relevant and applicable Advanced Decision to Refuse Treatment or an Advanced Care Plan.

For all completed applications, the Committee will keep records of:

a) the outcome of the assessments,
b) the date of the Protective Authorisation, if granted, and the duration,

c) the name of P's Representative, and
d) Any conditions on the Protective Authorisation.

11.103 Can a Protective Authorisation be transferred?

The Protective Authorisation can be transferred to a new placement if the arrangements for P's care involve similar restrictions and similar care arrangements. This would apply where P moves from one care home to another care home, but could potentially include transferring a Protective Authorisation from hospital to a nursing home placement. If P is subject to a Protective Authorisation in a care home and is admitted to hospital, provided that P is not subject to increased restrictions, the authorisation can avoid the need for the prescribed person in the hospital to grant a further Authorisation. The Capacity Professional will assess whether the Protective Authorisation can be transferred or whether to make a variation under S64 of the Law (See below).

11.104 Making a variation to a Protective Authorisation

If P is subject to a Protective Authorisation and moves to a new placement but the arrangements are significantly different or involve increased restrictions, it would not be appropriate to transfer the existing Protective Authorisation, therefore the Law allows for a variation, without the needs for a new authorisation. A Capacity Professional can vary a Protective Authorisation following appropriate consultation and a reassessment of any of the relevant qualifying requirements.

Case Example – Varying a Protective Authorisation

Mrs Aspen has been diagnosed with vascular dementia and is quite confused. She moved into a care home when it was no longer possible to maintain her safety at home and her care is funded by the committee. As Mrs Aspen has been assessed to lack capacity and as she is subject to restrictions in the care home, she has a Protective Authorisation in place. Over time, as Mrs Aspen's dementia progresses, her needs have increased. She has started to present with behaviour that challenges and is refusing her medications. The care home manager advises that Mrs Aspen's needs have increased to a level which cannot be managed in the home. A best interests meeting concludes that Mrs Aspen needs a nursing home placement. The social worker consults with the Capacity Professional who advises that as that the restrictions in the new placement will be at an increased level, a variation of the Protective Authorisation may be appropriate. The social worker consults with Mrs Aspen, her carers and her family to update the Significant Restriction, Best Interests and Contrary Decisions Requirements. The Capacity Professional grants the variation of the Protective Authorisation.

11.105 Suspending a Protective Authorisation

A Protective Authorisation can be suspended, for up to one month, by the Capacity Professional. This would apply where P spends regular periods in respite care, but

does not require a Protective Authorisation at other times. The Protective Authorisation would apply when P is in the care home for respite care, but would be suspended when P returns home. By way of example, it would also apply if the person temporarily leaves the Bailiwick for any reason. The Capacity Professional can re-activate the Protective Authorisation when P returns, provided that there have not been any significant changes requiring further restrictions on P.

11.106 What happens if a person, subject to a Protective Authorisation has regular visits to stay with their family, goes on holiday or has respite care?

Visits to stay with family	If the arrangements in the family home involve a significant restriction, the Protective Authorisation can be transferred or varied to cover these during such visits. If the person is not subject to the same level of restrictions and therefore not subject to a significant restriction, the authorisation will be suspended.
P goes away on holiday.	If the arrangements on holiday involve a significant restriction, the Protective Authorisation can be transferred to cover these during such times, as long as the holiday is within the Bailiwick of Guernsey. If the person is not subject to the same level of restrictions or goes outside the Bailiwick, the authorisation is suspended.
Respite care	If P has a Protective Authorisation in place and the arrangements in the respite placement involve a significant restriction, this should be included in their Protective Authorisation. If P does not already have a Protective Authorisation they may require a Protective Authorisation (under Process B) whilst in respite care.

11.107 Requesting a review or reassessment of the qualifying requirements by a Capacity Professional

The Law allows for a review or reassessment by the Capacity Professional of any of the qualifying requirements, if a reasonable request is made by any of the following:

a) P,
b) P's Representative (appointed for the Protective Authorisation Scheme),
c) an attorney under a Lasting Power of Attorney for Health and Welfare,
d) a person engaged in caring for P or
e) any person named by P as someone to be consulted.

This will apply if there has been a significant change in P's condition or circumstances or if P objects to staying in the relevant place or to the restrictions. A review should also be undertaken if P becomes subject to an order under the Mental Health Law. The Capacity Professional will complete or oversee the new assessment(s).

Scenario – requesting a reassessment of the qualifying requirements

Ms Angela Parkinson was admitted to hospital having sustained a fall and is found to have broken her hip, for which she will require surgery. She is also diagnosed with sepsis and delirium and is very confused. Although she is not safe to weight bear she tries to get out of bed and is at risk of falls. A member of staff is assigned to monitor her to maintain her safety. Ms Parkinson is assessed to lack capacity to consent to staying in the hospital to receive treatment and a Protective Authorisation is granted under Process C. Ms Parkinson's stay in hospital is extended beyond the initial 28 days as the social worker does not believe that she will be able to manage in her own home. She will need to remain in hospital for rehabilitation and whilst assessments are completed to see whether she can return home safely. The Capacity Professional oversees and grants a Protective Authorisation for four weeks. As Ms Parkinson's health starts to improve with treatment, the staff member caring for her believes that she may have regained capacity. The prescribed person requests a reassessment of the Capacity requirement. The Capacity Professional completes a new capacity assessment and concludes that Ms Parkinson has capacity to make her own decision about staying in hospital. The Protective Authorisation is ceased and Ms Parkinson can decide whether to stay in hospital or whether to return home.

11.108 Ending the Protective Authorisation

There are three ways in which a Protective Authorisation will cease to have effect. These are if:

a) at the end of the period granted (of a Protective Authorisation), it has not been renewed or extended, or
b) the Capacity Professional discharges it, or
c) the Tribunal makes an order discharging the Protective Authorisation.

