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APPENDICES

Appendix 1

Guidance to completion of Carefirst Mental Capacity Act Assessment form (either Form S or section xxx in Overview Assessment forms

Appendix 2

Mental Capacity Act and Deprivation of Liberty Training Pathway
1. Introduction

1.1 The Mental Capacity Act 2005 which came into force in 2007 provides a statutory framework to protect the rights of adults over the age of 16 in England and Wales who may lack capacity to make some decisions for themselves.

1.2 The Act promotes fair treatment for people who may be affected and has established a system for settling disputes and disagreements through the Court of Protection. It enables people to plan ahead through Lasting Powers of Attorney for a time when their mental capacity may be compromised by appointing others to deal with personal welfare issues and their property and financial affairs. The Court of Protection can also appoint deputies to manage decision making for those lacking capacity who have not authorised another person to assist them in advance. The Court of Protection has jurisdiction relating to the whole Act, and is supported by the Office of the Public Guardian.

1.3 There are substantial numbers of people in England and Wales who will lack the capacity to make decisions for themselves at a particular time. They could be people with both long term and short term temporary conditions such as: dementia, learning disabilities, mental health problems, people who have suffered stroke and head injuries, confusion, drowsiness or unconsciousness because of an illness or treatment for it or substance misuse.

1.4 The Council wishes to emphasise the importance of its staff being fully informed about the legislation, and accompanying government guidance. The Council holds the view that all agencies working with individuals lacking mental capacity need to have policies and procedures available to their staff.

2. The Code of Practice

2.1 Paid carers, social and healthcare professionals and providers must abide by the key principles of the Act and the Code of Practice which provides guidance to all those working with and/or caring for adults who may lack capacity, including informal carers and families. The Code of Practice describes the responsibilities of those who have a duty of care to a person lacking capacity when acting or making decisions with them or on their behalf. An office copy of the Mental Capacity Act Code of Practice should be available for team reference.

2.2 The Code

- Has statutory force which means that people who are working with and/or caring for adults who may lack capacity to make particular decisions have a legal duty to have regard to it. In particular, the Code of Practice focuses on those who have a duty of care to someone who lacks the capacity to agree to the care that is being
provided.
- Provides guidance not instruction
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But
- Professionals and care staff are legally required “to have regard to it”
- MCA applies more generally to everyone who cares for someone who lacks capacity
- Families should follow the guidance in the Code “as far as they are aware of it” ie acting in the person’s best interests when providing personal care.

3. The Five Key Principles

3.1 Section 1 of the Act sets out the five key principles which underpin the Act:

1. Presumption of capacity – every adult has the right to make his/her own decisions and must be assumed to have capacity unless it is proved otherwise

2. Individuals must be supported to make their own decisions – a person must be given all practicable help before anyone treats them as not being able to make their own decisions

3. Unwise decisions – just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision

4. Best interests – any act or decision taken about care or treatment under the Act for or on behalf of a person who lacks capacity must be made in their best interests, and

5. Least restrictive option – any action or decision made for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms whilst still meeting their best interests.

People with a duty of care for a person who lacks capacity have a responsibility to follow the guidance contained in the Code of Practice and reflect this in their records.

4. Assessment of Mental Capacity

4.1 The Act sets out a single clear legal test for assessing whether a person lacks capacity to take a particular decision at a particular time. The test is decision and time specific. The test should usually be carried out by the professional or person who is closest to the actual delivery of treatment. No one can be assessed as lacking capacity simply as a result of a particular medical condition, diagnosis, or by reference to their age, appearance or any condition or aspect of their behaviour. It is important to emphasise that these assessments are not exclusively carried out by
4.2 The mental capacity test has two stages:

4.2.1 Stage 1 Diagnostic Test

1. Is there an impairment of, or disturbance in, the functioning of the person’s mind or brain (permanent or temporary)

2. If yes, does the impairment or disturbance make the person unable to make the particular decision?

4.2.2 Stage 2 Functional Test

The person will be assessed as unable to make the particular decision if after appropriate help and support to make the decision has been given they cannot:

1. Understand the information relevant to that decision, including understanding the likely consequences of making, or not making the decision

2. Retain that information long enough to make a decision

3. Use or weigh that information as part of the process of making the decision

4. Communicate their decision (whether by talking, using sign language or any other means).

4.3 Every effort should be made to find an appropriate way of enabling the person to communicate their decision. The assessment should be made on the balance of probabilities – is it more likely than not that the person lacks capacity to make that particular decision? Health and care professionals must be able to show in the case record the reasons why they have concluded that the person lacks capacity to make that decision. Such records will be important in the event that a relative or advocate for the person challenges the assessment. The Code of Practice contains guidance on resolving disagreements about assessments of mental capacity.

