

DOCUMENT CONTROL	
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This policy applies to all staff employed by or seconded to Pennine Care NHS Foundation Trust who work directly or indirectly with patients liable to be detained under a relevant section of the Mental Health Act (MHA) 1983.	
Purpose:	
This policy aims to assist in identification of a detained patients Nearest Relative (NR), ensure the rights of a NR are communicated to the patient and NR, set clear processes for key issues relating to NRs, confirm the legal position of information sharing with NR's and to promote awareness, compliance and observation of the Guiding Principles of the Mental Health Act.	
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Other Trust documentation to which this policy relates (and when appropriate should be read in conjunction with):	
MHL001	Patients Absent without Leave Policy
MHL002	Section 17 Leave of Absence Policy
CL026	Policy for Seclusion, Time Out & other Restrictions Policy
CL032	Community Treatment Order Policy
MHL003	S132, S132A, and S133 MHA (provision of Information) Policy
CL049	Mental Health Act 1983, S117 Policy

CL058	Treatment of Patients subject to the Mental Health Act 1983 Part 4 and Part 4A
CL061	Admission, Entry & Exit Policy for Mental Health Wards
CL062	Mobile Phone Policy for Service Users and Visitors
CL081	Electro Convulsive Therapy Policy
CL087	Victims Policy
CO004	Confidentiality Policy
CO010	Incident Reporting, Management and Investigation Policy
CO023	Inclusive Involvement and Participation of Service Users and Carers Policy
Policy Associated Documents:	
TAD_MHL005_01	Order for Discharge Form
TAD_MHL005_02	Information for Nursing Staff
TAD_MHL005_03	Delegation by Nearest Relative
TAD_MHL005_04	Nearest Relative Powers of discharge
Other external documentation/resources to which this guideline relates:	
	The Code of Practice 2015 (particularly Chapter 4: Information for patients, nearest relatives, carers and others and Chapter 5: The nearest relative - should be referred to for guidance.
CQC Regulations	
This policy supports the following CQC regulations:	

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i. Guiding Principles

It is essential that all those undertaking the functions under the Mental Health Act 1983 (MHA) understand the five sets of overarching principles which should always be considered when making decisions in relation to care, support or treatment provided under the Act.

The five overarching principles are:

- **Least restrictive option and maximising independence**
Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.
- **Empowerment and involvement**
Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.
- **Respect and dignity**
Patients, their families and carers should be treated with respect and dignity and listened to by professionals.
- **Purpose and effectiveness**
Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.
- **Efficiency and equity**
Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

Staff must apply all the principles to all decisions. All decisions must be lawful and informed by good professional practice. Lawfulness necessarily includes compliance with the Human Rights Act 1998 (HRA) and Equality Act 2010. All five sets of principles are of equal importance, and should inform any decision made under the Act. The weight given to each principle in reaching a particular decision will need to be balanced in different ways according to the circumstances and nature of each particular decision.

Any decision to depart from the directions of the policy and the Code of Practice must be justified and documented accordingly in the patient's case notes. Staff should be aware that there is a statutory duty for these reasons to be cogent and appropriate in individual circumstances.

1. INTRODUCTION

The Trust is committed to ensuring the promotion of the therapeutic relationship between patients and carers and observing the safeguards and duties laid out within the Mental Health Act 1983 regarding the role of the Nearest Relative (NR).

The Trust is committed to improving the patients experience and communicating with patients and their NR's to promote and protect their rights.

To ensure the above this policy aims to:

- Assist in identification of a detained patients NR
- Ensure the rights of a NR are communicated to the patient and their NR
- Set clear processes for key issues relating to NRs including the discharge of their relative, displacement of a relative and delegation of the NR role
- Confirm the legal position of information sharing with NRs and ensure all is done to promote communication between Pennine Care staff and the NR
- Promote awareness, compliance and observation of the Guiding Principles of the Mental Health Act and of particular relevance to this policy the empowerment and involvement principle.

2. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

The **Medical Director** is responsible for ensuring the requirements of this policy are adhered to via the Mental Health Law Scrutiny Group.

Mental Health Law Forums are responsible for escalating issues to the Mental Health Law Scrutiny Group for investigation and monitoring the use of this policy in the Divisions.

Lead Managers, Team Supervisors, Health and Social Care Staff are responsible for the implementation of the policy and in particular, for ensuring staff observe the legal requirements relating to the NR role and the required processes as laid out within this policy.

All **health and social care staff** are responsible for ensuring that they are familiar with their individual responsibilities within this policy. Staff have a responsibility to report any issues relating to the implementation of this policy to the Mental Health Office, via their line management and the incident reporting process, as appropriate.

The observation of the requirements of this policy in the case of inpatients is the responsibility of the Nurse in charge of the ward the patient is currently admitted to and the MHL Administrator.

The **MHL Administrators** are responsible for ensuring the NR letters are sent and copies stored on patients files and MHA files.

