



A: Introduction

1. This purpose of this document is to provide for social workers and those working in front-line clinical settings an overview of the law and principles relating to the assessment of capacity. Its focus is on (a) how to apply the MCA 2005 principles when assessing capacity; and (b) how to record your assessment, primarily in the context of health and welfare decisions.
2. This document cannot take the place of legal advice. In any case of doubt as to the principles or procedures to apply, it is always necessary to consult your legal department. In particular, if it appears that the person in question is subject to undue influence or coercion, it is always vital to consult your legal department as soon as possible to consider whether and how their interests are to be secured.
3. The courts have now considered questions of capacity on many occasions, sometimes giving guidance as to how the Act should be applied in general terms, and sometimes applying the Act to particular factual scenarios.

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Disclaimer: This document is based upon the law as it stands as at May 2021; it is intended as a guide to good practice, and is not a substitute for legal advice upon the facts of any specific case. No liability is accepted for any adverse consequences of reliance upon it.

The picture at the top, "Colourful," is by Geoffrey Files, a young man with autism. We are very grateful to him and his family for permission to use his artwork.

¹ Useful guidance in relation to the questions that arise in the context of the management of property and affairs (called *Making Financial Decisions - Guidance for assessing, supporting and empowering specific decision-making*) can be downloaded for free at www.empowermentmatters.co.uk.

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4. We give references to cases in footnotes for those who want to read further: the key information is contained in the body of the Guide, in language which is hopefully not as legalistic as that sometimes adopted by the courts.
 5. A note on language. The word 'assessment' is in our experience all too often used to cover two completely different things: (1) the process of assessing whether or not a person has capacity to make a decision; and (2) the recording of the conclusion reached as to whether or not the person had capacity. It is important to keep the two concepts separate, in particular in circumstances where (too) many forms are labelled 'capacity assessment' when they are, in fact, forms to record the fact that the person does not have capacity to make a relevant decision. Forms to record the outcome of capacity assessments should enable the person completing them to set out that the person **has** capacity if that is the outcome of the assessment.
 6. It is also important to remember that an assessment for purposes of preparing a report on a person's capacity (in any context) is a different thing to a clinical assessment, or an assessment for other therapeutic purposes.³

B: Key principles

7. The core principles of the MCA 2005 are set out in s.1. They are:
 - s.1(2): a person (P⁴) must be assumed to have capacity unless it is established that he lacks capacity;
 - s.1(3): P is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success;
 - s.1(4): P is not to be treated as unable to make a decision merely because he makes an unwise decision;
 - s.1(5): an act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests; and
 - s.1(6): before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.
8. The presumption that P has capacity is fundamental to the Act. It is important to remember that P has to 'prove' nothing. The burden of proving a lack of capacity to take a specific decision (or

³ See *AMDC v AG & Anor* [2020] EWCOP 58 at para 28(a) per Poole J, talking about a report to the Court of Protection, but equally relevant to any other report, including for purposes of e.g. DoLS.

⁴ Strictly, of course, P is not 'P' unless they are the subject of proceedings before the Court of Protection who is alleged to lack capacity to take one or more decisions (Court of Protection Rules 2017, r 2.1), but it is a convenient shorthand.

decisions) always lies upon the person who considers that it may be necessary to take a decision on their behalf (or will invite a court to take such a decision). The standard of proof which must be achieved is on the balance of probabilities (s.2(4)). Accordingly, it will always be for the decision-maker to prove that it is more likely than not that P lacks capacity. Precisely how the presumption plays out in situations where there is objective reason to believe that P lacks capacity is addressed further at paragraphs 12 and 13 below.

9. Common phrases which suggest that the presumption is not being adopted include:

"One needs to be certain of her capacity."

"[P] is unable to fully understand, retain and weigh information."⁵

10. It is also important that it is the decision-maker who needs to have a reasonable belief that P lacks capacity. In a court setting, the decision-maker is the judge; outside the court setting, it is the person who is proposing to take the step in question on the basis that it is said to be in P's best interests.⁶ That does not mean that expert assistance cannot be sought (for instance as to whether the person has an impairment or disturbance of the mind or brain). But it does mean that the decision-maker cannot delegate the decision as to capacity to that expert. To give an example which occurs frequently in the clinical setting, if you are a doctor proposing to carry out a particular operation, you cannot delegate to a psychiatrist colleague the decision whether or not the person has capacity. You may – and in some complex cases may need - to get expert input from that psychiatric colleague, but it is ultimately you, as the treating doctor, to decide whether or not P lacks capacity. If you did not reasonably believe P lacked capacity, and went ahead with the operation in what you thought was P's best interests, you will have no defence under s.5 MCA 2005 to a claim for damages and/or criminal prosecution.

