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Form 1 – Statement of incapacity

Section 39(2)(e), Schedule 1 Paragraph 6(1)(e), Schedule 2 Paragraph 2(4)(d) and Schedule 3 Paragraph 4(1)(f)
The Mental Capacity (Deprivation of Liberty) Regulations (Northern Ireland) 2019

A statement of incapacity can only be carried out by a medical practitioner, a nurse, a midwife, a social worker, a dentist, an occupational therapists, a speech and language therapist or a practitioner psychologist who have received specific training in the 36 months prior to making the statement and has 3 years' experience in the last 10 in working with persons who lack capacity.

1. The person's details (a label can also be affixed here)

Name: _____

Address: _____

Date of Birth: _____

HSC number (if known): _____

2. The assessors details

Name: _____

Work address: _____

Phone number: _____

Job title, team and staff number: _____

3. Support to the person

Before deciding that someone lacks capacity, all practical help and support must be provided to enable the person to make a decision by themselves. This includes considering the environment and timing of the decision, ensuring that appropriate communication support is provided to the person and involving all relevant people who might help the person make the decision.

Has the environment for the decision been considered? (delete as appropriate)
Yes / No

Has the timing and timing for the decision been considered? **Yes / No**

Have all relevant people that may help the person make a capacitous decision been included? **Yes / No**

Have all practical help and support, including communication support, been given? **Yes / No**

Provide details.

Further sheets can be added if required.

4. **Three Elements Test of Mental Capacity**

Functional test

In relation to the detention amounting to deprivation of liberty, the person in section 1 is unable to (delete as appropriate):

- understand the information relevant to the deprivation of liberty.
- retain that information long enough to make the deprivation of liberty.
- appreciate and use and weigh that information.
- communicate his/her decision (whether by talking or any other means).

Provide details on how the person is unable to do the above and how this has been determined.

Further sheets can be added if required.

Diagnostic test

There is no need for a formal diagnosis, it is sufficient to have reasonable belief that there is an impairment of, or disturbance in the functioning of, the mind or brain.

Provide details on the impairment of, or disturbance in the functioning of, the mind or brain.

Further sheets can be added if required.

Causal link

For a statement of incapacity to be provided there must be a causal link between the inability to make a decision in relation to the detention amounting to a deprivation of liberty and the impairment of, or the disturbance in the functioning of, the mind or brain. If there is no causal link the person does not lack capacity in the meaning of the Mental Capacity Act.

Provide details on the causal link.

Further sheets can be added if required.

5. **Decision**

If a person is unable to make a decision because they have an impairment of, or disturbance in the function of, the mind or brain a statement of incapacity can be made.

Statement of Incapacity

In my opinion, on the balance of probabilities, there is a reasonable belief that the person **lacks capacity** within the meaning of the Mental Capacity Act in relation to the deprivation of liberty.

Signature: _____

Date: _____



Form 2 – Best interests determination statement

Section 39(2)(e), Schedule 1 Paragraph 6(1)(e), Schedule 2 Paragraph 2(4)(d) and Schedule 3 Paragraph 4(1)(f)
The Mental Capacity (Deprivation of Liberty) Regulations (Northern Ireland) 2019

A decision to deprive a person of liberty must be made in the person's best interests.

The decision maker must ensure that the rationale for any decision and its supporting evidence is recorded in the person's care plan or notes in line with professional and agency requirements. It is not necessary to duplicate the information on this form and it can be referenced where the information can be found.

1. The person's details (a label can also be affixed here)

Name: _____

Address: _____

Date of Birth: _____

HSC number (if available): _____

2. The assessors details

Name: _____

Work address: _____

Phone number: _____

Job title, team and staff number: _____

Professional relationship to person: _____

3. Consideration

Outline the reasoning why the deprivation of liberty is in the best interests of the person. This should include what other options have been considered, who has been involved in the decision and how the person's past and present wishes, feelings, beliefs, values and any other factors that the person would have included if he or she had capacity have been considered.

Further sheets can be added if required.



4. Checklist

Have you ensured you have not made assumptions based on the person's age, appearance, condition or behaviour?
Yes No

Have you considered all the relevant circumstances?
Yes No

Have you tried whatever is reasonable and practicable to permit and encourage the person to take part, or to improve their ability to take part, in making the decision?
Yes No

You must have special regard to past and present wishes and feelings and beliefs and values.

Have you had **special regard** to the person's past and present wishes and feelings (expressed verbally, in writing or through behaviour or habits)?
Yes No

Have you had **special regard** to any beliefs and values (religious, cultural or moral) and any other factors which would be likely to influence the decision?
Yes No

Have you considered the human rights of the person?
Yes No

Have you considered other options that may be less restrictive of the person's rights?
Yes No

Have you consulted all relevant people as far as it is practical and appropriate to do so, including any person named by the person, anyone engaged in caring for the person or interested in the person's welfare?
Yes No

Have you consulted any nominated person?
Yes No

Have you considered the risk of harm to others which may result in harm to the person?
Yes No

5. Statement

Best interests should be determined on the grounds of reasonable belief and must include special regard to the person's past and present wishes, feelings, beliefs, values and any other factors the person would have considered if he or she had capacity.