An application for a further Protective Authorisation should be made if the qualifying requirements continue to be met. There is no need to request a further authorisation if any of these are no longer met, for example if P's care arrangements no longer amount to a significant restriction. The Capacity Professional can discharge the Protective Authorisation if any of the qualifying requirements are no longer met, for example if P regains capacity.

11.109 Process to renew a Protective Authorisation

A Protective Authorisation can be renewed by a Capacity Professional for up to 11 months provided that all the qualifying requirements continue to be met and it is unlikely that there will be any significant change in P's condition which could affect those requirements. The Capacity Professional will review the requirements completed for the existing authorisation and commission new assessments as necessary. The Capacity Professional must consult with P, P's representative and carers however equivalent assessments can be used, if still valid.

11.110 What matters are not covered by a Protective Authorisation?

The Protective Authorisation cannot be used to authorise arrangements, which breach Article 8 of the European Convention on Human Rights for example restricting contact with family or friends see section 49(2) of the Law. Such matters will need to be referred to the Mental Health and Capacity Review Tribunal, which has the authority to make such decisions *(s19)(1) (b) and (c) of the Law).* See chapter 7 Code of Practice for more information on the role of the Tribunal.

Scenario – Restricting contact with family or friends

Mrs Andrews has been resident in Meadows House care home for five years. She had previously lived with her son, Brian, who is reported to be very important to her. She is under a Protective Authorisation with Brian named as her representative. Mrs Andrews has advanced dementia and she now has difficulty swallowing. The speech and language therapist ("SALT") has recommended that she has a pureed diet and thickened fluids. Brian, visits several times a week. He often arrives at lunchtime and stays until 10pm, when the staff have to ask him to leave. He frequently falls asleep for several hours during his visits. Of concern, however, is that Brian brings food and drinks for his mother and insists upon feeding her with food which has not been pureed, in defiance of the SALT advice. When the staff speak to Brian about his mother's dietary requirements, he becomes verbally aggressive. On several occasions the police have been called to remove him from the home, although they took no further action. Brian also encourages his mother to smoke in the garden, even though she has not smoked for many years and she suffers with asthma.

One day, Brian arrives to see his mother. He looks unkempt and smells of alcohol. During his visit he is increasingly belligerent to staff, and tries to prevent carers feeding his mother or from providing her with personal care. The other residents are showing distress at the situation. The manager asks Brian to leave but he refuses and continues to shout at staff. Eventually, the manager calls the police, who remove Brian from the care home, although again they take no further action. Following this incident, the care home manager writes to Mrs Andrews' son to advise that he can no longer visit his mother at the home. Brian is very unhappy about this, but the manager is not willing to discuss this with him.

Brian, as his mother's representative contacts the Capacity Professional to request a review of the Protective Authorisation, due to the increased restrictions imposed on his mother. The Capacity Professional advises that refusing Mrs Andrews to have contact with her son breaches her Article 8 rights, which cannot be authorised under a Protective Authorisation. The care home manager refuses to allow Brian to visit his mother. The Capacity Professional refers the matter to the MHCRT.

If it is agreed that Brian's continued visits are not in his mother's best interests and that he should be prevented from having contact with her, the tribunal has the right to make such a decision. Alternatively the tribunal may make recommendations to support supervised contact, if it is decided that this is in Mrs Andrews' best interests to have continued contact with her son.

11.111 The Protective Authorisation does not provide authorisation for the provision of care or treatment.
It authorises the significant restriction (the deprivation of P's liberty) in the relevant place, in order to be provided with care and/or treatment. The decision to provide the specific care or treatment is covered by s6 (Best Interests) of the Capacity Law.

11.112 Harm to others
The Protective Authorisation scheme supports care arrangements which are in place to prevent harm to people who lack capacity to consent to these. It does not authorise restrictions on a person to prevent harm to others, which should be considered under the Mental Health Law.

11.113 What action should be taken if it is believed that a person's rights are being restricted but no application has been made for a Protective Authorisation?
If P is staying in a care home registered with the Committee and lacks capacity to consent to the placement, this should be authorised under the Protective Authorisation Scheme under Process B. If an unauthorised significant restriction is identified, this should be referred to the Capacity Professional to investigate. The Capacity Professional will arrange for the completion of the relevant assessments for a Protective Authorisation.

11.114 If P is staying in hospital and lacks capacity to consent to these arrangements, this should be authorised under the Protective Authorisation Scheme under Process C. If an unauthorised significant restriction is identified, this should be referred to the Capacity Professional to investigate. The Capacity Professional will arrange for the completion of the relevant assessments for a Protective Authorisation.

11.115 Does the Protective Authorisation Scheme apply to all care homes?
The Law extends only to care homes approved by the Committee to accommodate persons under the Protective Authorisation Scheme. It does not apply to self funded placements in non-approved homes. However, if anyone has a concern about a person's care in a non-approved home, this should be referred to the safeguarding team. The safeguarding team will ensure that the Capacity Professional is advised and, if necessary, this can be referred to the Mental Health and Capacity Tribunal.

11.116 Can a person with fluctuating capacity be subject to a Protective Authorisation?
Decisions regarding those with fluctuating capacity will need to be considered on a case by case basis. Consideration should be given to whether the person has capacity to consent to the care plan, including the restrictions P is subject to. For example, P may have capacity during the morning, but is noted to be confused and sundowning in the evening, possibly trying to leave the care home. Can P understand that, at such times, carers may need to intervene? Can P agree to the care plan which includes being restricted by staff (being prevented from leaving, subject to supervision and control by staff?) If so, a Protective Authorisation would not be required. However, such an approach should be applied with caution. In a judgment in the Court of Protection, in 2011, the judge sought to differentiate between the different decisions that people make. The judge contrasted the difference between "isolated decisions" such as making a will or a Lasting Power of Attorney as opposed to ongoing acts, such as managing one's affairs.[37] This is described as the "longitudinal approach". In another case heard in 2019[38] the judge stated "As I have said, [P] is a man with multiple disadvantages but who can and does function remarkably well within the constraints of his care package…. Yet there is another side to the picture when [P] is overwhelmed by anxiety and speaks and behaves in a way he rapidly comes to regret. That anxiety is often but not always predictable and is liable to affect every part of his life and not just the issue of the moment, whatever that may be. It is the unpredictability of that anxiety and the seriousness and breadth of its impact which is decisive in this case in overturning the legal presumption of capacity….It is, in applying a longitudinal perspective to this, that highlights the incapacity."