The **MHL Manager** has a responsibility for ensuring the NR policy is updated, monitored and compliant with legislation. The MHL Manager will also ensure that the provision of the role of the NR is covered within the Trust training program on Mental Health Law and that

any learning requirements identified through the monitoring of this policy are included in future training programs.

3. DEFINITIONS

• Nearest Relative

The nearest relative (NR) is identified through a hierarchical list contained within section 26 of the MHA (and in relation to children and young people, sections 27 and 28) of the Act, who has responsibilities and certain rights, including the right to certain information (subject to the patient's consent) and to discharge in certain situations. The identity of the nearest relative may change with the passage of time – e.g. if the patient enters into a marriage or civil partnership. The nearest relative may be the patient's carer and it is important that they are recognised, particularly as they may have the most relevant information to share with professionals with regard to the patient's care and interests. If the nearest relative is not the carer, professionals should also involve the carer.

Notes:

- The NR is the person who is informed (unless the patient objects) or consulted with about the patient becoming subject to certain provisions of the Act, which includes the right to order discharge of the patient and to object to some provisions of the Act.
- The patient, any relative, a person who the patient usually resides with or an approved mental health professional may apply to a County Court for displacement of the NR.
- The term nearest relative (NR) should not be confused by the term 'next of kin'.

• Responsible Clinician

The approved clinician with overall responsibility for a patient's case. Certain decisions (such as renewing a patient's detention or placing a patient on a Community Treatment Order (CTO)) can only be taken by the responsible clinician.

• Approved Mental Health Professional (AMHP)

A social worker or other professional approved by a local social services authority (LSSA) to carry out a variety of functions under the Act.

• Independent Mental Health Advocates (IMHAs)

IMHAs are a statutory right and safeguard for people detained under the legislation. The objective of an IMHA is to provide support and represent the personal views of the patient. IMHAs may be involved in providing patients with information on their rights, medication and any restrictions or conditions to which they are subject. It is important to take whatever steps are practicable to ensure that patients understand that help is available to them from IMHA services and how they can obtain that help both verbally and in writing. It is also important that mental health professionals are aware and keep themselves up to date with this statutory right and safeguard through training, promoting awareness and communication so that they are in a better position to relay

this statutory information to the patient on a regular basis. IMHA input will be sought in the development and delivery of this training.

- **Hospital Managers**

The organisation (or individual) responsible for the operation of the Act in a particular hospital (e.g. an NHS Trust, an NHS Foundation Trust or the owners of an independent hospital). Hospital managers have various functions under the Act, which include the power to discharge a patient. In practice, most of the hospital managers' decisions are taken on their behalf by individuals (or groups of individuals) authorised by the hospital managers to do so. This can include clinical staff. Hospital managers' decisions about discharge are normally delegated to a 'managers' panel' of three or more people.

- **Mental Health Tribunal**

A judicial body which has the power to discharge patients from detention, supervised community treatment, guardianship and conditional discharge. First Tier Tribunal established under the Tribunals, Courts and Enforcement Act 2007.

- **Community Patient**

Patient who is subject to Section 17A of the MHA – Community Treatment Order.

- **Restricted Patient**

A part 3 patient who, following criminal proceedings, is made subject to a restriction order under section 41 of the Act, a limitation direction under section 45A or a restriction direction under section 49. The order or direction will be imposed on an offender where it appears that it is necessary to protect the public from serious harm. One of the effects of the restrictions imposed by these sections is that restricted patients cannot be given leave of absence or be transferred to another hospital without the consent of the Secretary of State for Justice, and only the Tribunal can discharge them without the Secretary of State's agreement. See also Unrestricted part 3 patient.

- **Next of Kin**

The next of kin is usually a relative or close friend chosen by someone soon after they are admitted to any sort of hospital. Within the MHA there are no legal powers for a next of kin. This can be someone other than the NR identified.

4. IDENTIFICATION OF NEAREST RELATIVE (NR)

The identification of the NR will often be the duty of the AMHP and Local Authorities will have separate guidance and policies on this process. In certain circumstances it will be necessary for staff working with patients to understand who the NR is and how particular changes in circumstances could mean a change of NR (at which point the MHL Office would need to be informed).

Section 26 of the Mental Health Act sets out the list of who should be identified as the NR, but this is often a complex and difficult task depending on the patient's social circumstances. Where the patient is a child, different criteria apply if they are in care, has a

guardian or is subject to a residence order. There can be only one NR and the list is defined in Section 26 is as follows:

A relative on this list who the patient 'ordinarily resides' with, or is caring for the patient would move to the top of the list in most cases

- (a) husband or wife or civil partner;
- (b) son or daughter;
- (c) father or mother;
- (d) brother or sister;
- (e) grandparent;
- (f) grandchild;
- (g) uncle or aunt;
- (h) nephew or niece.