Best interests determination statement

It is my opinion, using reasonable belief, that it is in the best interests of the person to be deprived of liberty.

Signature: _____

Date: _____

DRAFT

Further sheets can be added if required.



Form 5 – Application for trust panel authorisation

Schedule 1 Paragraph 6

The Mental Capacity (Deprivation of Liberty) Regulations (Northern Ireland) 2019

If more space is required additional sheets or information may be attached to this form. Information may also be copied from other sources, such as medical notes, and reference may be made to them without such document's inclusion.

1. The person's details (a label can also be affixed here)

Name: _____
Address: _____
Date of Birth: _____
HSC number (if known): _____

2. Person who is making the application

Name: _____
Work address: _____
Phone number: _____
Job title, team and staff number: _____
Professional relationship to person: _____

3. Person in charge of P's care or treatment (if same as applicant, leave blank)

Name: _____
Work address: _____
Phone number: _____
Job title, team and staff number: _____
Professional relationship to person: _____

4. Length of deprivation of liberty

How long authorisation is being sought? _____ (maximum 6 months)

5. Details about the deprivation of liberty

What is the place or places of the deprivation of liberty, including address and which trust it is in?
A deprivation of liberty authorisation must specify the place of the deprivation. The authorisation can cover deprivation of liberty in more than one place, for example in the place of residence of the person and in the day care centre, or the ordinary place of residence of the person and in a named place of respite.



6. Capacity whether to apply to the Review Tribunal

In your opinion, if the intervention was to be authorised, does the person lack (or probably lack) capacity to decide whether an application to the Review Tribunal should be made? **Yes / No** (delete as appropriate)

*The question relates to capacity **whether** an application should be made. Even if the person does not have capacity to understand what the Tribunal is, what the process is or how an application should be made the person may still have capacity whether an application should be made.*

The decision does not relate to where the person is and where the deprivation of liberty is taking place, as capacity relates to care arrangements that has the effect of detention in amounting to a deprivation of liberty.

If yes a Form 7 has to be included in the application.

If no a Form 7 does not have to be included in the application.

7. Annexes that must be attached to the Application

Annex A – statement of incapacity on **Form 1**.

Annex B – best interests determination statement on **Form 2**.

Annex C – consultation with the nominated person on **Form 3**.

Annex D – medical report on **Form 6**.

Annex E – statement on capacity to apply to the Review Tribunal on **Form 7** (if required).

Annex F – care plan.

A copy of P's care plan must be attached to the application.

8. Declaration

Declaration

I confirm I am eligible to make this application.

To the best of my knowledge all information in this application is correct and all required information is included.

Signature: _____

Date: _____

Form 6 – Medical report

Schedule 1 Paragraph 7(1)), Schedule 2 Paragraph 4(1) and Schedule 3 Paragraph 5(1)
The Mental Capacity (Deprivation of Liberty) Regulations (Northern Ireland) 2019

A medical report must be attached to a Form 5, application for trust panel authorisation, Form 8, short-term detention authorisation and Form 16, application for trust panel extension authorisation.

The medical report must be done by a medical practitioner who is suitably qualified to make formal assessments of capacity and that is unconnected with the person.

1. The person's details (a label can also be affixed here)

Name: _____

Address: _____

Date of Birth: _____

HSC number (if known): _____

2. Medical practitioner who is making the report

Name: _____

Work address: _____

Phone number: _____

Job title, team and staff number: _____

Professional relationship to person: _____

3. Criteria for authorisation – lack of capacity

Have you personally completed a Form 1 – statement of incapacity? **Yes / No** (delete as appropriate)

If yes, continue to section 4.

If no, fill out the rest of section 3.

Provide details of how the person lacks capacity to make the decision, including how the statement of incapacity has been considered.

References can be made to Form 1 – formal assessment of capacity.

Further sheets can be added if required.

4. Criteria for authorisation – best interests

Have you personally completed a Form 2 – best interests determination statement? **Yes / No** (delete as appropriate)

If yes, continue to section 5.

If no, fill out the rest of section 4.

Provide details of how the intervention is in the person's best interests, including how the best interests determination statement has been considered.

References can be made to Form 2 – best interests statement.

Further sheets can be added if required.

5. Prevention of serious harm condition

Would failing to detain the person in circumstances amounting to a deprivation of liberty create a risk of serious harm to the person or of serious physical harm to other persons and is the detention in question proportionate to the likelihood of harm to the person or of physical harm to other persons and the seriousness of the harm concerned?

Yes / No (delete as appropriate)

Provide details of how the prevention of serious harm condition is met.

Further sheets can be added if required

6. Statement

Statement

I am unconnected with the person in section 1.

In my opinion the criteria for authorisation are met and I have examined the person in section 1 no more than two days before the date on which this report was signed.

Signature: _____

Date: _____

Form 7 – Statement that the person lacks capacity whether an application should be made to the Review Tribunal

Section 39(3), Schedule 1 Paragraph 6(2), Schedule 2 Paragraph 2(5) and Schedule 3 Paragraph 4(2)
The Mental Capacity (Deprivation of Liberty) Regulations (Northern Ireland) 2019

A person can lack capacity in relation to the intervention but still have capacity whether an application should be made to the Review Tribunal in relation to the authorisation, or extension of the authorisation, of the intervention.