Guidance on completing the MCA Assessment can be found in Appendix 1.

5. Independent Mental Capacity Advocate (IMCA) Service

5.1 The Act provides for a specialist advocacy service to support adults who lack capacity with serious major potentially life-changing decisions when they have no one other than paid staff to represent and help them. An IMCA is not required if the person has family members or friends who take an interest in their welfare or support from a deputy of the Court of
Protection or an attorney appointed under a Lasting Power of Attorney.

5.2 An IMCA should be involved when a person who is "un-befriended" lacks capacity to make a decision concerning:

- Serious medical treatment provided by NHS
- A proposal to move into long-term care of more than 28 days in hospital or 8 weeks in a care home
- A long-term move (8 weeks or more) to different accommodation e.g. hospital or care home.

5.3 The definition of un-befriended is where the NHS body or Local Authority is satisfied that there is no person, other than one engaged in providing care or treatment for the person in a professional or paid capacity, who would be able and willing to be consulted in determining what would be in their best interests.

5.4 Local authorities and the NHS in England also have powers to extend the IMCA service to the following situations if they are satisfied that the person would benefit particularly from the involvement of an IMCA advocate:

- Care reviews about accommodation or changes to accommodation
- Adult protection cases (even if the person who lacks capacity has family and/or friends).

An IMCA does not have to be involved if the treatment or move into hospital or care home is required under the Mental Health Act 1983.

5.5 Except in emergency situations, it is the duty of the decision-maker to engage an IMCA before making the decision on behalf of the person who he/she has assessed as lacking capacity to make that particular decision.

See Procedure No: 8.8 for detailed guidance on the IMCA service in Bromley.

6. Providing Care to People who lack Capacity

6.1 Section 5 of the Act provides legal protection from liability where a person is carrying out actions in connection with the care or treatment of people who lack capacity to give consent.

6.2 Provided that a care worker has complied with the Act in assessing a person's capacity to give consent to the action and has acted in the person's best interests he/she will be able to deliver personal care, take action in relation to their safety and adult protection without their consent and will be protected from liability. The care worker should record the actions taken and the factors taken into consideration in doing so. This applies to general acts undertaken in the person’s best interests. In emergencies, the care worker should act in the person’s best interests to
provide urgent care without delay.

7. Providing Medical Treatment to People who lack Capacity

7.1 Similarly, it is the responsibility of health care professionals, including doctors and nurses, to follow the same assessment of capacity process as above, to be able to diagnose and treat patients who do not have the capacity to give their consent, including emergency procedures.

7.2 Serious medical treatments may need to be referred to the Court of Protection – see Code of Practice for detailed guidance.

8. Restraint

8.1 Section 6 of the Act covers the limitations on protection from liability when restraining a person who lacks capacity to give consent. It defines restraint as the use or threat of force where a person without capacity resists. It also covers any restriction of liberty or movement whether or not the person resists.

8.2 In addition to the basic requirements for the person to lack capacity and for the restraint to be in the person’s best interests the following conditions must be met in order for the worker to be protected from liability for restraint:
   - The person using restraint must reasonably believe that it is necessary in order to prevent harm to the person who lacks capacity
   - The restraint must be in proportion to the likelihood and the seriousness of the potential harm.

8.3 There is no protection from liability under Section 6 of the MCA if the restraint amounts to Deprivation Of Liberty within the meaning of Article 5(1) of the European Convention on Human Rights.

8.4 Arising from a judgement of the European Court of Human Rights in the “Bournewood” case, the Government has amended the Mental Capacity Act by introducing additional safeguards in the Mental Health Act 2007. This covers people who lack capacity to make decisions about their care, who are deprived of their liberty to protect them from harm, in hospitals and care homes. See detailed guidance on the Deprivation Of Liberty Safeguards

9. Advance Decisions to Refuse Treatment

9.1 The Act creates new statutory rules for people aged 18 or over to make advance decisions to refuse treatment that they would not want to have, should they lose the capacity to refuse consent to this treatment for themselves in the future. There are safeguards to ensure that the advance decision is valid and applicable to the treatment in question. Where the advance decision refuses treatment that is necessary to sustain the person’s life, it must be in writing, signed, witnessed and also contain the express statement that the decision stands “even if life is at risk” which
must also be in writing, signed and witnessed.

