

**Services Instruction**

**Referral Form**

**LITIGATION FRIEND**

**Tel:** 01656 649557 **Fax:** 01656 768775

**Email:** imca**@**mhmwales.org

MHM Wales provides a Litigation Friend Service to represent and support people who meet the referral criteria across Wales.

**PLEASE NOTE: Referrals can only be accepted from relevant personnel employed by a Local Authority, NHS Trust or LHB.**

**RELEVANT PERSON**

|  |  |
| --- | --- |
| **Relevant Persons Name:** |  |
| **Date of Birth:** |  |
| **Address:** |  |
| **Postcode:** |  |
| **E-mail:** |  |
| **Telephone Number:** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Where is the RP Residing? (*Please Tick* 🗸)** | | | | | |
| **Own home** |  | **Care/ Nursing Home** |  | **General Hospital** |  |
| **Psychiatric Hospital** |  | **Supported Living** |  | **Other** |  |

|  |
| --- |
| **Brief details of case:** |
|  |

**Risks**

|  |  |
| --- | --- |
| **Are There any Risks Associated with this Referral? ( *Please Tick* 🗸)** | |
| **Yes 🗆**  **If there are any risks, please provide more information here:** | **No 🗆** |

**Care co-ordinator CONTACT DETAILS:**

|  |  |
| --- | --- |
| **Name:** |  |
| **Position:** |  |
| **Address:** |  |
| **Postcode:** |  |
| **Email:** |  |
| **Telephone Number :** |  |

**Local Authority or Local Health Board SOLICITOR CONTACT DETAILS:**

|  |  |
| --- | --- |
| **SOLICITOR:** |  |
| **Contact Name:** |  |
| **Address:** |  |
| **Postcode:** |  |
| **Email:** |  |
| **Telephone Number:** |  |

|  |
| --- |
| **REASON FOR INSTRUCTION:** |
| What issues have arisen for this case to be taken to the Court of Protection.  Main issues and people involved.  Restrictions on P. |

|  |  |
| --- | --- |
| **Case Number (If An Application Has Been Made)** |  |

**Are there any deadlines or important meeting dates?**

|  |
| --- |
|  |

**Consent from Referrer**

I would like MHM Wales to provide a Litigation Friend Service. They can keep the information on this form, and other information I provide needed to do the work. I am providing this information and asking for this referral in the best interests of the person concerned.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Print Name** |  | **Signature** |  | **Date** |  |

**Equality and Monitoring Information**

**Communication**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **What is the person’s primary method of communication? ( *Please Tick* 🗸)** | | | | | | | |
| **English** |  | **Another spoken language** | | |  | **Gesture/ vocalisations/ facial expressions** |  |
| **BSL** |  | **Welsh** |  | **Other** |  | **No obvious means of communication** |  |

**Ethnic Background**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **White British** |  | **White Irish** |  | **Black Caribbean** |  | **White/ Black Caribbean** |  |
| **White/ Asian** |  | **Bangladeshi** |  | **Indian** |  | **Chinese** |  |
| **Other White Background** |  | **Black African** |  | **Other Black Background** |  | **White/ Black African** |  |
| **Other Mixed Background** |  | **Pakistani** |  | **Other Asian Background** |  | **Other Ethnic Group** |  |

**Client Group/ Reason for Lacking Capacity?**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Learning Disability** |  | **Autistic Spectrum Disorder** |  | **Mental Health** |  | **Serious Physical Illness** |  |
| **Dementia** |  | **Acquired Brain Injury** |  | **Unconscious** |  | **Other** |  |

**Evaluation form for Decision Makers**

MHM Wales are keen to hear what is working well with the Litigation Friend service, and what needs to improve. It would be very helpful if you could complete the following evaluation form that will assist us to improve our service. Please refer to the Mental Capacity Act and DOLS Codes of Practice if you are uncertain about the Litigation Friend role and responsibilities.