The person does not need to have the capacity to make an application to the Review Tribunal. The determination of capacity only relates to whether an application should be made or not.

*The assessment relates to capacity **whether** an application should be made. Even if the person does not have capacity to understand what the Tribunal is, what the process is or how an application should be made the person may still have capacity whether an application should be made.*

The decision does not relate to where the person is and where the deprivation of liberty is taking place, as capacity relates to care arrangements that has the effect of detention in amounting to a deprivation of liberty.

1. **The person’s details (a label can also be affixed here)**

Name: _____

Date of Birth: _____

HSC number (if known): _____

2. **Length of deprivation of liberty**

How long authorisation is being sought? _____

3. **Details of capacity assessment**

Provide details on the capacity assessment and why the person lack (or probably lacks) capacity whether an application should be made to the Review Tribunal if the intervention is authorised.

Further sheets can be added if required.



4. **Views of the person**

Is the person resisting the intervention or expressing any objections to the intervention? (Please note, lack of resistance or objection does not mean consent and does not in itself mean the person has capacity in relation to whether an application should be made to the Tribunal.) **Yes / No** (delete as appropriate)

If yes, provide details:

Further sheets can be added if required

Has the person expressed any wishes or feelings, in the past or at present, whether an application should be made to the Review Tribunal? **Yes / No** (delete as appropriate)

If yes, provide details:

Further sheets can be added if required

5. **Statement**

Statement

In my opinion the person in section 1 lacks (or probably lacks) capacity to decide whether an application to the Review Tribunal in relation to a trust panel authorisation or extension by extension report or trust panel extension authorisation should be made.

Signature: _____

Date: _____

The completed Form 7, together with all other forms completed for the application for trust panel authorisation, authorisation for short-term detention, extension authorisation or application for trust panel extension authorisation must be sent to the Attorney General:

- by the trust immediately after the trust panel has provided an authorisation as a result of an application for trust panel authorisation or trust panel extension authorisation; or
- by the person completing an extension report immediately after signing that report.



Form 8 – Short-term detention authorisation for examination or examination followed by treatment

Schedule 2 Paragraph 2(4)

The Mental Capacity (Deprivation of Liberty) Regulations (Northern Ireland) 2019

1. The person's details (a label can also be affixed here)

Name: _____

Address: _____

Date of Birth: _____

HSC number (if known): _____

2. Person who is making the authorisation report

Name: _____

Work address: _____

Phone number: _____

Job title, team and staff number: _____

Professional role (delete as appropriate):

Approved Social Worker

Healthcare Professional (designated by the hospital to make authorisation reports)

The person making the report should normally be an approved social worker. If not, explain why it is in the best interests of the person being detained that another healthcare professional is making the report:

Further sheets can be added if required.

3. Responsible medical practitioner (if same as person making the authorisation, leave blank)

Name: _____

Work address: _____

Phone number: _____

Job title, team and staff number: _____

Professional relationship to person: _____

4. Hospital of detention

In what hospital, including ward and address, is the person being detained?

5. Examination or examination followed by treatment

Provide details of the examination, and if followed by treatment, details of the treatment (if known):

Further sheets can be added if required.



6. Capacity whether to apply to the Review Tribunal

In your opinion, does the person lack (or probably lack) capacity to decide whether an application to the Review Tribunal should be made? **Yes / No** (delete as appropriate)

*This assessment relates to capacity **whether** an application should be made to the Tribunal. Even if the person does not have capacity to understand what the Tribunal is, what the process is or how an application should be made the person may still have capacity whether an application that challenges the care arrangements that amount to a deprivation of liberty should be made or not.*

The decision does not relate to where the person is and where the deprivation of liberty is taking place, as capacity relates to care arrangements that has the effect of detention in amounting to a deprivation of liberty.

If yes a Form 7 has to be attached to the authorisation.

If no a Form 7 does not have to be attached to the authorisation.

7. Objection from the nominated person

Is the nominated person providing a reasonable objection to the short-term detention for examination or examination followed by treatment? **Yes / No** (delete as appropriate)

If yes a Form 9 has to be attached to the authorisation.

If no a Form 9 does not have to be attached to the authorisation.

8. Annexes that must be attached to the authorisation

Annex A – statement of incapacity on **Form 1**.

Annex B – best interests determination statement on **Form 2**.

Annex C – consultation with the nominated person on **Form 3**.

Annex D – medical report on **Form 6**.

Annex E – statement on capacity to apply to the Review Tribunal on **Form 7** (if required).

Annex F – approved social worker report on **Form 9** (if required).

9. Declaration

Declaration

I have seen the person in section 1 personally no more than two days before the date below.

In my opinion, based on the content of this authorisation including all the attachments, the criteria for detention are met and all information in this report is correct.

This report authorises the detention in circumstances amounting to a deprivation of liberty in the hospital noted at section 4 for the purpose of examination or examination followed by treatment as outlined in section 5.