11.117 The assessor completing the capacity assessment needs to demonstrate that they had a reasonable belief that P has or lacks capacity to make the relevant decision (whether to be accommodated in the relevant place to receive care and/or treatment) at the time that the decision needs to be made. However, complex cases should be referred to the Tribunal for a decision as to whether the Protective Authorisation is required and, if it is, whether this should be granted.

[37] *A,B & C v X, Y & Z* [2011] EWHC 2400 (COP)
[38] Cheshire West And Chester Council v PWK *[2019] EWCOP 57*

11.118 Life saving treatment and Protective Authorisations

If a patient is so ill that they would be at risk of dying if they were not in hospital (ie they have to be in hospital in order to receive treatment) this is not a significant restriction and would not need to be assessed for a Protective Authorisation. However, if as P's treatment progresses, their condition improves, P's ongoing care could become a significant restriction. If life-saving treatment is being provided in care homes or hospitals, including for the treatment of COVID-19, this does not amount to a deprivation of liberty (or significant restriction), as long as the treatment is the same as would normally be given to any patient without a mental disorder.

12. Ill treatment or Neglect

12.0 Section 75 of the Law provides an offence for ill treatment or neglect. This applies where a person (P) lacks capacity to consent to the relevant act which amounts to wilful neglect or ill treatment. This applies where a person (D) is:

i) has the care of P, or
ii) is P's attorney under a Lasting Power of Attorney or
iii) is a guardian appointed by the Court for P

D can be providing care in a paid or unpaid capacity. If there is evidence that D has wilfully neglected or ill treated P, D can be prosecuted under the Law.

12.1 Examples of wilful ill treatment or neglect include where D does not provide P with required care or treatment for example, medication, nutrition and hydration and where P lacks capacity to make their own decision about care and treatment. It can also include failing to offer P medical treatment which may be in P's best interests.

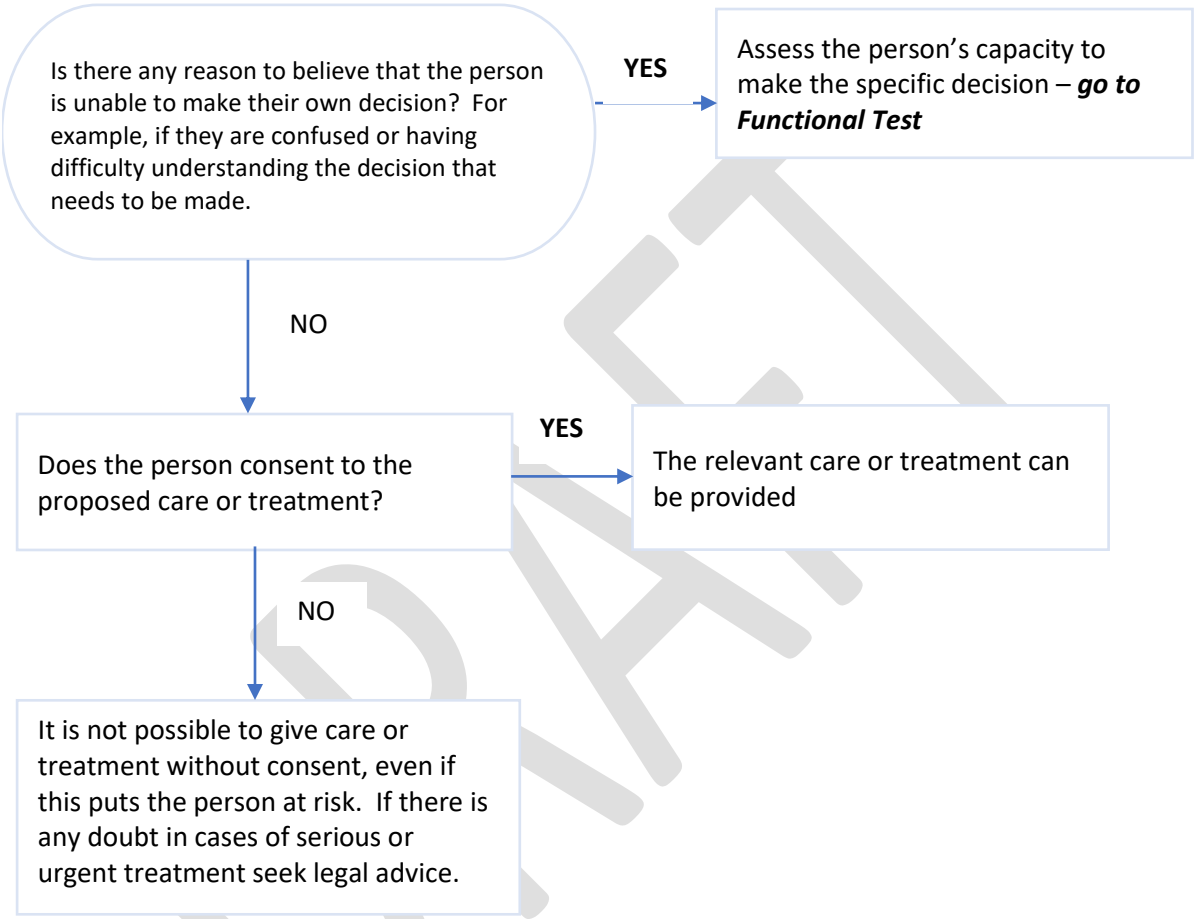
12.2 The offence applies to paid and unpaid carers, as well as to professionals. In 2011 a senior carer in a care home was prosecuted for the ill treatment of two residents. She had put a large amount of sugar as well as vinegar in a resident's tea and had slapped another resident. She was sentenced to 6 months in prison. The judge stated "Elderly people have a right to be treated with respect by everyone in the community. When they are ill and living in residential homes, they are entitled to expect, and we must demand, that they are properly cared for. What this appellant did was the opposite of that."[39]