The following points relate to determining whether someone is a 'relative':

- Any relationship of the half-blood is treated as a relationship of the whole blood (s26(2)) e.g. half-siblings are treated as if they were full siblings.
 - *One person is said to be of the whole blood to another when they are both descended from the same pair of ancestors, e.g. two brothers who have the same parents. Persons are said to be of the half-blood to one another when they are descended from one common ancestor only e.g. two brothers who have the same father but different mothers. (Osborn's Concise Law Dictionary 8ed)*
- An illegitimate person is treated as if he were the legitimate child of
 - his mother (s26(2)(a)).
 - his father only if he has parental responsibility within the meaning of s3 Children Act 1989 (s26(2)(b)).
- A cohabitee who lives with the patient 'as' husband/wife/civil partner, and has done so for six months or more, is treated as being the husband/wife/civil partner (s26(6)).
 - This person could only be NR if there is no marriage/civil partnership, or the husband etc. is disqualified (see below).
- A person who is not a relative at all (i.e. not on the list above) can become a relative if the patient ordinarily resides with him, and has done so for five years or more (s26(7)) but:
 - This person is added to the bottom of the hierarchy (below 'nephew or niece').
 - This person could only be NR if there is no marriage/civil partnership, or the husband etc. is disqualified (see below).
- Step-children or step-parents – and cousins – are not on the list of relatives (though could become relatives via the 'five year' rule).

- An adopted child (even when an adult) is treated as the child of an adoptive parent and not of a natural parent which has been replaced (s46(2) [Adoption and Children Act 2002](#)).

Which of the relatives is nearest relative?

- In general, for an adult patient, the nearest relative can be found in the category of relative appearing first in the list above (s26(1), s26(3)), for instance 'husband or wife or civil partner'.
- Where more than one relative survives within a category above then (by s26(3):
 - relatives of the whole blood are preferred to those of the same description of the half-blood;
 - the elder/eldest is preferred; and
 - the sex of the relative is irrelevant.
- Where the patient ordinarily resides with or is cared for by one or more of his relatives (or this was the case before admission), then those relatives are preferred over any others (by s26(4)).
 - This priority rule applies even to 'five-year rule' relatives.
 - If more than one such caring/resident relative exists, the nearest relative is chosen according to the whole-blood/eldest priority rule above.

Who is disqualified from being a 'relative'?

- A dead person (s26(3)).
- Where *the patient is ordinarily resident in the UK, Channel Islands or Isle of Man*, and the would-be nearest relative is not so resident, then that person is treated as if he were dead (s26(5)(a)).
- Where would-be NR is the husband or wife or civil partner, but there has been a permanent separation (either by agreement or court order) or on-going desertion, that person is treated as if he were dead (s26(5)(b)).
- Any person under 18 years of age is treated as if he were dead (s26(5)(c)).
 - Except for a husband, wife or civil partner, or father or mother of the patient.

The Act includes additional provisions to identify the nearest relative of a child or young person. For example:

- If the child or young person is subject to a care order (or interim care order) under the Children Act 1989, the relevant local authority will be the nearest relative, save for where the young person is married or in a civil partnership, in which case their spouse or civil partner will be the nearest relative (section 27 of the Act)
- Individuals who have been appointed as guardians (section 5 of the Children Act 1989) or special guardians (section 14A of the Children Act 1989) and those named in a child arrangements order as a person with whom the child or young person is to live

(formerly known as a residence order) (section 8 of the Children Act 1989) will be the child or young person's nearest relative (section 28 of the Act), and

- Unmarried fathers will only be treated as the child or young person's 'father' for the purpose of section 26 of the Act if they have obtained 'parental responsibility'. This may be acquired through a number of routes such as a parental responsibility agreement, subsequent marriage to the mother of the child or young person or by obtaining a child arrangements order as a person with whom the child or young person is to live (formerly known as a residence order). Unmarried fathers can acquire parental responsibility for their children born after 01.12.2003 by registering themselves as the father on their child's birth certificate.

It is important to remember that the nearest relative for the purposes of the Act may not be the same person as the patient's 'next-of-kin'. The identity of the nearest relative may change with the passage of time – e.g. if the patient enters into a marriage or civil partnership. The nearest relative may be the patient's carer and it is important that they are recognised, particularly as they may have the most relevant information to share with professionals with regard to the patient's care and interests. If the nearest relative is not the carer, professionals should also involve the carer.

Patients remanded to hospital under sections 35 and 36 of the Act, subject to interim hospital orders under section 38 or subject to special restrictions under part 3 of the Act (restricted patients – see chapter 22) do not have nearest relatives (as defined by the Act).

Where there is no nearest relative: Where an AMHP discovers, when assessing a patient for possible detention or guardianship under the Act (or at any other time), that the patient appears to have no nearest relative, the AMHP should advise the patient of their right to apply to the county court for the appointment of a person to act as their nearest relative. If the patient lacks capacity to decide to apply themselves, the AMHP should apply to the county court.

Further information on identification of the NR in individual situations should be sought from the MHL Office. This will particularly be relevant in the case of Emergency applications i.e. Section 5(2) where the requirement to inform the Nearest Relative still exists. If NR details are known nursing staff can communicate this information to the NR.