Signature: _____

Date: _____

Form 9 – Consultation with approved social worker

Schedule 2 Paragraph 5

The Mental Capacity (Deprivation of Liberty) Regulations (Northern Ireland) 2019

Form 9 is only required if the nominated person provides a reasonable objection to the short-term detention for examination or examination followed by treatment.

1. The person's details (a label can also be affixed here)

Name: _____

Address: _____

Date of Birth: _____

HSC number (if known): _____

2. Approved social worker consulted with

Name: _____

Work address: _____

Phone number: _____

Job title, team and staff number: _____

Professional relationship to person: _____

3. Person completing Form 9 (if same as person completing Form 8, leave blank)

Name: _____

Work address: _____

Phone number: _____

Job title, team and staff number: _____

Professional relationship to person: _____

4. Consultation with approved social worker

Provide details on how an approved social worker has been consulted in relation to the short-term detention for examination or examination followed by treatment, including the views of the approved social worker and the approved social worker's opinion if the short-term detention is in the person's best interests.



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Further sheets can be added if required.



Form 10 – Short-term detention admission exception certificate

Schedule 2 Paragraph 9(3)

The Mental Capacity (Deprivation of Liberty) Regulations (Northern Ireland) 2019

If the person is not admitted to hospital within 2 days of the completion of a medical report a new medical report and a new short-term detention authorisation report have to be made unless an exception certificate has been completed.

By signing the short-term detention admission exception certificate the admission to hospital can be delayed by up to 12 days to the 14th day after the completion of the medical report. If the person is not admitted within the period certified on the exception certificate a new medical report and a new short-term detention authorisation report have to be made.

1. The person's details (a label can also be affixed here)

Name: _____

Address: _____

Date of Birth: _____

HSC number (if known): _____

2. Person who is making the certificate

Name: _____

Work address: _____

Phone number: _____

Job title, team and staff number: _____

Professional role (delete as appropriate):
responsible medical practitioner
alternative medical practitioner

3. Responsible medical practitioner (if same as person making the certificate, leave blank)

Name: _____

Work address: _____

Phone number: _____

Job title, team and staff number: _____

4. Length of delay

When was the medical report completed? _____

How long can the admission to hospital be delayed? (the delay can be no less than 2 days and no longer than 14 days after the completion of the medical report) _____

Form 11 – Short-term detention admission report

Schedule 2 Paragraph 11(4)

The Mental Capacity (Deprivation of Liberty) Regulations (Northern Ireland) 2019

If more space is required additional sheets or information may be attached to this form.

1. The person's details (a label can also be affixed here)

Name: _____

Address: _____

Date of Birth: _____

HSC number (if known): _____

2. Person who is making the report

Name: _____

Work address: _____

Phone number: _____

Job title, team and staff number: _____

Professional role (delete as appropriate):

responsible medical practitioner

alternative medical practitioner

medical practitioner (member of staff)

3. Responsible medical practitioner (if same as person making the report, leave blank)

Name: _____

Work address: _____

Phone number: _____

Job title, team and staff number: _____

4. Examination or care

What examination or care will be provided to the person?

Further sheets can be added if required.

5. Harm

How would failure to detain the person, for the purposes of examination or care as outlined in section 4, create a risk of serious harm to the person or serious risk of physical harm to others?

Further sheets can be added if required.

6. **Proportionality**

Explain the likelihood of harm to the person or physical harm to others, the seriousness of the harm and how the detention is proportionate to the harm.

Further sheets can be added if required.

7. **Capacity**

Does the person lack capacity in relation to the short-term detention? **Yes / No** (delete as appropriate)

Explain how the person lacks capacity and which part of the functional test the person is unable to do.

Further sheets can be added if required.

8. **Best interests**

Is the short-term detention in person's best interests? **Yes / No** (delete as appropriate)

Explain the best interests determination.

Further sheets can be added if required.

9. **Nominated person**

Has the nominated person been consulted? **Yes / No** (delete as appropriate)

Has the nominated person provided any further/new information since the creation of the short-term detention authorisation report? **Yes / No** (delete as appropriate)

If yes, complete a Form 3 and attach to the report.

10. **Declaration**

Declaration

In my opinion the condition for detention are met and the authorisation can continue.

Signature: _____

Date: _____

If the person signing the declaration is not a responsible medical practitioner or another medical practitioner a further admission report must be made within 48 hours of this report being signed.



Form 12 – Short-term detention further admission report

Schedule 2 Paragraph 13(4)

The Mental Capacity (Deprivation of Liberty) Regulations (Northern Ireland) 2019

If more space is required additional sheets or information may be attached to this form.

1. **The person's details (a label can also be affixed here)**

Name: _____

Address: _____

Date of Birth: _____

HSC number (if known): _____

2. **Person who is making the report**

Name: _____

Work address: _____

Phone number: _____

Job title, team and staff number: _____

Professional role (delete as appropriate):
responsible medical practitioner
alternative medical practitioner

3. **Responsible medical practitioner (if same as person making the report, leave blank)**

Name: _____

Work address: _____

Phone number: _____

Job title, team and staff number: _____

4. **Examination or care**

What examination or care will be provided to the person?