12.3 In 2018 a solicitor who held an Enduring Power of Attorney (EPA) for her mother was charged with neglect following the death of her mother, with whom she had been living. Her mother was found in a filthy state, malnourished and with urine sores. The solicitor was initially convicted and sentenced to prison, although she appealed successfully as the EPA had not been registered and the jury had not been directed to consider whether her mother lacked capacity.

[39] https://www.39essex.com/cop_cases/r-v-heaney/

Appendix 1: Capacity and Best Interests

You should always start with the presumption that the person has capacity to make their own decision. Ensure that you have provided the person with all the information relevant to the decision that needs to be made, in a format that supports their understanding.



Functional Test

1. Is the person able to understand the information relevant to the specific decision? e.g. what are the different options? Can they understand the reasonably foreseeable risks and consequences of the decision?

YES

NO

The person lacks capacity to make their own decision at this time.
Go to Diagnostic test

2. Can the person retain the information to make their own decision? This only needs to be long enough to make the decision. Can they explain what you are discussing?

YES

NO

The person lacks capacity to make their own decision at this time.
Go to Diagnostic test

3. Can the person use/ weigh the relevant information and can they communicate their decision? Is the person able to take account of the relevant information to make their decision.

YES

NO

The person lacks capacity to make their own decision at this time.
Go to Diagnostic Test

4. Can the person communicate their decision?
This does not need to be speech. Consider what support can be provided to the person to make their decision.