5. RIGHTS OF A NEAREST RELATIVE

The nearest relative can require the local authority (verbally or in writing), in which the 'patient' is living, to arrange for an approved mental health professional (AMHP) to 'consider the patient's case' including whether there is a need for compulsory admission to hospital. The local authority must inform the nearest relative in writing, of the reasons if no application for admission is made (section 13(4), Code 14.36 and 14.102).

The nearest relative can make an application (section 11(1)), provided there are valid medical recommendation(s), for the person's compulsory admission to hospital either for assessment (section 2 – form A1) or for treatment (section 3 – form A5) or in an emergency (section 4 – form A9). The nearest relative, if the applicant, must have seen the 'patient' within 14 days (24 hours if section 4) before making an application (section

11(5)). The Code of Practice (paragraph 14.30) notes that AMHPs are ‘usually a more appropriate applicant’.

‘If the nearest relative is the applicant, any AMHP, and other professionals involved in the assessment of the patient, should give advice and assistance. They should not assist in a patient’s detention unless they believe it is justified and lawful’ (Code 17.11). If the nearest relative does make the application, e.g. where the AMHP disagrees with need or urgency for compulsory admission and the person is detained in hospital under section 2 or section 3, the hospital managers must request the relevant local authority to provide them with a social circumstances report (section 14).

The nearest relative may make an application (section 11(1)), provided there are two valid medical recommendations, for the person to be received into guardianship (section 7). The nearest relative would complete form G1. The nearest relative can be consulted, (section 11(4)(b)), whenever practicable, by an AMHP before a decision is made about a patient’s possible compulsory admission to hospital for assessment (section 2) or for treatment (section 3).

While there is no requirement for the nearest relative to be informed and consulted when a CTO is being considered, the Code 29.10 notes that ‘consultation at an early stage with the patient and those involved in the patient’s care will be important, including family and carers’.

The nearest relative can formally object ((section 11(4), Code 14.65) to the making of an application by an AMHP for admission for treatment (section 3) or guardianship (section 7). If the nearest relative took this step, compulsory admission to hospital or reception into guardianship could not proceed at that time. The mental health professionals would in turn give urgent consideration to seeking the ‘displacement’ of the nearest relative in an application to the County Court (section 29(3)(c)).

The nearest relative can order a patient’s discharge (section 23)

From detention (section 2 or section 3)

From a community treatment order (CTO) (section 17A) but only where the CTO followed detention under section 3. This would also discharge the suspended section 3 underpinning the CTO.

The nearest relative must give 72 hours’ notice in writing to the hospital.

The nearest relative’s order may be barred if within the 72 hours, the patient’s responsible clinician provides a written report (M2) that they consider that the patient, if so discharged, ‘would be likely to act in a manner dangerous to other persons or to himself’ (section 25; regulation 25(1) (a) and (b), Mental Health Regulations 2008, and Code 32.20 – 32.25). The barring report prevents the nearest relative from ordering discharge at any time in the six months following the date of the report (section 25(1)(b), section 25(1A)). If the patient were detained under section 2 the nearest relative cannot take the matter further. If the patient is detained under section 3 or on a CTO following section 3, then the nearest relative may, within 28 days of the barring report being issued, apply to the Mental Health Tribunal for the patient’s discharge instead (section 66(1)(g), section 66(2)(d)). For the situation when the matter is considered by the hospital managers’ panel, see Code 38.20.

The nearest relative can order a patient's discharge (section 23) from guardianship (section 7). There is no power for the responsible clinician to bar discharge.

Although they cannot order the discharge of a part 3 CTO patient, the nearest relative can apply to the Tribunal instead, in certain circumstances.

The nearest relative should be given 7 days' notice, if practicable, by the hospital before a patient is discharged from detention under sections 2 or 3 or from a CTO (section 133). This duty does not apply if the patient or the nearest relative has requested that this information should not be given.

The functions of the nearest relative can be delegated to another person (Reg. 24, Mental Health Regulations, 2008, Code 5.5).

Delegation must be in writing and could be an ordinary letter.

As delegation could be time limited or until further notice, it is important that this issue is clearly addressed. It must also be signed and dated. Authorisation may be transmitted electronically (provided the new person is willing to receive it in that format). Delegation is not completed until received (and accepted), by the new person. The nearest relative must give notice of the delegation to the patient; the managers of the hospital if the person is detained and/or subject to a community treatment order; the local social services authority (and the private guardian, if any) if the person is subject to guardianship.

Nearest relatives can apply to the First-tier Tribunal if they have been displaced by the County Court on the grounds of either an unreasonable objection to detention or guardianship (section 29(3)(c)) or exercising their power of discharge (section 23) from detention or a CTO (including where it is considered the nearest relative is likely to do so) 'without due regard to the welfare of the patient or the interests of the public' (section 29(3)(d)). Application can be made once in the first year following displacement and once in each subsequent year (section 29(6), section 66(1)(h), section 66(2)(g)). The acting nearest relative has a separate power to make an application.