9.2 People detained under the **Mental Health Act 1983** can be treated for their mental illness without consent. An advance decision to refuse such treatment would not be valid.

9.3 People cannot make an advance decision to ask for medical treatment – they can only say what types of treatment they would refuse. People cannot make an advance decision to ask for their life to be ended.

9.4 Health professionals do not have to act on an advance decision if they have religious or moral objections: they should make their conscientious objection known and responsibility for management of the patient’s care should be transferred to another health professional.

9.5 Health and social care professionals must refer to the Code of Practice for detailed guidance on these complex issues.

10. **Advance Statements**

10.1 Advance decisions can only be made to **refuse** treatment. Nobody has the legal right to demand specific treatment either at the time or in advance but people can make statements indicating their wishes or preferences in advance. The MCA Code of Practice (Chapter 9 Para 9.5) indicates that healthcare professionals should take the statement into consideration when deciding what is in a patient’s best interests if the patient lacks capacity.

11. **Excluded Decisions**

11.1 The MCA excludes some types of decisions which cannot be made by one person on behalf of another who lacks capacity. These include decisions or actions which are either so personal to the individual or because they are governed by other legislation: for example, marriage or civil partnership, divorce, sexual relationships and voting.

12. **Lasting Power of Attorney**

12.1 The Act allows people over the age of 18 to choose and appoint someone to act under a Lasting Power of Attorney if in the future they lack the capacity to make these decisions for themselves.

12.2 There are two types of LPA:
   - A health and welfare LPA
   - A property and financial affairs LPA

12.3 A person must have capacity when the LPA is set up. An LPA must be registered with the Office of the Public Guardian before it can be used. A property and affairs LPA can be used at any time after it is registered, unless the donor (the person making the LPA) has specified that it must not be used while they still have the capacity to make decisions about
their finances. A personal welfare attorney has no power to consent to or refuse treatment, at any time or make decisions about any welfare matter when the donor has the capacity to make the decision for himself/herself.

12.4 The finances and property of adults who lack mental capacity can be protected by the use of an LPA. Adults should be encouraged to plan ahead for a time when they may become mentally incapacitated through the nomination of an “attorney” who can manage their financial affairs and/or their health and personal welfare.

13. Enduring Power of Attorney

13.1 Enduring Powers of Attorney created and registered with the Court of Protection before the implementation of the MCA are still valid and the attorney can carry on acting for a donor who does not have capacity to make decisions about his/her finances and property. It is no longer possible to create a new EPA. If an EPA has not been registered because the donor is still able to make decisions about their finances, the donor can:
- Destroy the EPA and make a new property and affairs LPA, or
- Keep the EPA for finance decisions, and
- Make a separate LPA for health and welfare decisions, if they wish.

Refer to the MCA Code of Practice for more detailed guidance.

14. Appointee and Deputyship Service

14.1 The Council has an Appointee and Deputyship Service which will manage the finances of people who lack mental capacity to deal with their own finances and have no appropriate family member, trusted friend, neighbour or solicitor who is willing to undertake this task. The London Borough of Bromley will only act if there is no alternative to safeguard the financial interests of the service user.

14.2 The Appointee service relates to the management of finances of service users who are in receipt of welfare benefits and state pension only. Where LBB acts as the Appointee, the service will receive benefits, pay bills, repay debts and manage the day to day finances of the service user. There is no charge to service users for this service.

14.3 Where the adult who lacks mental capacity has assets in excess of £16,000, and no-one else willing to manage their finances, LBB will apply to the Court of Protection to be appointed as a Deputy. The Court of Protection and the Deputy levies an annual charge against the service user’s estate for administering assets.

14.4 Contact the Appointee and Deputyship Service for a Referral Pack:

Tel: 020 8461 7485/7929/7570.
15. **Court of Protection**

15.1 The Court of Protection deals with all issues related to the Mental Capacity Act. Application can be made to the Court to appoint a deputy for someone who lacks mental capacity.

