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| Case ID Number:  |
| **DEPRIVATION OF LIBERTY SAFEGUARDS FORM 5****STANDARD AUTHORISATION GRANTED** |
| Full name of the person being deprived of liberty  |  |
| Name and address of the care home or hospital where the deprivation of liberty is authorised. |  |
| Name, address and contact details of the Supervisory Body |  |
| **THE SUPERVISORY BODY’S DECISION** |
| This standard authorisation is to come into force on:Date: Time:  |
| This standard authorisation is to expire at the end of the day on:Date:  |
| The reasons for this period are:*(The period specified must not exceed the maximum period specified in the best interests assessment)* |
| **THE PURPOSE OF THE AUTHORISATION IS SO THAT THE PERSON CAN BE LAWFULLY DEPRIVED OF LIBERTY IN THE HOSPITAL OR CARE HOME SO THAT THEY CAN RECEIVE CARE/TREATMENT THERE**  |
| **CONDITIONS TO WHICH THE STANDARD AUTHORISATION IS SUBJECT** *The care home or hospital must comply with these conditions.* |
| This standard authorisation **IS NOT** subject to any conditions. |  |
| This standard authorisation **IS** subject to the following conditions set out immediately below. |  |
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| Any additional conditions placed by the Supervisory Body authoriser |
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| **The authorisation is granted because the Supervisory Body has received written copies of all required assessments and concludes each qualifying requirement is met for the following reasons.** |
| **AGE REQUIREMENT**  |
| The Supervisory Body has seen evidence to confirm that the person is over 18  |  |
| **NO REFUSALS REQUIREMENT**  |
| The person has not made an Advance Decision or appointed a Lasting Power of Attorney for Health and Welfare under the MCA 2005 and no Deputy for Health and Welfare has been appointed by the Court of Protection ***or*** |  |
| Any Advance Decision the person has made does not prevent them being given the treatment proposed, and any decisions made by a donee of a Lasting Power of Attorney or Deputy for Health and Welfare do not conflict with the proposals for their accommodation, treatment or care |  |
| **MENTAL HEALTH REQUIREMENT**  |
| The Supervisory Body has seen current evidence that the person is suffering from a mental disorder within the meaning of the Mental Health Act 1983 (disregarding any exclusion for persons with a learning disability) ***or***  |  |
| Anequivalent Mental Health Assessment is being used, dated |  |
| **ELIGIBILITY REQUIREMENT** |
| The Supervisory Body has seen current evidence that accommodating the person is not ineligible to be deprived of liberty by the MCA 2005 by virtue of falling into one of the Cases A-E set out in paragraph 2 of Schedule 1a to the MCA 2005, ***or*** |  |
| An equivalent Eligibility Assessment is being used, dated |  |
| **MENTAL CAPACITY REQUIREMENT** |
| The Supervisory Body has seen current evidence that the person lacks capacity to make their own decision about whether they should be accommodated in the care home or hospital for the purposes of being given care and or treatment. This is because of an impairment or disturbance in the functioning of their mind or brain, ***or***  |  |
| An equivalent Mental Capacity Assessment is being used, dated |  |
| **BEST INTERESTS REQUIREMENT** |
| The Supervisory Body has seen current evidence provided by the Best Interest Assessor. This confirms that it is in the person’s best interests to be deprived of their liberty and that the deprivation is necessary to prevent harm to the person, and the deprivation is a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm, ***or*** |  |
| An equivalent Best Interests Assessment is being used, dated |  |
| **CONFIRMATION OF SUPERVISORY BODY SCRUTINY** |
| I confirm I have carried out the required scrutiny on behalf of the supervisory body of each assessment provided, and I agree with all the conclusions. | Signature |  |
| Print Name |  |
| Date |  |

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| **Please note: These two pages are to be sent to the Representative only** |
| **APPOINTMENT OF A REPRESENTATIVE - 1st copy to be retained by representative** |
| **Details of the person to be appointed**The Supervisory Body appoints the person named below to represent the relevant person, in so doing it confirms that they meet the eligibility requirements of the Deprivation of Liberty Safeguards provisions of the Mental Capacity Act 2005. This person was identified as representative by: |
| The Relevant Person |  |
| The Best Interests Assessor |  |
| The Best Interests Assessor indicated that they were not able to select an eligible person as representative. It is therefore necessary for the Supervisory Body to select a representative for this person. |  |
| Full name of Relevant Person’s Representative |  |
| Address |  |
| Telephone |  |
| Email |  |
| Relationship to Relevant Person |  |
| This appointment lasts for the same period as the Standard Authorisation to which it relates. |

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| **APPOINTMENT OF A REPRESENTATIVE** **2nd copy – to be returned to Supervisory Body by the Representative** |
| **Details of the person to be appointed**The Supervisory Body appoints the person named below to represent the relevant person, in so doing it confirms that they meet the eligibility requirements of the Deprivation of Liberty Safeguards provisions of the Mental Capacity Act 2005. This person was identified as representative by: |
| The Relevant Person |  |
| The Best Interests Assessor |  |
| The Best Interests Assessor indicated that they were not able to select an eligible person as representative. It is therefore necessary for the Supervisory Body to select a representative for this person.  |  |
| Full name of Relevant Person’s Representative |  |
| Address |  |
| Telephone |  |
| Email |  |
| Full name of Relevant Person |  |
| Relationship to Relevant Person |  |
| This appointment lasts for the same period as the Standard Authorisation to which it relates. |
| **Agreement of the appointed representative:**I am willing to be appointed as this person’s representative under the Deprivation of Liberty Safeguards provisions of the Mental Capacity Act 2005 and I am aware of the functions that I am expected to perform |
| **Signed** |  |
| **Date** |  |
| **Please now return this page only to the Supervisory Body indicated below** |
| Name and address of the Supervisory Body  |  |
| Person to contact at the Supervisory Body | Name |  |
| Telephone |  |
| Email |  |