The patient or the nearest relative can apply to the Mental Health Tribunal for the patient's discharge when the patient is subject to an unrestricted hospital order (section 37) in the period between 6 and 12 months after the making of the hospital order and in any subsequent period of one year.

The nearest relative can, in addition to the patient's own right, apply to the Mental Health Tribunal for discharge when the patient is subject to a guardianship order (section 37) within the first 12 months of the order and in any subsequent 12 month period (section 69(1)(b)(ii)).

6. INFORMING THE NR OF THEIR RIGHTS & OTHER INFORMATION

The information provided to the nearest relative should be given at the same time as it is given to the patient by the AMHP, or within a reasonable time afterwards. Hospital Managers also have a continuing duty to inform patient's NR's of their rights. However this is subject to the restrictions contained within the Data Protection Act and staff are asked to speak with the patient and explain that we will be sending their NR specific information

regarding their legal rights and ask if they object to this. The Section 132 Patient's Rights Monitoring Form should be used to record this discussion.

A patient's objection must be a valid and capable objection. If the Nurse providing the rights to the patient deems the patient to be incapable of making this decision they must observe the Mental Capacity Act¹ and determine whether it is in a patient's best interests for the information still to be shared with the patients NR. This is particularly important where the NR is a care giver and there exists a need to promote and protect the therapeutic relationship between patient and NR. If there are any concerns regarding this, the Nurse should discuss with the patients Responsible Clinician at the earliest opportunity and notify the MHL Office using the Section 132 Patient's Rights Monitoring Form. When making a decision in the patients best interests under the MCA account must be taken of the patient's previous attitude towards information sharing with their NR.

The Department of Health Patients' information leaflets² will then be sent to the NR by the MHL Office within a maximum of 7 days from receipt of the completed s132 Patient's Rights Monitoring Form authorising this.

Where practicable the patients NR should be informed of the patient's discharge from detention or CTO. This includes discharge from detention onto CTO and the Code of Practice requires where possible this is done at least 7 days prior to discharge. To facilitate this requirement the Responsible Clinician should notify the MHL Office as soon as possible if they are planning to discharge a patient within the next 7 days. If the NR is informed verbally, the Nurse in charge should make sure this is clearly documented in the patient's records. The MHL Office will ensure the NR is notified following the completion of a Section 23 Form or if the section lapses if this has been authorised on the completed s132 Patient's Rights Monitoring Form.

Where a patient's section is being renewed or transferred it is the responsibility of the MHL Office to check whether there are any recorded objections to informing the NR from the patient and then write to the NR with details of the renewal or transfer.

The option of the patient completing a statement of their wishes and feelings should be discussed with them when they have capacity to make decisions regarding the release of information to their NR. This should be recorded in their care plans and should be used to inform the release of information in the patients best interests when they do not have capacity and may be refusing the disclosure.

Where authority to provide information has been established care plans should be discussed and shared with the NR. This is the responsibility of the named nurse or Care Coordinator and evidence of this discussion and provision of information should be documented in the patient's notes.

Section 17 leave planning should allow for discussion with the NR and Responsible Clinicians should ensure any home leave is provided for allowing sufficient time for ward

¹ Section 2, 3 and 4 of the MCA particularly

² http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089275

staff to contact and agree with the NR if they are not available at the time of granting leave. A copy of the leave form should be provided to the NR if the patient doesn't object³.

Where a patient is absent without leave the patient's NR must be informed if the patient has not objected to information being shared, or where staff believe the NR may be at risk. Telephone contact should be made with the NR at the earliest opportunity following the AWOL being recorded. The NR must also be informed when the patient has or is returned.

If there are plans to transfer a patient to another hospital their NR must be informed as soon as possible to allow for their views to be considered as part of the transfer process. The MHL Office will write to a patient's NR when they receive a transferred patient to confirm the new contact details and this will be completed as soon as the patient's consent is received on the s132 Patient's Rights Monitoring Form.

7. DISCHARGE BY NEAREST RELATIVE⁴

Patients detained under Section 2, 3, and 17A can be discharged by their NR from their section. The NR must give the Trust 72 hours' notice of their intention to discharge and this must be in writing. There is no standard form for this purpose but a template has been developed that may be used and this can be found in TAD_MHL005_01 of this policy. Staff should assist any NR wishing to make an order for discharge and provide them with the template if requested. Discharge can also be requested by the NR on Section 7, this cannot be barred by anyone and the patient would no longer be subject to guardianship.

The NR may hand this form to any member of staff, send it by post to the hospital site or deliver it using the Trust's internal mail system. If handed to a member of staff who is not authorised to receive the notice of discharge on behalf of the Hospital Managers' i.e. unqualified staff or general Administration worker they should inform the NR and immediately take the request to the ward manager, senior nurse or MHL Office.