15.2 The Court will also:

- make decisions on serious cases about healthcare or treatment
- make declarations about whether or not a person has capacity to make a particular decision
- make decisions about the property and financial affairs of a person who lacks capacity
- make decisions in relation to lasting powers of attorney
- make serious welfare decisions previously considered under the inherent jurisdiction of the high court – this would cover situations where there was a dispute about the best interests of a vulnerable adult and there were concerns about abuse.

16. **Best Interests**

16.1 The concept of acting in an individual’s best interests is a critical one under the MCA. It applies to any act done, or decision made, in relation to any care or treatment, on behalf of someone where there is a reasonable belief that the person lacks capacity.

16.2 Any decision maker, whether family member, health or social care professional, must be able to demonstrate that they have acted in the individual’s best interests.

16.3 The decision maker has to work out what is in the service user's best interests by encouraging involvement from the individual where appropriate, by consulting people with knowledge of the person and their past wishes, beliefs, values and culture, by avoiding generalisations based on age, appearance or behaviour. There is a statutory checklist covering this in s4 of the legislation.

16.4 The decision maker is the person who requires or needs the decision to be made and should be as close to the actual carrying out of the decision as possible. A nurse may need a decision about day to day nursing care intervention, a doctor may require a decision about treatment, and a care manager may require a decision about carers at home, or a placement. Each decision maker is personally and professionally responsible for clarifying the individual's best interests only in relation to the Decision Maker's particular professional area. It should always be made very clear exactly what the decision is that needs to be taken.

16.5 Families are likely to be the Decision Makers for individuals where they are providing most of the day to day care, and where the decision relates to the nature of that care.
16.6 Best interests is not just about working out what the individual would have wanted but exploring the pros and cons of a specific objective decision for that individual.

16.7 It would be appropriate to hold a specially arranged best interests meeting in situations where serious decisions have to be made for people who lack capacity or where decisions are finely balanced, or the subject of dispute or disagreement. The majority of decisions required to support day to day care decisions (e.g. what to wear or what to eat) will not require a formal consideration of best interests. A formal Mental Capacity and Best Interests Assessment form should be used as the basis for recording the discussion and the outcome of the meeting.

16.8 An IMCA will need to be involved for certain serious decisions where there is no person to support the individual other than paid professional staff.

16.9 In the event that there is disagreement about an individual’s best interests then advocacy, mediation, second opinion, or the complaints procedure should be used before application is made to the Court of Protection.

17. Practice Implications and Safeguarding

17.1 Care workers and care managers should have a clear view as to whether an individual has capacity or not to take a particular decision.

17.2 For everyday care tasks e.g. washing, dressing, meals the assessment of capacity is likely to be at a more informal level. Care records should give an indication of client’s preferences and choices. See MCA Section 5.

17.3 For more serious matters where professionals are proposing major changes a more formal assessment of capacity will be necessary. Such matters include living arrangements, family contact, financial affairs or making decisions around adult protection and safety. The diagnostic and functional test of capacity should be undertaken and full use made of Independent Mental Capacity Advocates. Care should be taken to ensure that the statutory checklist applying to best interests decision making is followed.

18. Criminal Offences of Ill-treatment or Wilful Neglect

18.1 The Act refers to two criminal offences of ill-treatment or willful neglect of a person who lacks capacity to make relevant decisions. A person convicted of such an offence can be fined or imprisoned for a term of up to five years.

18.2 These offences apply to a person who:
   - Has the care of a person who lacks capacity
   - Is the donee of a lasting power of attorney or an enduring power of attorney
• Is a deputy appointed for the person by the Court.

19. Training

19.1 The Bromley Safeguarding Adults Board has a training strategy to support the implementation of the Act in Bromley providing awareness training for staff of local statutory partners and more detailed training for decision-makers. It is linked with the safeguarding training programme in order to ensure that health and social care staff of the partner agencies and independent sector providers have the opportunity to develop a good understanding of the core principles of the Mental Capacity Act and how it underpins good practice before undertaking the higher levels of safeguarding adults training.