Further sheets can be added if required.

5. **Harm**

How would failure to detain the person, for the purposes of examination or care as outlined in section 4, create a risk of serious harm to the person or serious risk of physical harm to others?

Further sheets can be added if required.

6. **Proportionality**

Explain the likelihood of harm to the person or physical harm to others, the seriousness of the harm and how the detention is proportionate to the harm.

Further sheets can be added if required.

7. **Capacity**

Does the person lack capacity in relation to the short-term detention? **Yes / No** (delete as appropriate)

Explain how the person lacks capacity and which part of the functional test the person is unable to do.

Further sheets can be added if required.

8. **Best interests**

Is the short-term detention in person's best interests? **Yes / No** (delete as appropriate)

Explain the best interests determination.

Further sheets can be added if required.

9. **Nominated person**

Has the nominated person been consulted? **Yes / No** (delete as appropriate)

Has the nominated person provided any further/new information since the creation of the short-term detention authorisation report? **Yes / No** (delete as appropriate)

If yes, complete a Form 3 and attach to the report.

10. **Declaration**

Declaration

In my opinion the condition for detention are met and the authorisation can continue.

Signature: _____

Date: _____



Form 13 – Short-term detention further report

Schedule 2 Paragraph 14(5)

The Mental Capacity (Deprivation of Liberty) Regulations (Northern Ireland) 2019

If more space is required additional sheets or information may be attached to this form.

1. **The person's details (a label can also be affixed here)**

Name: _____

Address: _____

Date of Birth: _____

HSC number (if known): _____

2. **Person who is making the report**

Name: _____

Work address: _____

Phone number: _____

Job title, team and staff number: _____

Professional role (delete as appropriate):
responsible medical practitioner
alternative medical practitioner

3. **Responsible medical practitioner (if same as person making the report, leave blank)**

Name: _____

Work address: _____

Phone number: _____

Job title, team and staff number: _____

4. **Examination or care**

What examination or care will be provided to the person?

Further sheets can be added if required.

5. **Harm**

How would failure to detain the person, for the purposes of examination or care as outlined in section 4, create a risk of serious harm to the person or serious risk of physical harm to others?

Further sheets can be added if required.

6. **Proportionality**

Explain the likelihood of harm to the person or physical harm to others, the seriousness of the harm and how the detention is proportionate to the harm.

Further sheets can be added if required.

7. **Capacity**

Does the person lack capacity in relation to the short-term detention? **Yes / No** (delete as appropriate)

Explain how the person lacks capacity and which part of the functional test the person is unable to do.

Further sheets can be added if required.

8. **Best interests**

Is the short-term detention in person's best interests? **Yes / No** (delete as appropriate)

Explain the best interests determination.

Further sheets can be added if required.

9. **Nominated person**

Has the nominated person been consulted? **Yes / No** (delete as appropriate)

Has the nominated person provided any further/new information since the creation of the short-term detention authorisation report? **Yes / No** (delete as appropriate)

If yes, complete a Form 3 and attach to the report.

10. **Declaration**

Declaration

In my opinion the condition for detention are met and the authorisation can continue.

Signature: _____

Date: _____

Form 14 – Extension authorisation (extension by report)

Section 39(2)

The Mental Capacity (Deprivation of Liberty) Regulations (Northern Ireland) 2019

If more space is required additional sheets or information may be attached to this form. Information may also be copied from other sources, such as medical notes, and reference may be made to them without such document's inclusion.

1. The person's details (a label can also be affixed here)

Name: _____

Address: _____

Date of Birth: _____

HSC number (if known): _____

2. Person who is making the authorisation

Name: _____

Work address: _____

Phone number: _____

Job title, team and staff number: _____

3. Person in charge of the person's care (if same as person making the extension authorisation, leave blank)

Name: _____

Work address: _____

Phone number: _____

Job title, team and staff number: _____

4. Extension being authorised

Is the report a first or subsequent extension? **First / Subsequent** (delete as appropriate)

How long is the extension for? (delete as appropriate)

6 months (maximum for first extension)

12 months (maximum for subsequent extension)

other – please specify: _____

5. Details about the deprivation of liberty

What is the place or places of the deprivation of liberty, including address and which trust it is in?

A deprivation of liberty authorisation must specify the place of the deprivation. The authorisation can cover deprivation of liberty in more than one place, for example in the place of residence of the person and in the day care centre, or the ordinary place of residence of the person and in a named place of respite.

6. **Criteria for continuation – lack of capacity**

Have you personally completed a Form 1 – statement of incapacity? **Yes / No** (delete as appropriate)

If yes, continue to section 7.

If no, fill out the rest of section 6.

Provide details of how the person lacks capacity to make the decision, including how the statement of incapacity has been considered.

Further sheets can be added if required.

7. **Criteria for continuation – best interests**

Have you personally completed a Form 2 – best interests determination statement? **Yes / No** (delete as appropriate)

If yes, continue to section 8.

If no, fill out the rest of section 7.

Provide details of how the intervention is in the person’s best interests, including how the best interests determination statement has been considered.

Further sheets can be added if required.