Any member of ward staff who has been notified by a NR that they intend to discharge must immediately notify the nurse in charge who will ensure that:

- A copy of the written notice is provided to the patient and the NR
- The receipt of the request for discharge must be completed on the form indicating time and date of receipt
- Explain to the NR and patient that the Responsible Clinician will need to review the patient and they will be informed when this review is due to take place.
- Immediately telephone the Responsible Clinician / covering Clinician and inform them of the notice of discharge and when the 72 hours will end allowing the RC to plan whether or not to bar the request for discharge or allow for the discharge to take place at the end of the 72 hour notice period.

³ Code of Practice (2015) Para 27.22

⁴ Section 23 and 25 of the MHA

- Telephone MHL Office and inform them of the notice of discharge and the planned discharge date or whether a barring order has been made. If out of hours leave a message on the answering machine.
- Make an entry in the ward diary for one days' time to chase the Responsible Clinician and also an entry for when the 72 hour period expires to make sure a decision has been made regarding allowing the discharge to take place or whether a barring order has been made and this has been communicated to the patient.
- Named nurse to be informed of the NR notice of discharge and to discuss this with patient.

A checklist has been devised for this purpose and should be completed in all cases by the nurse in charge or the MHL Office. See TAD_MHL005_01 if the discharge notice from the NR is presented in any other format i.e. solicitor's letter then the local form must still be used to evidence actions taken. It is important that swift action is taken as when the letter is receipted the Responsible Clinician has only 72 hours in which to review and make a decision. It may be necessary to contact the on call consultant and this should be discussed with the nurse in charge.

The Responsible Clinician must assess the patient and decide whether it will be necessary to complete a statutory 'barring report' stating that if discharged the patient would be likely to act in a manner dangerous⁵ to themselves or others (please refer to TAD_MHL005_04). Once this assessment is complete the Responsible Clinician must tell the nurse in charge of the ward and the MHL Office of their decision. Statutory Form M2 must be completed by the Responsible Clinician and given to the MHL Office immediately if the decision is to bar discharge.

If a barring report is issued then MHL Office will arrange for a Hospital Managers hearing to be arranged within 10 days of the date of the barring report. Any exceptions in adhering to this should be reported to the MHL Manager. It may be following review that the Responsible Clinician does not issue a barring notice, in these circumstances the patient would become informal following 72 hours from the date and time of receipt on the NR discharge letter.

Prior to the Responsible Clinician issuing a barring report, the Nearest Relative may withdraw their discharge notice. If this happens there will not be a requirement to complete Form M2 or the subsequent Hospital Managers hearing. For this reason it is essential that the Responsible Clinician and the nurse in charge must discuss the reasons for the request for discharge with the NR to establish whether there are any alternatives to a discharge order request from the NR. Any withdrawal should be in writing from the NR. Once the RC has furnished a barring report, it is too late for the nearest relative to withdraw their order for discharge.

⁵ This question focuses on the probability of dangerous acts, such as causing serious physical injury or lasting psychological harm, not merely on the patient's general need for safety and others' general need for protection.. Code of Practice (2015) 32.23

Dependent upon the circumstances of the individual discharge those involved in the patient's care may wish to consider requesting a displacement of the NR if they believe they have exercised their discharge power without due regard to the welfare of the patient or the interests of the public⁶ although where possible this action should be avoided and a resolution found to any disagreements between the NR and the clinical team. If a displacement is necessary the Responsible Clinician should contact the MHL Office for further discussion and advice.

It will be the responsibility of the MHL Office following receipt of the discharge notice / barring report to ensure the NR is kept informed. Outside office hours the verbal provision of information will be the responsibility of the nurse in charge. At the earliest opportunity the MHL Office will send a letter to the NR explaining the processes and confirming receipt of the discharge notice.

If the Hospital Managers uphold the section at the hearing then the NR will not be able to request discharge for six months from the date of the barring report. In the case of patients detained for treatment or community treatment order patients they will however be able to apply to the Tribunal. This will be communicated both verbally and in writing by the MHL Office. The NR of a patient detained under section 2 has no right to appeal to the tribunal.

8. DELEGATION OF NEAREST RELATIVE ROLE⁷

The role of the NR may be delegated to any other person except the patient, someone who does not live in the UK / under 18 years of age or has been displaced by the court previously.

Delegation must take place in writing and a form has been devised for this purpose (see TAD_MHL005_03. Delegation is not completed until received (and accepted), by the new person. The nearest relative must give notice of the delegation to the patient; the managers of the hospital if the person is detained and/or subject to a community treatment order; the local social services authority (and the private guardian, if any) if the person is subject to guardianship. This may be done electronically if required. Proof of a delegation is required and a copy should be available within the MHA file, medical notes and community notes. If proof of a delegation does not exist then this could invalidate the section.

Delegation can be revoked by the NR at any time and this must again be done in writing and can be submitted electronically.

All of the patient's records (hospital and community) and the local social services authority must be updated and provided with a copy of the NR delegation once received by the MHL Office.