20. Further Information

20.1 The Code of Practice is available on the Department of Health website and at:

MCA Code of Practice

Appendix 1

To be inserted when finalised

Reference material
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1.2 The Act promotes fair treatment for people who may be affected and has established a system for settling disputes and disagreements through the Court of Protection. It enables people to plan ahead through Lasting Powers of Attorney for a time when their mental capacity may be compromised by appointing others to deal with personal welfare issues and their property and financial affairs. The Court of Protection can also appoint deputies to manage decision making for those lacking capacity who have not authorised another person to assist them in advance. The Court of Protection has jurisdiction relating to the whole Act, and is supported by the Office of the Public Guardian.

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3. **Unwise decisions** – just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision

4. **Best interests** – any act or decision taken about care or treatment under the Act for or on behalf of a person who lacks capacity must be made in their best interests, and

5. **Least restrictive option** – any action or decision made for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms whilst still meeting their best interests.

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   - A property and financial affairs LPA

12.3 A person must have capacity when the LPA is set up. An LPA must be registered with the Office of the Public Guardian before it can be used. A property and affairs LPA can be used at any time after it is registered, unless the donor (the person making the LPA) has specified that it must not be used while they still have the capacity to make decisions about
their finances. A personal welfare attorney has no power to consent to or refuse treatment, at any time or make decisions about any welfare matter when the donor has the capacity to make the decision for himself/herself.

12.4 The finances and property of adults who lack mental capacity can be protected by the use of an LPA. Adults should be encouraged to plan ahead for a time when they may become mentally incapacitated through the nomination of an “attorney” who can manage their financial affairs and/or their health and personal welfare.

13. **Enduring Power of Attorney**

13.1 Enduring Powers of Attorney created and registered with the Court of Protection before the implementation of the MCA are still valid and the attorney can carry on acting for a donor who does not have capacity to make decisions about his/her finances and property. It is no longer possible to create a new EPA. If an EPA has not been registered because the donor is still able to make decisions about their finances, the donor can:

- Destroy the EPA and make a new property and affairs LPA, or
- Keep the EPA for finance decisions, and
- Make a separate LPA for health and welfare decisions, if they wish.

Refer to the MCA Code of Practice for more detailed guidance.

14. **Appointee and Deputyship Service**

14.1 The Council has an Appointee and Deputyship Service which will manage the finances of people who lack mental capacity to deal with their own finances and have no appropriate family member, trusted friend, neighbour or solicitor who is willing to undertake this task. The London Borough of Bromley will only act if there is no alternative to safeguard the financial interests of the service user.

14.2 The Appointee service relates to the management of finances of service users who are in receipt of welfare benefits and state pension only. Where LBB acts as the Appointee, the service will receive benefits, pay bills, repay debts and manage the day to day finances of the service user. There is no charge to service users for this service.

14.3 Where the adult who lacks mental capacity has assets in excess of £16,000, and no-one else willing to manage their finances, LBB will apply to the Court of Protection to be appointed as a Deputy. The Court of Protection and the Deputy levies an annual charge against the service user’s estate for administering assets.

14.4 Contact the Appointee and Deputyship Service for a Referral Pack:

Tel: 020 8461 7485/7929/7570.
15. **Court of Protection**

15.1 The Court of Protection deals with all issues related to the Mental Capacity Act. Application can be made to the Court to appoint a deputy for someone who lacks mental capacity.

15.2 The Court will also:

- make decisions on serious cases about healthcare or treatment
- make declarations about whether or not a person has capacity to make a particular decision
- make decisions about the property and financial affairs of a person who lacks capacity
- make decisions in relation to lasting powers of attorney
- make serious welfare decisions previously considered under the inherent jurisdiction of the high court – this would cover situations where there was a dispute about the best interests of a vulnerable adult and there were concerns about abuse.

16. **Best Interests**

16.1 The concept of acting in an individual’s best interests is a critical one under the MCA. It applies to any act done, or decision made, in relation to any care or treatment, on behalf of someone where there is a reasonable belief that the person lacks capacity.

16.2 Any decision maker, whether family member, health or social care professional, must be able to demonstrate that they have acted in the individual's best interests.

16.3 The decision maker has to work out what is in the service user's best interests by encouraging involvement from the individual where appropriate, by consulting people with knowledge of the person and their past wishes, beliefs, values and culture, by avoiding generalisations based on age, appearance or behaviour. There is a statutory checklist covering this in s4 of the legislation.