11. It is important to understand that it is not only medical professionals – and in particular psychiatrists – who can carry out a capacity assessment. There will be some circumstances under which the particular expertise of a medical professional will be required, but that is because of their expertise, not because of the position that they hold. A capacity assessment is, in many ways, an attempt to have a real conversation with the person on their own terms, and applying their own value system.⁷ It is frequently the case that professionals or others who know the person better, and in particular who have seen the person over time, will be able to do a more robust capacity assessment than a person (of whatever discipline) 'parachuted' in for a snapshot

⁵ These are both taken from the judgment of Peter Jackson J in *Heart of England NHS Foundation Trust v JB* [2014] EWHC 342 (COP), with the key words emphasised.

⁶ For more on this, see our [Guidance Note: Determining and Recording Best Interests](#).

⁷ See *Kings College NHS Foundation Trust v C* [2015] EWCOP 18, in particular at paragraph 38.

assessment.⁸ But before having the capacity conversation with P it is most important to do your homework and consider what we might call the circumstantial evidence. In other words, ensure you are familiar with P's circumstances, incidents where risks have materialised etc.

12. Except in s.21A DoLS applications, the Court of Protection can make interim decisions and declarations about P's best interests where it has evidence before it to establish that there is reason to believe that P may lack capacity to make the decisions.⁹ This means that it is possible to make an application where those concerned with P's circumstances have been unable (perhaps because they have been prevented by a third party) to complete a COP3 form to the level of detail usually required. In such circumstances, it will always be necessary to make clear in a supporting witness statement why the person or body bringing the application has reasonable grounds to believe that P may lack the relevant capacity and must, in particular, show what they have done to secure P's participation in the assessment. One of the first steps that the court will then take is to bring about a proper capacity assessment; that capacity assessment will then determine whether or not it has jurisdiction to take further steps in relation to P. The position in s.21A applications is different because there is already evidence – in the form of the evidence about capacity underpinning the authorisation; the court will not therefore make any interim declaration about capacity but will take whatever steps it needs to do (including calling the person who provided the evidence for authorisation purposes) to be able to reach a decision about P's capacity.¹⁰
13. Finally, the very act of deciding to carry out a capacity assessment is not, itself, neutral, and the assessment process can, itself, often be (and be seen to be) intrusive. You must always have grounds to consider that one is necessary.¹¹
14. Conversely, you must also be prepared to justify a decision not to carry out an assessment where, on its face, there appeared to be a proper reason to consider that the person could not take the relevant decision:
 - Whilst the presumption of capacity is a foundational principle, you should not hide behind it to

⁸ See in this regard both *A Local Authority v SY* [2013] EWHC 3485 (COP) at paragraph 22 (emphasising that “appropriately qualified social worker is eminently suited to undertake [...] capacity assessments” for completing a COP3 form) and *PH v A Local Authority v Z Limited* [2011] EWHC 1704 (COP) at paragraph 56. By “appropriately qualified” social worker is meant a social worker who can properly claim to have the necessary expertise (and be able to explain why they do).

⁹ See *DP v LB Hillingdon* [2020] EWCOP 45.

¹⁰ See *DP v LB Hillingdon* [2020] EWCOP 45.

¹¹ See *Re SB (capacity assessment)* [2020] EWCOP 43 as an example of a case where the Court of Protection decided that it was not necessary or appropriate to order a further capacity assessment in a case where (1) nothing was actually going to turn on the outcome of that assessment; and (2) the very process of carrying out that assessment might itself cause P anxiety and distress.

avoid responsibility for a vulnerable individual.¹² In our experience, this can happen most often in the context of self-neglect where it is unclear whether or not the person has capacity to make decisions.¹³

- If you have proper reason to think that the person may lack capacity to take a relevant decision, especially if the consequence of what they are wanting to do is likely to lead to serious consequences for them, it would be simply inadequate for you simply to record (for instance) “as there is a presumption of capacity, [X] decision was the person’s choice.”¹⁴ Indeed, the more serious the issue, the more one should document the risks that have been discussed with P and the reasons why it is considered that P is able and willing to take those risks.