It is the responsibility of the NR to inform the patient and the hospital of a delegation but the MHL Office will also write to the patient and the new NR to inform them of the change within 7 days of receipt.

⁶ Section 29(2)(d) of the MHA

⁷ Regulation 24 of the Mental Health Regulations 2008

A delegated NR cannot delegate the power to another person and their delegation must be revoked and a new delegation made.

9. DISPLACEMENT OF THE NEAREST RELATIVE

- The MHA allows displacement of a NR by a county court on the following grounds:
 - That the patient has no identifiable nearest relative within the meaning of this Act, or that it is not reasonably practicable to ascertain whether he has such a relative, or who that relative is;
 - The nearest relative is incapable of acting as such because of illness or mental disorder;
 - The nearest relative has objected unreasonably to an application for admission for treatment or a guardianship application;
 - The nearest relative has exercised the power to discharge a patient without due regard to the patient's health or wellbeing or the safety of the public;
 - The nearest relative is otherwise not a suitable person to act as such;
- An application to displace can be made by:
 - The patient(or if the patient lacks capacity, the patient's litigation friend e.g. advocate or carer)
 - Any relative of the patient
 - Anyone with whom the patient is residing (or was prior to admission)
 - An AMHP.
- AMHPs will need to consider making an application for displacement or appointment if:
 - They believe that a patient should be detained in hospital under section 3 of the Act, or should become a guardianship patient, but the nearest relative objects, or
 - They believe that the nearest relative is likely to discharge a patient from detention or guardianship unwisely.
- They should also consider doing so if they think that:
 - A patient has no identifiable nearest relative or their nearest relative is incapable of acting as such
 - They have good reasons to think that a patient considers their nearest relative unsuitable and would like them to be replaced, and
 - It would not be reasonable in the circumstances to expect a patient, or anyone else, to make an application.
- AMHPs should bear in mind that some patients may wish to apply to displace their nearest relative but may be deterred from doing so by the need to apply to the county court.

- It is entirely a matter for the court to decide what constitutes ‘suitability’ of a person to be a nearest relative. Factors which an AMHP might wish to consider when deciding whether to make an application to displace a nearest relative on those grounds, and when providing evidence in connection with an application, could include:
 - Any reason to think that the patient has suffered, or is suspected to have suffered, abuse at the hands of the nearest relative (or someone with whom the nearest relative is in a relationship), or is at risk of suffering such abuse
 - Whether the patient is afraid of the nearest relative or seriously distressed by the possibility of the nearest relative being involved in their life or their care, or
 - Whether the patient and nearest relative are unknown to each other, there is only a distant relationship, or their relationship has broken down irretrievably. This is not an exhaustive list.
- In all cases, the decision to make an application lies with the AMHP personally. Before making an application for displacement, AMHPs should consider other ways of achieving the same end, including:
 - Whether the nearest relative will agree to delegate their role as the patient’s nearest relative to someone else, or
 - Providing or arranging support to the patient (or someone else) to make an application themselves. This could include support from an independent mental health advocate (IMHA) (see chapter 6 Code of Practice 2015).
 - All local authorities should provide clear practical guidance to help the AMHP decide whether to make an application and how to proceed. Before producing such guidance, local authorities should consult with the county court. Local authorities should ensure that they have access to the necessary legal advice and support.
 - People making an application to the county court will need to provide the court with the facts that will help it make a decision on the application. Exactly what will be required will depend on the type of application and the specific circumstances of the case.
 - When applying to displace a nearest relative, AMHPs should nominate someone to become the acting nearest relative in the event that application is successful. Wherever practicable, they should first consult the patient about the patient’s own preferences and any concerns they have about the person the AMHP proposes to nominate. AMHPs should also seek the agreement of the proposed nominee prior to an application being made, although this is not a legal requirement.
 - Local authorities should provide clear practical guidance to help the AMHP decide whom it is appropriate to nominate when making an application to displace a nearest relative.
 - If the patient has any concerns that any information given to the court on their views on the suitability of the nearest relative may have implications for their own safety, an application can be made to the court seeking its permission not to make the current nearest relative a party to the proceedings. The reasons for the patient’s concerns should be set out clearly in the application.

- Hospital managers should provide support to detained patients to enable them to attend the court, if they wish, subject to the patient being granted leave under section 17 for this purpose.
- If, exceptionally, the court decides to interview the patient (as the applicant), the court has the discretion to decide where and how this interview takes place and whether it should take place in the presence of, or separate from, other parties. The patient should be fully supported in this, including through the use of an advocate to support them.
- If the court decides that the nearest relative should be displaced and finds the proposed replacement to be suitable, and the person is willing to act as nearest relative, the court will appoint them.
- People making an application to the county court will need to provide the court with the facts that will help it make a decision on the application. Exactly what will be required will depend on the type of application and the specific circumstances of the case.
- When applying to displace a nearest relative, AMHPs should nominate someone to become the acting nearest relative in the event that application is successful. Wherever practicable, they should first consult the patient about the patient's own preferences and any concerns they have about the person the AMHP proposes to nominate. AMHPs should also seek the agreement of the proposed nominee prior to an application being made, although this is not a legal requirement, that they have access to the necessary legal advice and support.
In the case of a patient wishing to seek displacement of their NR staff should notify the MHL Office who will advise the steps necessary to begin this process. Support should be given to the patient in understanding the process and consequences of displacement.
- The local LSSA will be responsible for coordinating the displacement process when an AMHP makes the application for displacement.