16.4 The decision maker is the person who requires or needs the decision to be made and should be as close to the actual carrying out of the decision as possible. A nurse may need a decision about day to day nursing care intervention, a doctor may require a decision about treatment, and a care manager may require a decision about carers at home, or a placement. Each decision maker is personally and professionally responsible for clarifying the individual's best interests only in relation to the Decision Maker's particular professional area. It should always be made very clear exactly what the decision is that needs to be taken.

16.5 Families are likely to be the Decision Makers for individuals where they are providing most of the day to day care, and where the decision relates to the nature of that care.
16.6 Best interests is not just about working out what the individual would have wanted but exploring the pros and cons of a specific objective decision for that individual.

16.7 It would be appropriate to hold a specially arranged best interests meeting in situations where serious decisions have to be made for people who lack capacity or where decisions are finely balanced, or the subject of dispute or disagreement. The majority of decisions required to support day to day care decisions (e.g. what to wear or what to eat) will not require a formal consideration of best interests. A formal Mental Capacity and Best Interests Assessment form should be used as the basis for recording the discussion and the outcome of the meeting.

16.8 An IMCA will need to be involved for certain serious decisions where there is no person to support the individual other than paid professional staff.

16.9 In the event that there is disagreement about an individual’s best interests then advocacy, mediation, second opinion, or the complaints procedure should be used before application is made to the Court of Protection.

17. Practice Implications and Safeguarding

17.1 Care workers and care managers should have a clear view as to whether an individual has capacity or not to take a particular decision.

17.2 For everyday care tasks e.g. washing, dressing, meals the assessment of capacity is likely to be at a more informal level. Care records should give an indication of client’s preferences and choices. See MCA Section 5.

17.3 For more serious matters where professionals are proposing major changes a more formal assessment of capacity will be necessary. Such matters include living arrangements, family contact, financial affairs or making decisions around adult protection and safety. The diagnostic and functional test of capacity should be undertaken and full use made of Independent Mental Capacity Advocates. Care should be taken to ensure that the statutory checklist applying to best interests decision making is followed.

18. Criminal Offences of Ill-treatment or Wilful Neglect

18.1 The Act refers to two criminal offences of ill-treatment or willful neglect of a person who lacks capacity to make relevant decisions. A person convicted of such an offence can be fined or imprisoned for a term of up to five years.

18.2 These offences apply to a person who:

- Has the care of a person who lacks capacity
- Is the donee of a lasting power of attorney or an enduring power of attorney
19. Training

19.1 The Bromley Safeguarding Adults Board has a training strategy to support the implementation of the Act in Bromley providing awareness training for staff of local statutory partners and more detailed training for decision-makers. It is linked with the safeguarding training programme in order to ensure that health and social care staff of the partner agencies and independent sector providers have the opportunity to develop a good understanding of the core principles of the Mental Capacity Act and how it underpins good practice before undertaking the higher levels of safeguarding adults training.

20. Further Information

20.1 The Code of Practice is available on the Department of Health website and at:

MCA Code of Practice

Appendix 1

To be inserted when finalised

Reference material
Mental Capacity Act

- Mental Capacity Act 2005
- MCA Code of Practice
- Department of Health website [www.dh.gov.uk](http://www.dh.gov.uk) use search engine
- Making decisions: series of 5 titles
  - OPG601 Making decisions. About your health, welfare or finance. Who decides when you can’t?
  - OPG602 Making decisions. A guide for family, friends and other unpaid carers
  - OPG603 Making decisions. A guide for people who work in health and social care
  - OPG604 Making decisions. A guide for advice workers
  - OPG605 The MCA; helping and supporting people who are unable to make some decisions for themselves Easy Read
  - OPG606 Making decisions. The Independent Mental Capacity Advocate service

- CQC The MCA 2005 Guidance for providers
of human trafficking; under the NRM, this is a matter for UKHTC or the UK Border Agency. (For more information on the NRM and referral forms see SOCA’s website at http://www.soca.gov.uk/about-soca/about-the-ukhtc/national-referral-mechanism )

Anyone considered under the NRM to be a possible victim of human trafficking is entitled to support – provided centrally, not locally - for a minimum recovery and reflection period of 45 days, during which any action to remove them from the UK is halted. This is where The Salvation Army comes in; it has been engaged by the Government as the central contractor to oversee and co-ordinate the provision of care to adult victims of trafficking during, and in the run up to, this period. This includes support from the start of the referral process where there is an immediate need. Such care is provided either by The Salvation Army or by its partner agencies.