**Was the service easy to access and instruct?**

Yes 🗆 No 🗆

|  |
| --- |
| **If no please detail** |
|  |

**Did the litigation explain their roles and responsibilities clearly and effectively?**

Yes 🗆 No 🗆

|  |
| --- |
| **If no please detail** |
|  |

**Was the Litigation Friend effective in supporting and representing the person through the decision-making process?**

Yes 🗆 No 🗆

|  |
| --- |
| **If no please detail** |
|  |

**Did the Litigation Friend agree a timescale for submitting their report and then submit within that timescale?**

Yes 🗆 No 🗆

|  |
| --- |
| **If no please detail** |
|  |

|  |
| --- |
| **Any other comments about the quality of the service. Please detail** |
|  |

**Thank you very much for taking the time to complete this feedback. We will use the information to improve our service.**

**Please return this form to**

**MHM Wales**

**Union Offices**

**Quarella Road**

**Bridgend**

**CF31 1JW**

**Or Email**

[**imca@mhmwales.org**](mailto:imca@mhmwales.org)



**LITIGATION FRIEND SERVICE**

**THE ROLE**

On completion of the referral form the appointed Litigation Friend would meet with the client to ascertain (where possible) their wishes and feelings in relation to the issues. Following these meeting(s), all COP Forms associated with the Litigation Friend role would be completed. The Litigation Friend would then take all steps to liaise with the client and all appointed legal representatives to give the client a voice, and to facilitate their full participation in proceedings. The extent of the Litigation Friend role would depend on the level of support required and the circumstances of the client but would include attending court with, or, on behalf of the client where required.

Where the client is represented by solicitors or counsel, we would not ordinarily seek to make any changes in this respect but would continue to instruct current representation in relation to the matter.

**FUNDING**

This is not a ‘free of charge’ service. MHM Wales can provide this service at an hourly rate of £30.00. Issues of funding have been problematic in this area, and there are several options:

* Private Funding.
* Supervisory Body – Costs for the Litigation Friend Service to be met by the Supervisory Body by prior agreement.
* Health Board – Costs for the Litigation Friend Service to be met by the Health Board by prior agreement.
* Combined/Split Funding provided by SB/HB as agreed (see above)
* Public Funding – Costs to be met via a prior authority application upon the public funding certificate.
* Order of the Court – an order may be sought from the Court at the first available Directions Hearing in relation to the funding for this service, where there is an available Litigation Friend but no available funding.

\*Please note that travel and disbursement costs are billable separately at our normal rate.

**COSTS INDEMNITY**

Should appropriate funding be secured by the client/client’s solicitor we would also seek to be indemnified in relation to any implications in cost arising from any proceedings issued.

******MHM Wales**

**Appointment of a Litigation Friend Agreement**

|  |  |
| --- | --- |
| Date |  |
| Name of Relevant Person |  |
| Our Ref |  |
| **Purchase Order Number\*** |  |

*\*A valid Purchase Order Number must be clearly quoted otherwise the referral will be rejected. A valid PO is a PO that has been raised to a sufficient value to cover that engagement; use of an old PO number will not be valid and cause payment to be delayed.*

Dear Sirs

Thank you for requesting MHM Wales to undertake the role of Litigation Friend for the above-mentioned Relevant Person.

As agreed, you will pay for this service at a rate of £30.00 per hour for all work plus mileage rate of 45p per mile. A one off £30.00 central administration charge is payable for each authorisation received to cover initial administration duties in processing the authorisation and all invoicing work associated with the authorisation.

Please be mindful and read the service information sheet before signing this agreement. Any queries, please contact [imca@mhmwales.org](mailto:imca@mhmwales.org) or 01656 649557.

Invoices will be sent to you on a regular basis.

Please sign below to confirm acknowledgement and agreement of the above and return it to our accounts department [accounts@mhmwales.org](mailto:accounts@mhmwales.org) for invoicing purposes.

|  |  |  |  |
| --- | --- | --- | --- |
| Contact Name: |  | | |
| Postal Address |  | | |
| Email Address |  | | |
| Signature: |  | Date: |  |

Please notify us of any changes required to this agreement.