10. DEFECTIVE CONSULTATION

Where an application for a patient's admission to hospital appears to be duly made, the Trust may act upon it. If, subsequently the Hospital Managers receive information that suggests the application was defective for example the incorrect nearest relative was consulted then the continued detention may be unlawful. The MHL Office on receiving this information must consult with the MHL Manager as soon as possible.

If an AMHP signs an application despite the fact that the patient's nearest relative has objected to it, the patient's detention would be unlawful from the outset.⁸ The MHL Office would consult the MHL Manager and Responsible Clinician and follow the process outlined for a fundamentally defective application.

A patient's detention will not be invalidated if the AMHP learns of the existence of a previously unknown relative who would be the patient's NR. This relative should be informed of the application and his or her power of discharge under s.23 if consent has

⁸ TTM v London Borough of Hackney [2011]

been received on the s132 form. The MHL Office will ensure evidence has been obtained which satisfies the AMHP has correctly carried out their duty under section 11(4) i.e. usually the AMHP assessment report.

11. LEARNING LESSONS

Where an incident arises regarding a NR related process the details of this will be discussed with the local Mental Health Law Forum. This group will then advise any changes to local protocol, escalate required changes to this policy to the Mental Health Law Scrutiny Group and notify the MHL Manager of the issue and agreed action plan.

It will be the responsibility of the MHL Administrator to receive practice issues with the application of this policy and to notify the MHL Manager to allow the issues to be shared across the Trust and changes to process and policy to be made.

12. TRAINING

The MHL Manager is responsible for ensuring this policy is embedded into the Trust's training programme.

Where additional training needs are identified by the Mental Health Law Forums as a result of the incident reporting procedure the MHL Administrator will work with the borough to provide the additional training.

13. EQUALITY IMPACT ANALYSIS

As part of its development, this document was analysed to consider / challenge and address any detrimental impact the policy may have on individuals and or groups protected by the Equality Act 2010. This analysis has been undertaken and recorded using the Trust's analysis tool, and appropriate measures will be taken to remove barriers and advance equality of opportunity in the delivery of this policy / procedure

14. FREEDOM OF INFORMATION EXEMPTION ASSESSMENT

Under the Freedom of Information Act (2000) we are obliged to publish our policies on the Trust's website, unless an exemption from disclosure applies. As part of its development, this policy was assessed to establish if it was suitable for publication under this legislation. The assessment aims to establish if disclosure of the policy could cause prejudice or harm to the Trust, or its staff, patients, or partners. This assessment has been undertaken using the Trust's Freedom of Information Exemption Guide, and will be reviewed upon each policy review.

15. INFORMATION GOVERNANCE ASSESSMENT

This Policy has been analysed to ensure it is compliant with relevant information law and standards as in place at the time of approval, and are consistent with the Trust's

interpretation and implementation of information governance components such as data protection, confidentiality, consent, information risk, and records management.

Compliance will be reviewed against any changes to legislation / standards or at the next review of this document.

16. SAFEGUARDING

All staff have a responsibility to promote the welfare of any child, young person or vulnerable adult they come into contact with and in cases where there are safeguarding concerns, to act upon them and protect the individual from harm.

All staff should refer any safeguarding issues to their manager and escalate accordingly in line with the Trust Safeguarding Families Policy and Local Safeguarding Children/Adult Board processes.

17. MONITORING

The application of this policy will be overseen by the Mental Health Law Scrutiny Group.

The processes and principles of this policy where applicable will be included in audits where this is considered appropriate. The results of any audits will be shared across the Trust through the Mental Health Law Scrutiny Group, the Local Mental Health Law and Acute Care Forums.

The requirements of this policy will be used as a standard for investigations into complaints and investigations relating to Nearest Relative rights and provision of information where applicable.

Adherence to and monitoring of this policy will provide compliance and evidence of the following fundamental standards for the Trusts registration:

- **Care and treatment must reflect service users' needs and preferences;**

This means people's views and needs must be taken into account.

The effective application of this policy , including adherence to any standards identified within will be subject to monitoring using an appropriate methodology and design, such as clinical audit.

Monitoring will take place on a biannual basis and will be reportable to the Quality Group via the Clinical Effectiveness and Quality Improvement Team.

18. REVIEW

This policy will be reviewed three-yearly unless there is a need to do so prior to this; e.g. change in national guidance.

19. REFERENCES

Code of Practice & Mental Health Act 1983

MHL005 Nearest Relative Policy V4