|  |
| --- |
| Case ID Number: Click here to enter text.  |
| **DEPRIVATION OF LIBERTY SAFEGUARDS FORM 3A****BEST INTEREST ASSESSMENT – NO DEPRIVATION** |
| This form is being completed in relation to a request for a standard authorisation. | Click here to enter text. |
| This form is being completed in relation to a review of an existing standard authorisation under Part 8 of Schedule A1 to the Mental Capacity Act 2005.  | Click here to enter text. |
| Full name of the person being assessed | Click here to enter text. |
| Date of birth *(or estimated age if unknown)* | Click here to enter text. | Est. Age:  | Click here to enter text. |
| Name and address of the care home or hospital where the person is, or may become, deprived of liberty | Click here to enter text. |
| The present address of the person being assessed if different from above. | Click here to enter text. |
| Name and address of the Assessor | Click here to enter text. |
| Profession of the Assessor | Click here to enter text. |
| Name of the Supervisory Body | Click here to enter text. |
| **MATTERS THAT I HAVE CONSIDERED AND TAKEN INTO ACCOUNT** |
| **Note:** *before embarking on the full best interests assessment consultation process, the Best Interests Assessor may first wish to check that there is* prima facie *evidence that a deprivation of liberty may be occurring, or is likely to occur, since, if it is apparent that there is no deprivation of liberty, the full best interests consultation process will be unnecessary.* |
| I have considered and taken into account the views of the relevant person |[ ]
| I have considered what I believe to be all of the relevant circumstances and, in particular, the matters referred to in Section 4 of the Mental Capacity Act 2005 |[ ]
| I have taken into account the conclusions of the mental health assessor as to how the person’s mental health is likely to be affected by being deprived of liberty |[ ]
| I have taken into account any assessments of the person’s needs in connection with accommodating the person in the hospital or care hom |[ ]
| I have taken into account any care plan that sets out how the person’s needs are to be met while the person is accommodated in the hospital or care home. |[ ]
| In carrying out this assessment, I have taken into account any information given to me, or submissions made, by any of the following:1. any relevant person’s representative appointed for the person
2. any IMCA instructed for the person in relation to their deprivation of liberty
 |[ ]

|  |
| --- |
| **In carrying out this assessment I have met or consulted with the following people:** |
| **NAME** | **ADDRESS** | **CONNECTION TO PERSON BEING ASSESSED** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **BACKGROUND INFORMATION** |
| ***Note:*** *Background and historical information relating to the current or potential deprivation of liberty. This sets the context: why is the person in that particular care home or hospital; why do they need residential care; what else has been tried; what else has failed.*Click here to enter text. |
| **VIEWS OF THE RELEVANT PERSON** |
| Click here to enter text. |
| **VIEWS OF OTHERS** |
| ***Note:*** *Record the documents used in the assessment, e.g. current care plans, medical notes, daily record sheets, risk assessments etc, as well as conversations with interested persons and the Mental Health Assessor.* Click here to enter text. |

|  |
| --- |
| **BEST INTEREST ASSESSMENT**  |
| WHY THE PERSON IS NOT DEPRIVED OF THEIR LIBERTY *In my opinion although the person is, or is to be, kept in the hospital or care home for the purpose of being given care or treatment the circumstances do not amount to a deprivation of liberty for the following reasons:*Click here to enter text. |
| **ANY OTHER RELEVANT INFORMATION***Please use the space below to record any other relevant information and any other interested persons consulted by you. This should include observations on any care planning issues.* |
| Click here to enter text. |
| **PLEASE NOW SIGN AND DATE THIS FORM** |
| Signed | Click here to enter text. |
| Date | Click here to enter a date. |
| Time | Click here to enter text. |