6. What does this mean in terms of help for local authorities?

As a local authority, you are able to refer possible adult victims (with their consent) direct to the National Referral Mechanism. If the possible adult victim is in immediate need of support, and consents to a referral being made, you can also contact The Salvation Army, on its 24 hour helpline (0300 3038151). The Salvation Army will then:

- Carry out an initial needs and risk assessment by telephone or, where this is not possible, face to face. If the possible victim is eligible for support, this can be provided by way of accommodation-based or outreach support. Outreach is appropriate where the victim already has suitable accommodation or is eligible for accommodation from another source.
- Where necessary, arrange for any urgent medical needs to be met and for the possible victim to be transported to a place of safety.
- On entry to the service each possible victim will be allocated a Support Worker and undergo a second, more comprehensive, risk and needs assessment, the outcome of which will inform a personalised Support Plan. The Support Worker will, for the duration of the recovery and reflection period, assist the possible victim in meeting their personal goals. These might include:
  - Access to interpretation and translation services
  - Help to access medical treatment, counselling, and legal advice
  - Support to engage with criminal proceedings against traffickers or to claim compensation
  - Support to move on effectively from the service. This may involve practical support to return home, if they choose, or to secure housing, state benefits, employment, education and training.

See our website at http://www.salvationarmy.org.uk/uki/Trafficking for more information on the help that The Salvation Army can provide.

If you are in any doubt whether to refer someone to the National Referral Mechanism or The Salvation Army, you can go to UKHTC’s tactical advisors for advice.

7. Is there any training available to local authorities?

We are producing an e-learning package explaining how to identify victims and make referrals under the National Referral Mechanism. This should be available via our website shortly. It is not part of The Salvation Army’s responsibilities to provide
training but some local authorities have made use of specialist training available from Stop the Traffik (see http://www.stopthetraffik.org/resources/training.aspx ). This includes training on how to identify human trafficking.

8. Useful numbers

UKHTC tactical advisors 0844 778 2406 (see sections 4 and 6 above)
The Salvation Army helpline 0300 3038151 (see section 6 above)
Metropolitan Police phoneline 0800 783 2589 (to give information in confidence)
The Salvation Army is a Christian Church and Registered Charity.
The Salvation Army
UK Territory with the Republic of Ireland
101 Newington Causeway
London SE1 6BN
Telephone: 020 7367 4500
Email: thq@salvationarmy.org.uk
Website: www.salvationarmy.org.uk
22 November 2013

Police say the case in which three women are believed to have been imprisoned in a London home for more than 30 years is "unique" and is not like previous human trafficking and slavery cases encountered in London.

But it follows a number of disturbing cases of slavery, captivity and human trafficking in Britain in recent years.

Official figures on the scale of the problem come from the UK Human Trafficking Centre, part of the National Crime Agency.

In 2012, it identified 2,255 potential victims of human trafficking - an increase of 178 (9%) on 2011, according to its report.

Of these potential victims, 778 were either found to have been trafficked or were awaiting a conclusive decision on their status. Of the 778 potential victims, 402 people - or 52% - were found to have been trafficked.

The top five nationalities of those identified were Romanian, Polish, Nigerian, Vietnamese and Hungarian.

Some 71% of the potential victims were adults, while 24% were children. The age of 99 potential victims was unknown.

Five people were found guilty of human trafficking charges after a woman was snatched from Slovakia The two most prevalent types of exploitation reported were sexual exploitation, which accounted for 35% of the potential victims, followed by labour exploitation (23%).

Of the potential child victims, 28% reported being sexually exploited, and 24% reported criminal exploitation.

'Like Dickens'

In October, Azam Khan was jailed for 12 years for assaulting, raping and holding a woman prisoner after she was snatched from Slovakia and trafficked to Lancashire.

Khan, 34, of Burnley, was said to have "bought" the vulnerable 20-year-old and "married" her at a local mosque to try to halt his deportation from the UK to Pakistan.

Five other people - Imrich Bodor, Abdul Sabool Shinwary, Kristina Makunova and Petra Dzudzova - helped in the trafficking of the woman, who was unable to speak English or ask for help.

Prosecutor Joe Boyd at the trial in Preston Crown Court described the victim's story as like "something from a 19th Century novel by Dickens".