8. Prevention of serious harm condition

Would failing to detain the person in circumstances amounting to a deprivation of liberty create a risk of serious harm to the person or of serious physical harm to other persons and is the detention in question proportionate to the likelihood of harm to the person or of physical harm to other persons and the seriousness of the harm concerned? **Yes / No** (delete as appropriate)

Provide details of how the prevention of serious harm condition is met.

Further sheets can be added if required

9. Opinion of the responsible person

Has the responsible person provided a statement on Form 15 that in his or her opinion the criteria for continuation are met for each of the interventions in section 4? **Yes / No** (delete as appropriate)

If yes, Form 15 must be attached to the report.

If no, the authorisation cannot be extended by the making of a report. An application has to be made to the trust panel on Form 16.

10. Capacity whether to apply to the Review Tribunal

In your opinion, does the person lack (or probably lack) capacity to decide whether an application to the Review Tribunal should be made? **Yes / No** (delete as appropriate)

*This assessment relates to capacity **whether** an application should be made to the Review Tribunal. Even if the person does not have capacity to understand what the Tribunal is, what the process is or how an application should be made the person may still have capacity whether an application should be made that challenges the care arrangements that amount to a deprivation of liberty.*

The decision does not relate to where the person is and where the deprivation of liberty is taking place, as capacity relates to care arrangements that has the effect of detention in amounting to a deprivation of liberty.

If yes a Form 7 has to be included in the application.

If no a Form 7 does not have to be included in the application.

11. **Annexes that must be attached to the authorisation**

Annex A – statement of incapacity on **Form 1**.

Annex B – best interests determination statement on **Form 2**.

Annex C – consultation with the nominated person on **Form 3**.

Annex D – statement on capacity to apply to the Review Tribunal on **Form 7** (if required).

Annex E – responsible person statement on **Form 15**.

Annex F – care plan.

A copy of P's care plan must be attached to the application.

12. **Declaration**

Declaration

I confirm I am eligible to make this extension report.

In my opinion the criteria for continuation are met in respect of the deprivation of liberty and the authorisation is extended for the period mentioned in section 4.

Signature: _____

Date: _____

Form 15 – Responsible person statement

Section 39(2)(d)

The Mental Capacity (Deprivation of Liberty) Regulations (Northern Ireland) 2019

If more space is required additional sheets or information may be attached to this form.

1. The person's details (a label can also be affixed here)

Name: _____

Address: _____

Date of Birth: _____

HSC number (if known): _____

2. The responsible person

Name: _____

Work address: _____

Phone number: _____

Job title, team and staff number (if applicable): _____

3. The responsible person criteria

Have you completed the statement of incapacity? **Yes / No** (delete as appropriate)

If yes, you cannot complete the responsible person statement as the person making the report and the person who completes the statement of incapacity must be different.

Are you unconnected with the person in section 1? **Yes / No** (delete as appropriate)

If no, you cannot complete the responsible person statement as the person making the report must be unconnected with the person.

Role that qualifies as a responsible person (delete as appropriate):

an approved social worker who is involved in relevant care or treatment of the person.

a person designated by the managing authority in the hospital or care home where the person is an in-patient or resident.

if the person is subject to a community residence requirement or attendance requirement, a person designated by the HSC trust in which the person is residing.

4. Criteria for extension

Provide details on how the criteria for extension have been **met / not been met** (delete as appropriate).

Lined area for providing details on how the criteria for extension have been met or not been met. The area contains horizontal lines for writing and a large, light gray diagonal watermark that reads "DRAFT".

Further sheets can be added if required.

5. Statement

Statement

In my opinion, based on the balance of probabilities, the criteria for continuation for deprivation of liberty are met.

If you do not believe the criteria has been met, fill out the form and outline the reasons why the criteria are not met, but do not sign the form!

Signature: _____

Date: _____



Form 16 – Application for trust panel extension authorisation

Schedule 3 Paragraph 4(1)(a)

The Mental Capacity (Deprivation of Liberty) Regulations (Northern Ireland) 2019

If more space is required additional sheets or information may be attached to this form. Information may also be copied from other sources, such as medical notes, and reference may be made to them without such document's inclusion.

More than one intervention can be applied for in one application. If required more than one form can be used for one application.

1. The person's details (a label can also be affixed here)

Name: _____

Address: _____

Date of Birth: _____

HSC number (if known): _____

2. Person who is making the application

Name: _____

Work address: _____

Phone number: _____

Job title, team and staff number: _____

Professional relationship to person: _____

3. Person in charge of P's care or treatment (if same as applicant, leave blank)

Name: _____

Work address: _____

Phone number: _____

Job title, team and staff number: _____

Professional relationship to person: _____

4. Extension(s) being applied for and length of authorisation

Is the report a first or subsequent extension? **First / Subsequent** (delete as appropriate)

How long is the extension for? (delete as appropriate)

6 months (maximum for first extension)

12 months (maximum for subsequent extension)

other – please specify: _____

5. Details about the deprivation of liberty

What is the place or places of the deprivation of liberty, including address and which trust it is in?