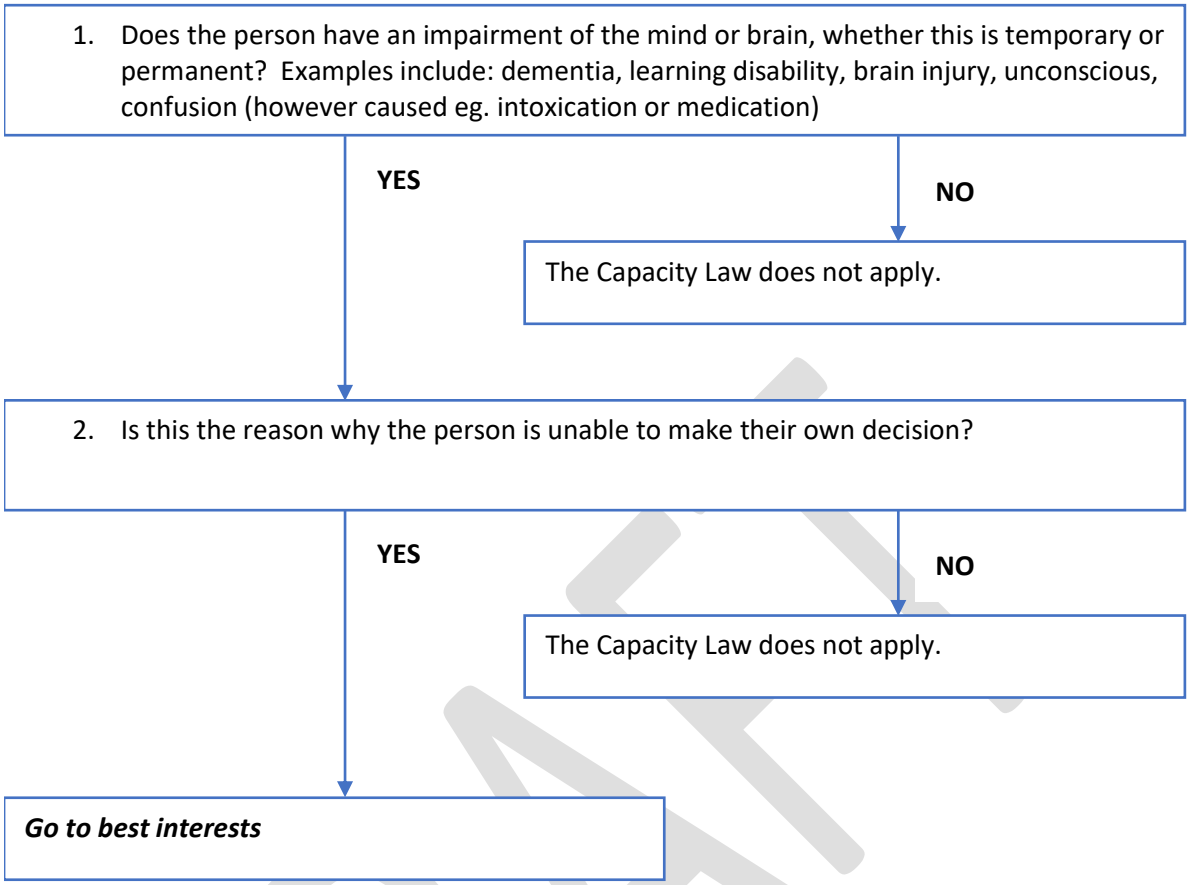
YES

NO

Go to Diagnostic Test

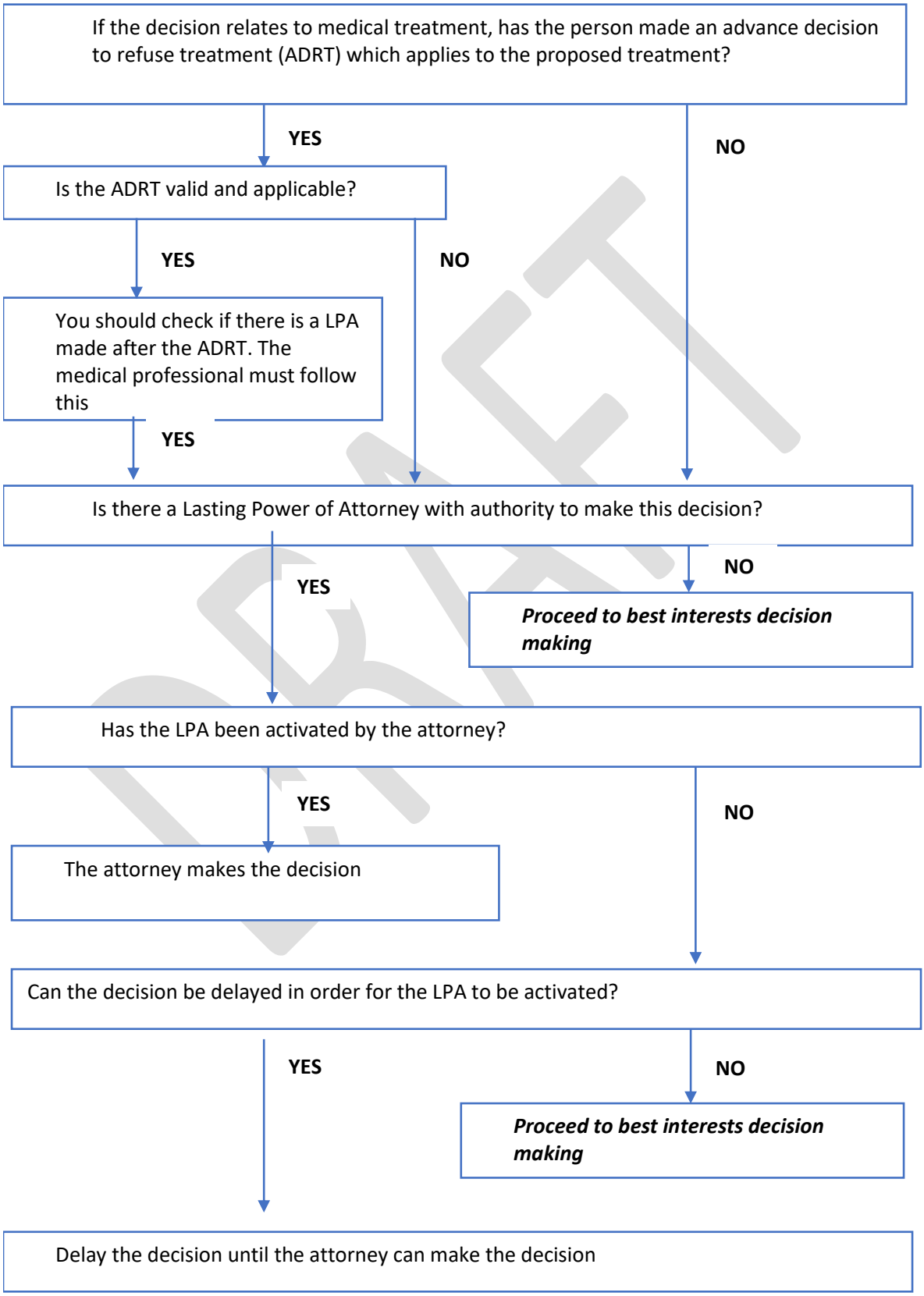
If the person can do all these elements they have capacity to make their own decision.

Diagnostic test



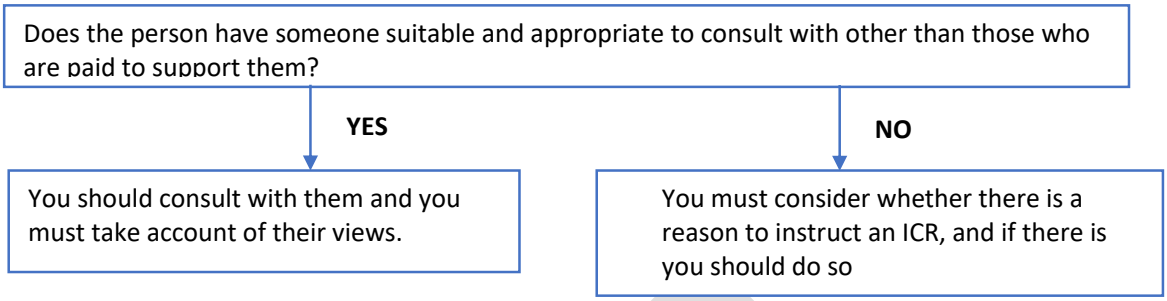
Best Interests

If the person lacks capacity to give consent, care and/or treatment can only be given of it is in the person's best interests. Even if the person is compliant with the care/treatment this does not constitute consent.



Best Interests Decision Making

If there is no valid or relevant Lasting Power of Attorney the decision should be made in the person's best interests.
You should consult with anyone named by the person to be consulted as well as friends, family, carers who are interested in the person's welfare.



Decision
The decision maker is responsible for deciding what is in the person's best interests. To do so the decision maker should consider:

a) the person's past and present wishes including, any ADRT (where this is not valid or applicable to the decision) and any Advanced Care Plan,
b) all the relevant circumstances,
c) the views of those consulted,
d) whether there is a less restrictive option available,
but they should not:
e) base the decision solely on the person's age, gender, sexuality, disability, race, appearance or behaviour
f) (for life sustaining treatment decisions) be motivated by a desire to bring about the person's death.