'Unpleasant and manipulative'

Also in October, a couple who trafficked a 10-year-old girl to the UK, then repeatedly raped and kept her as a servant for nearly a decade, were jailed.
Ilyas and Tallat Ashar brought the girl, who is deaf, from Pakistan and kept her at their home in Eccles, Salford, where she slept in the cellar.

Ilyas Ashar, 84, who was found guilty of 13 counts of rape, was jailed for 13 years at Manchester Crown Court.

Tallat Ashar, 68, convicted of benefit fraud and trafficking, got five years.

Judge Peter Lakin, sentencing, said the couple were "deeply unpleasant, highly manipulative and dishonest people".

'Prisoner'

In 2010, a BBC Radio 4 File on 4 programme interviewed three victims of domestic servitude.

One of them, Patience Asuquo, from Nigeria, said she was brought to London to work in the home of a solicitor, Kenny Gbaja.

She said she was promised £50 a week as a nanny - but was instead subjected to verbal and physical abuse over a period of three years, and was not allowed to leave the house without permission.

"I was treated like a slave, like a prisoner," she said.

Following an enquiry, Gbaja was charged with common assault and given a 12-month conditional discharge.

'Appalling greed'

Saeeda Khan ordered Mwanahamisi Mruke around by ringing a bell. Section 71 of the Coroners and Justice Act 2009, which came into force in 2010, created a new offence of holding another person in slavery or servitude or requiring them to perform forced or compulsory labour.

And in 2004, Parliament created a specific offence of trafficking someone into the UK for forced labour.

Former hospital director Saeeda Khan was believed to be the first person convicted under that law when a jury found her guilty of trafficking a Tanzanian woman into the country to work as her domestic slave.

Khan, 68, was ordered to pay £25,000 to Mwanahamisi Mruke, 47 - who was flown from Tanzania in 2006 and made to work 18-hour days for Khan, 68, at her home in Harrow, north-west London - in 2011.

The judge at Southwark Crown Court, who also gave her a suspended nine-month prison term, said she was guilty of "the most appalling greed".

Operation Netwing

Many forced labour investigations have focused on the trafficking of women in to the sex trade in the UK.
But in September 2011, police acting under Operation Netwing raided the Greenacres caravan site in Leighton Buzzard, Bedfordshire, and freed 24 people who were being held against their will in filthy and cramped conditions.

Some of the men had been held for up to 15 years, and others for just a few weeks. Some of them were from Poland, Latvia and Lithuania; others were British citizens.

The men were deemed “vulnerable” and had been recruited at soup kitchens and off the street with the promise of paid work, food and lodgings.

In May, Tommy Connors Senior, 53, was jailed for eight years and his son Patrick, 21, for five years at Luton Crown Court.

Men were found in squalid conditions at the Bedfordshire site. The pair had been convicted last July of servitude, compulsory labour and assault charges after a trial at the same court.

Five members of the same traveller family were all jailed in December last year.

William Connors, 52, wife Mary, 48, their sons, John, 29, and James, 20, and son-in-law Miles Connors, 24, were convicted of conspiracy to require a person to perform forced or compulsory labour between April 2010 and March 2011 following a three-month trial at Bristol Crown Court.

‘Immediate measures’

Hungarian nationals Joszef Budai, 24, and Andrea Novak, 20, were jailed for eight years after being found guilty of trafficking young women into Britain and forcing them to work as sex slaves.

They were sentenced at Croydon Crown Court in March 2010, after being convicted of a string of trafficking and prostitution offences.

Judge Simon Pratt described the case as “the closest to human slavery as you could possibly get”.

While figures detailing the total number of potential victims of human trafficking in 2013 are not yet available, a report was published this month based on National Referral Mechanism (NRM) statistics - a process used to identify trafficked individuals and provide them with protection and support.

It found that from April to June this year, 383 potential victims of trafficking - comprising individuals from 52 countries - were referred to the NRM.

As of 1 October, 114 potential victims were found to have been trafficked, while 58 people were awaiting a ‘reasonable grounds’ decision and 70 people were awaiting a conclusive decision on their status.

Frank Field MP, Chair of the Modern Slavery Bill Evidence Review and Vice Chair of the Human Trafficking Foundation, called for “immediate measures” including a new Modern Slavery Bill.

"All of the evidence to date highlights the need for urgent action," he said. "Modern slavery is alive and well in Britain, and needs to be stopped."