A deprivation of liberty authorisation must specify the place of the deprivation. The authorisation can cover deprivation of liberty in more than one place, for example in the place of residence of the person and in the day care centre, or the ordinary place of residence of the person and in a named place of respite.

6. Capacity whether to apply to the Review Tribunal

In your opinion, if the extension was to be authorised, does the person lack (or probably lack) capacity to decide whether an application to the Review Tribunal should be made? **Yes / No** (delete as appropriate)

*The question relates to capacity **whether** an application should be made. Even if the person does not have capacity to understand what the Tribunal is, what the process is or how an application should be made the person may still have capacity whether an application should be made that challenges the care arrangements that amount to a deprivation of liberty.*

The decision does not relate to where the person is and where the deprivation of liberty is taking place, as capacity relates to care arrangements that has the effect of detention in amounting to a deprivation of liberty.

If yes a Form 7 has to be included in the application.

If no a Form 7 does not have to be included in the application.

7. Annexes that must be attached to the Application

Annex A – statement of incapacity on **Form 1**.

Annex B – best interests determination statement on **Form 2**.

Annex C – consultation with the nominated person on **Form 3**.

Annex D – medical report on **Form 6**.

Annex E – statement on capacity to apply to the Review Tribunal on **Form 7** (if required).

Annex F – responsible person statement on **Form 15**.

Annex G – care plan.

A copy of P's care plan must be attached to the application.

8. Declaration

Declaration

I confirm I am eligible to make this application.

To the best of my knowledge all information in this application is correct and all required information is included.

Signature: _____

Date: _____

Form 17 – Notification of application for trust panel authorisation and trust panel extension authorisation

Schedule 1 Paragraph 14(1)(a) and Schedule 3 Paragraph 7(1)(a)
The Mental Capacity (Deprivation of Liberty) Regulations (Northern Ireland) 2019

To:
Name: _____
Address: _____

This is to notify you that the _____ (trust name) has on _____ (date) received an application under the Mental Capacity Act (Northern Ireland) 2016 in respect of
Name: _____
Address: _____

for a trust panel to authorise, or extend an authorisation for, a deprivation of liberty.

The trust has constituted a panel to consider the application. The panel has 7 working days to make a decision from the date of receiving the application. The panel can authorise the intervention, refuse to grant an authorisation or provide an interim authorisation for a maximum of 21 days.

If you like more information about the reasons for the application you can contact the trust directly.

Enclosed with this letter is a leaflet providing information on the trust panel and a person's rights under the Mental Capacity Act.

Trust details

Trust: _____
Address: _____

Reference number: _____
Contact person: _____
Phone number: _____
Email: _____

Form 18 – Notification of trust panel decision

Schedule 1 Paragraph 19(3) and Schedule 3 Paragraph 9(3)
The Mental Capacity (Deprivation of Liberty) Regulations (Northern Ireland) 2019

To: _____
Name: _____
Address: _____

This is to notify you that a trust panel constituted under the Mental Capacity Act (Northern Ireland) 2016 in the _____ (trust name) has on _____ (date) made a decision respect of

Name: _____
Address: _____

The trust panel has **granted / extended / refused / granted an interim** (delete as appropriate) authorisation for a deprivation of liberty.

If you like more information about the reasons for the decision you can contact the trust directly.

A decision by the trust panel to grant, extend or grant an interim authorisation can be appealed to the Review Tribunal.

Enclosed with this letter is a leaflet providing information on the trust panel, the Review Tribunal and a person's rights under the Mental Capacity Act.

Trust details

Trust: _____
Address: _____

Reference number: _____

Contact person: _____

Phone number: _____

Email: _____

Form 19 – Notification of short-term detention

Schedule 2 Paragraph 7(1)

The Mental Capacity (Deprivation of Liberty) Regulations (Northern Ireland) 2019

To: _____
Name: _____
Address: _____

This is to notify you that a short-term detention for examination or examination followed by treatment under the Mental Capacity Act (Northern Ireland) 2016 at _____ (name of hospital) in the _____ (trust name) has on _____ (date) been

authorised in respect of

Name: _____
Address: _____

If you like more information about the reasons for the decision you can contact the trust directly.

The decision to authorise a short-term detention for examination or examination followed by treatment can be appealed to the Review Tribunal.

Enclosed with this letter is a leaflet providing information on short-term detentions, the Review Tribunal and a person's rights under the Mental Capacity Act.

Trust details

Trust: _____
Address: _____

Reference number: _____
Contact person: _____
Phone number: _____
Email: _____

Form 20 – Notification of an extension

Section 43(5)

The Mental Capacity (Deprivation of Liberty) Regulations (Northern Ireland) 2019

To: _____
Name: _____
Address: _____

This is to notify you that an authorisation under the Mental Capacity Act (Northern Ireland) 2016 in the _____ (trust name) has on _____ (date) been extended in respect of
Name: _____
Address: _____

The extension relates to an authorisation for a deprivation of liberty.

If you like more information about the reasons for the decision to extend the authorisation you can contact the trust directly.

The decision to extend the authorisation can be appealed to the Review Tribunal.

Enclosed with this letter is a leaflet providing information on the extension process, the Review Tribunal and a person's rights under the Mental Capacity Act.