What happens if there is disagreement about what is in the person's best interests?

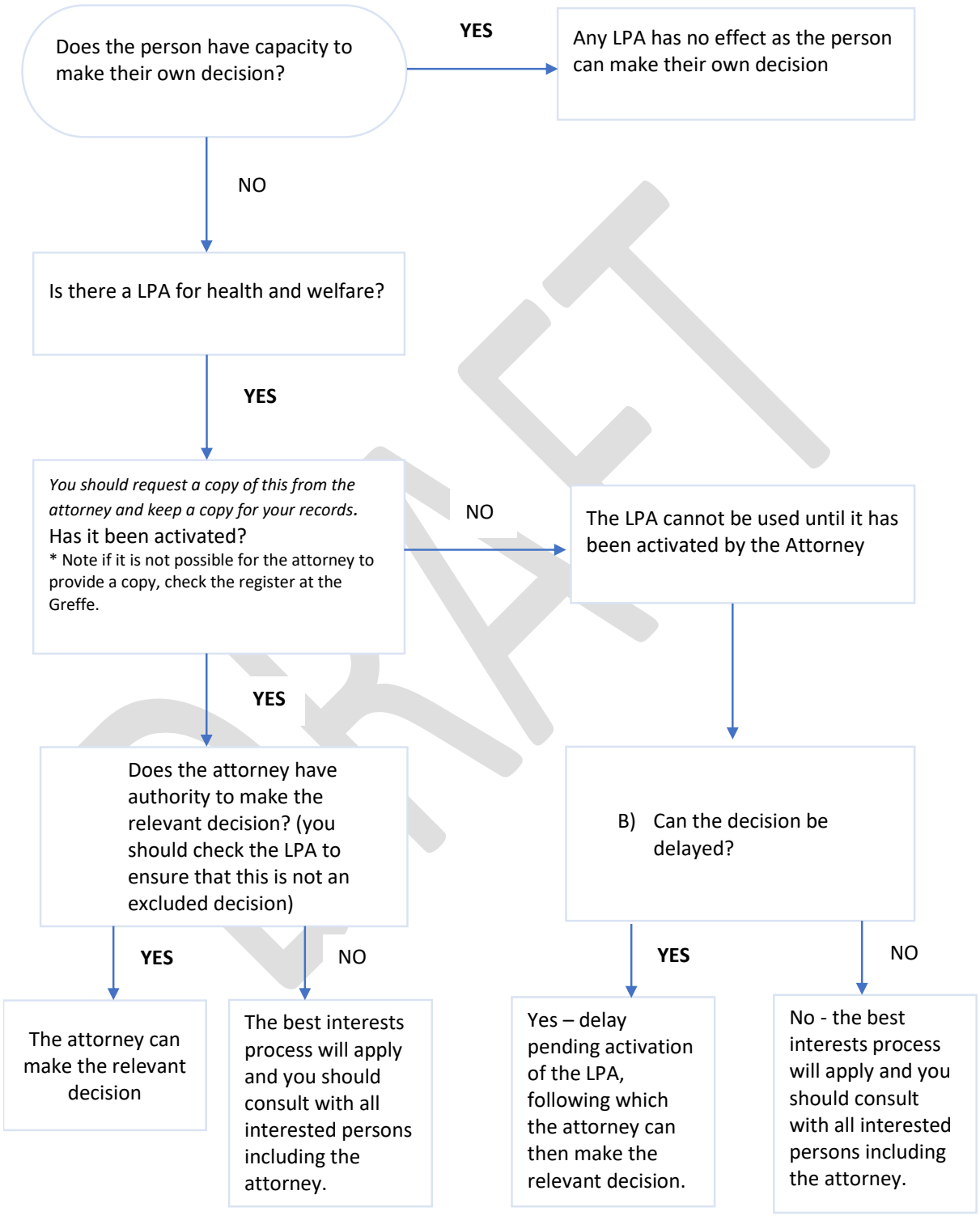
Ideally you would aim to reach agreement about the person's best interests and this may be achieved by further explanation of the risks and benefits of the options under discussion. Ultimately the decision maker has the responsibility for making the decision, although disagreements should be noted. If the decision is one that has significant consequences, for example withdrawal of life sustaining treatment, this should be referred to the relevant Court for a decision, where there is a disagreement between doctor and family/friends about the person's best interests.

Restraint
The Capacity Law defines restraint as:
A person (D) restrains another (P) if:
a) D uses or threatens to use physical, mechanical or chemical restraint, or other force on P
b) D restricts, or threatens to restrict, P's freedom of movement (including isolation, seclusion or segregation)
Or if D authorises another person to do any of the above.

The Capacity Law permits the use of restraint if:

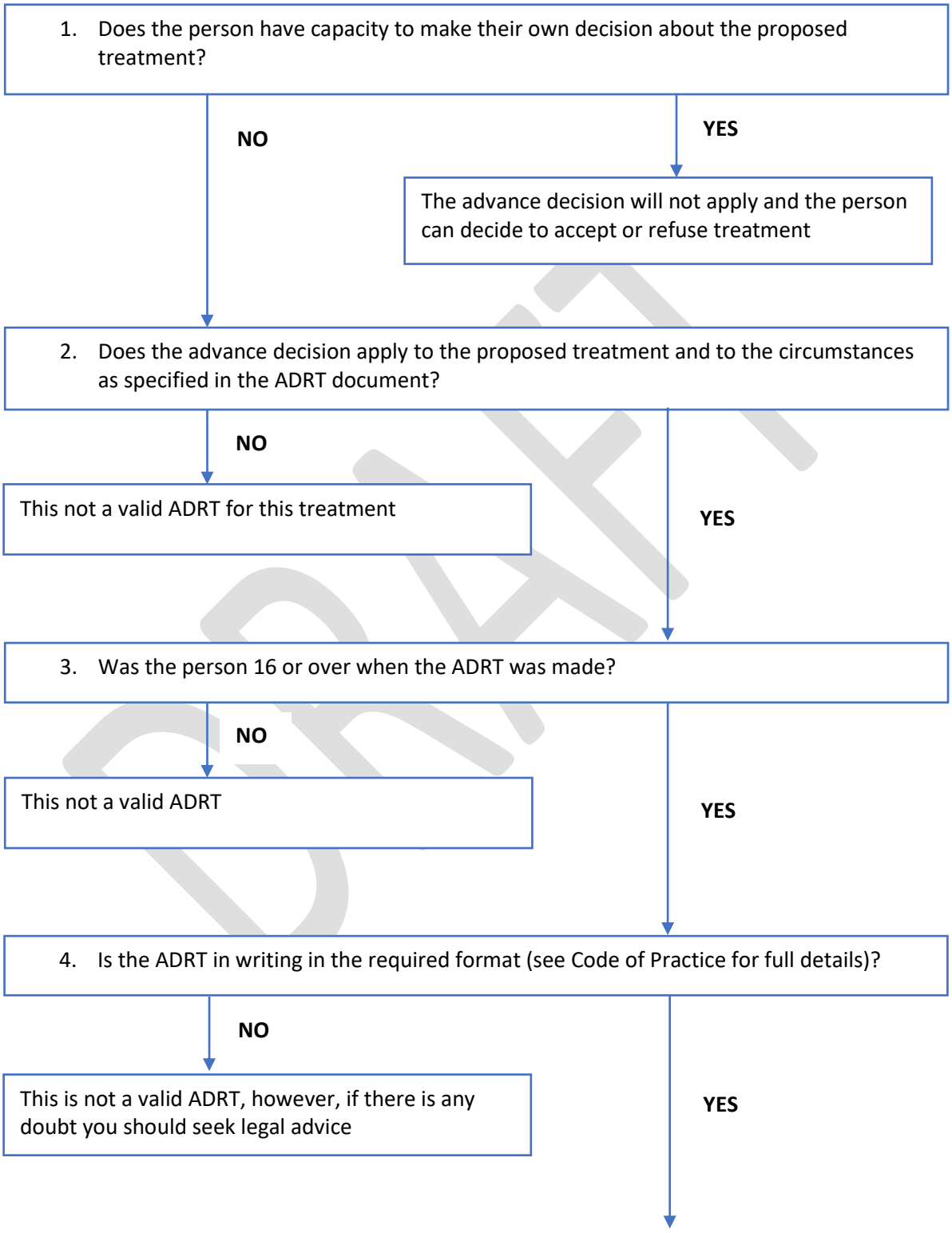
i) the individual taking the action reasonably believes it is necessary to in order to prevent harm to P and
ii) the restraint is a necessary and proportionate response to the likelihood of harm and the seriousness of that harm and
iii) it should only be for minimal time

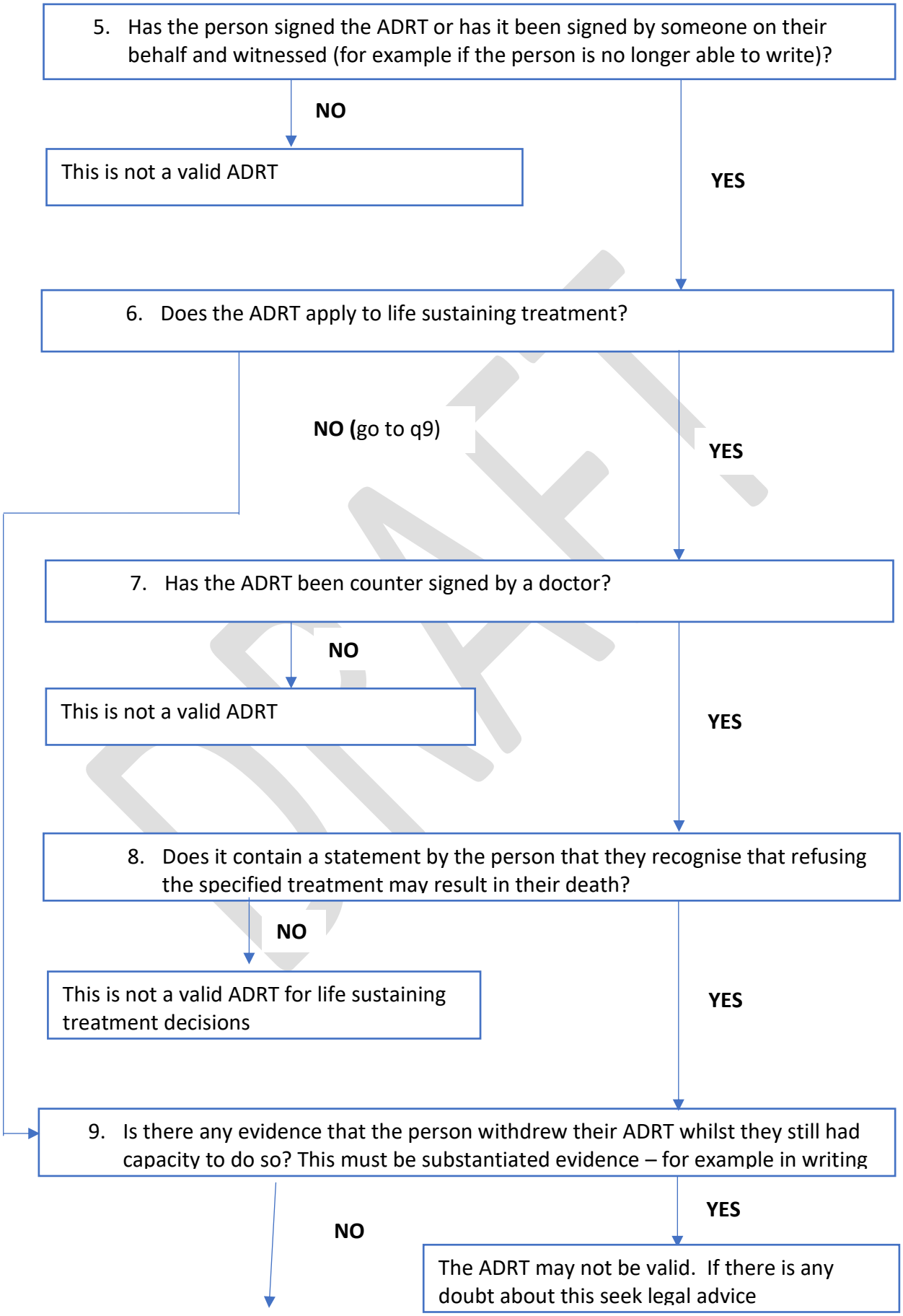
Appendix 2: Lasting Power of Attorney Guidance for Health and Social Care Staff