Trust details

Trust: _____
Address: _____

Reference number: _____
Contact person: _____
Phone number: _____
Email: _____

Form 21 – Discharge from detention

Section 57(4)

The Mental Capacity (Deprivation of Liberty) Regulations (Northern Ireland) 2019

When a person is discharged from detention under the Mental Capacity Act (Northern Ireland) 2016 this Form must be provided to the person being discharged and to any other person the person being discharged has asked to be notified.

To:
Name: _____
Address: _____

This is to notify you that:

Name: _____
Address: _____

has on _____ (date) been discharged from detention amounting to deprivation of liberty by virtue of the Mental Capacity Act (Northern Ireland) 2016.

The effect of the discharge from detention is that a previous authorisation (authorising the detention amounting to a deprivation of liberty by virtue of a short-term detention in hospital, trust panel authorisation, trust panel extension authorisation or an extension report) under the Mental Capacity Act (Northern Ireland) 2016 is revoked. That authorisation cannot be used again as an additional safeguard and if a new detention amounting to a deprivation of liberty is necessary a new authorisation is required.

Enclosed with this letter is a leaflet providing information on deprivations of liberty under the Mental Capacity Act and the effect of the discharge from detention.

Trust details

Trust: _____
Address: _____

Reference number: _____
Contact person: _____
Phone number: _____
Email: _____

Form 22 – Appointment, revocation, making of a declaration or revoking a declaration in relation to nominated person

A person who has capacity can at any time appoint a nominated person, revoke such appointment, declare that certain persons, or persons of a certain description, should not be a nominated person and revoke such a declaration.

All section reference refer to the Mental Capacity Act (Northern Ireland) 2016.

This form is not required for making an appointment, revocation, making of a declaration or revoking a declaration but may be helpful as it contains all the information required.

1. The person's details

Name: _____

Address: _____

Date of Birth: _____

HSC number (if known and available): _____

2. Decision

This is (delete as appropriate)

an appointment of a nominated person under section 70

a revocation of an appointment under section 71(1)

the making of a declaration under section 77(1)

the revocation of a declaration under section 77(5)

If the decision is an appointment or revocation of a nominated person go to section 3.

If the decision is the making of a declaration go to section 4.

If the decision is the revocation of a declaration go to section 5.

3. Appointment or revocation of appointment

Person that should be **appointed nominated person / revoked as the nominated person** (delete as appropriate).

Name: _____

Address: _____

Date of Birth: _____

HSC number (if known and available): _____

4. Declaration

The person, persons or persons of the described description should not be the nominated person.

Provide details:

Further sheets can be added if required.

5. Revocation of previous declaration

A previous declaration made is revoked and the person, persons or persons of the described description can now be the nominated person.

Provide details:

Further sheets can be added if required.

6. Witness

The witness must be ordinary resident in Northern Ireland, has known the person in section 1 personally for at least two years and is not a relative of the person in section 1.

Provide details of the witness.

Name: _____

Address: _____

Date of Birth: _____

HSC number (if known and available): _____

Certification by witness

I meet the criteria to be a witness.

In my opinion the person in section 1 understands the effect of the appointment, revocation, declaration or revocation of a declaration and the person has not been subjected to any undue pressure in relation to the appointment, revocation, declaration or revocation of a declaration.

If the decision is an appointment of a nominated person, in my opinion the person in section 1 understands that the appointment may result in information about the person (including sensitive personal information) being disclosed to the nominated person.

Signature: _____

Date: _____

7. Signature by person

Signature by person

I am the person in section 1 and the appointment, revocation, declaration or revocation of a declaration is my capacitous decision.

Signature: _____

Date: _____

8. Addition sheet

If the person in section 1 is physically unable to sign the declaration in section 7 this sheet may be inserted in place of section 7. The addition sheet must be signed by a person on behalf of the person in section 1. That person must be unconnected with the person in section 1. The addition sheet must also be witnessed by an additional witness.

Provide details of the person signing on behalf of the person in section 1.

Name: _____

Address: _____

Date of Birth: _____

Statement

In my opinion the person in section 1 is physically unable to sign section 7 and I am therefore signing on behalf of the person in section 1.

In my opinion the person in section 1 understands the effect of the appointment, revocation, declaration or revocation of a declaration and the person has not been subjected to any undue pressure in relation to the decision.

If the decision is an appointment of a nominated person, in my opinion the person in section 1 understands that the appointment may result in information about the person (including sensitive personal information) being disclosed to the nominated person.

Signature: _____

Date: _____

The witness must be ordinary resident in Northern Ireland, has known the person in section 1 personally for at least two years and is not a relative of the person in section 1. The witness cannot be the same person as in section 6.

Provide details of the additional witness.

Name: _____

Address: _____

Date of Birth: _____

Certification by additional witness

In my opinion the person in section 1 understands the effect of the appointment, revocation, declaration or revocation of a declaration and the person has not been subjected to any undue pressure in relation to the decision.

If the decision is an appointment of a nominated person, in my opinion the person in section 1 understands that the appointment may result in information about the person (including sensitive personal information) being disclosed to the nominated person.

Signature: _____

Date: _____