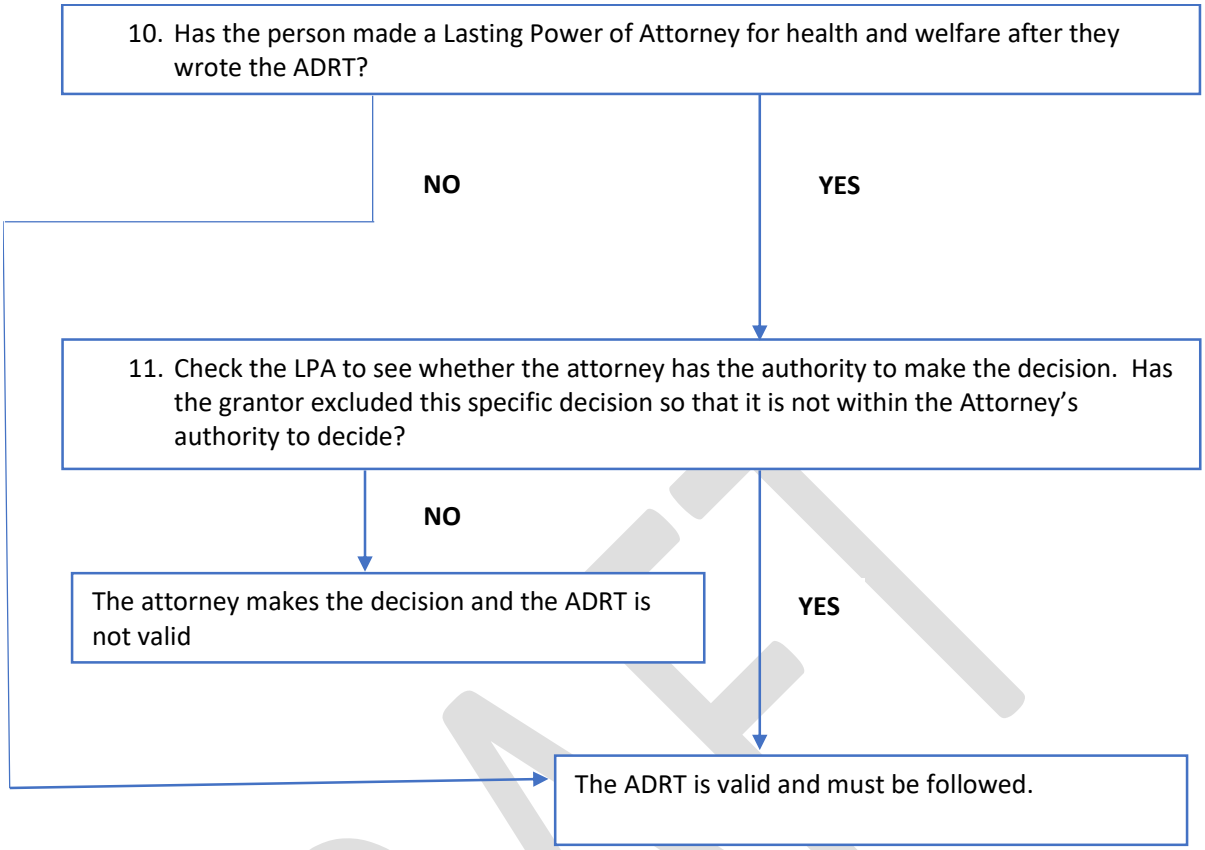


Appendix 3: Checklist for Advance Decision to refuse treatment

To confirm whether an advance decision to refuse treatment is valid




5. Has the person signed the ADRT or has it been signed by someone on their behalf and witnessed (for example if the person is no longer able to write)?
NO
This is not a valid ADRT
YES
6. Does the ADRT apply to life sustaining treatment?
NO (go to q9)
YES
7. Has the ADRT been counter signed by a doctor?
NO
This is not a valid ADRT
YES
8. Does it contain a statement by the person that they recognise that refusing the specified treatment may result in their death?
NO
This is not a valid ADRT for life sustaining treatment decisions
YES
9. Is there any evidence that the person withdrew their ADRT whilst they still had capacity to do so? This must be substantiated evidence – for example in writing
NO
YES
The ADRT may not be valid. If there is any doubt about this seek legal advice


10. Has the person made a Lasting Power of Attorney for health and welfare after they wrote the ADRT?
NO
YES
11. Check the LPA to see whether the attorney has the authority to make the decision. Has the grantor excluded this specific decision so that it is not within the Attorney's authority to decide?
NO
The attorney makes the decision and the ADRT is not valid
YES
The ADRT is valid and must be followed.

Appendix 4: When to bring Tribunal proceedings to challenge a Protective Authorisation