15. Useful guidance on how to think about the presumption can be found in this passage from the judgment in *Royal Bank of Scotland Plc v AB*:¹⁵

The presumption of capacity is important; it ensures proper respect for personal autonomy by requiring any decision as to a lack of capacity to be based on evidence. Yet the section 1(2) presumption like any other, has logical limits. When there is good reason for cause for concern, where there is legitimate doubt as to capacity [to make the relevant decision], the presumption cannot be used to avoid taking responsibility for assessing and determining capacity. To do that would be to fail to respect personal autonomy in a different way

16. It is also important to remember that some people can ‘talk the talk, but not walk the walk’, especially if they have had numerous prior capacity assessments. See further Section E below.

C: What does it mean to lack capacity to make a decision?

17. The law gives a very specific definition of what it means to lack capacity for purposes of the MCA 2005. It is a legal test, and not a medical test, and is set down s.2(1) MCA 2005,¹⁶ which provides

¹² As the House of Lords Select Committee looking at the MCA 2005 reported, this unfortunately happens all too frequently – in our experience, most often in the context of self-neglect. House of Lords Select Committee on the MCA 2005 (2014) *Mental Capacity Act 2005: Post-legislative scrutiny*, HL Paper 139, at paragraph 105.

¹³ See, for instance, the cases discussed in *Learning from SARS: A report for the London Safeguarding Adults Board* (July 2017)

¹⁴ Framed in human rights terms, a public body may well not be able to show that it has discharged its operational duty under Article 2 ECHR to take practicable steps to secure the life of a vulnerable individual if it relies unthinkingly upon the presumption of capacity where there are proper reasons to consider that they may lack it. In *Arskaya v Ukraine* [2013] ECHR 1235, the European Court of Human Rights found a breach of the Article 2 ECHR operational duty where the doctors took refusal of life-saving treatment where “despite S. showing symptoms of a mental disorder, the doctors took those refusals at face value without putting in question S.’s capacity to take rational decisions concerning his treatment. Notably, if S. had agreed to undergo the treatment, the outcome might have been different.” (para 87).

¹⁵ [2020] UKEAT 0266_18_2702. The judgment relates to capacity to conduct proceedings before the Employment Tribunal, but the principles are of broader application.

¹⁶ Referred to as the “core determinative provision” in *PC and NC v City of York Council* [2013] EWCA Civ 478 at paragraph 56.

that:

'a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or the brain'

18. To apply the test, it can best be broken down into three questions:

- (1) Is the person able to make a decision? If they cannot:
- (2) Is there an impairment or disturbance in the functioning of the person's mind or brain? If so:
- (3) Is the person's inability to make the decision because of the identified impairment or disturbance?

19. The ordering of the first and second questions set out above is the opposite to that set out in the Code of Practice as it stands at present.¹⁷ However, we consider that the case-law is now clear that the ordering set out in the Act itself must be followed.¹⁸ There are also three sound 'policy' reasons why this order should be followed:

- (a) There is a danger that you will mentally 'tick off' the presence of an impairment or disturbance and then will not sufficiently question whether that impairment or disturbance is actually **causing** the inability to make the decision;¹⁹
- (b) Linked to this, there is also a risk that the structuring perpetuates the discriminatory approach to those with mental disorders, as it essentially loading the capacity assessment against them by 'pre-filling' the first element of the test. In other words, it makes it – subconsciously – easier to move for you to move from thinking 'this person has schizophrenia' to concluding 'this person lacks capacity to make [X] decision.'
- (c) Focusing on what it is thought that the person is functionally unable to do means that support can be targeted appropriately, for instance to help them understand the information relevant to the decision, or to use and weigh it. If, with that support, the person is able to make the decision, there is then no need to go further: they have capacity to make it.

20. That having been said, depending upon the circumstances, it may be that more focus needs to be placed upon either the causal impairment or the functional test – for instance – if P is in a psychiatric ward with a clear diagnosis of a mental disorder, then it may be that more attention is required to considering whether that disorder means that they are unable to take the specific

¹⁷ The Code of Practice is under revision as at December 2020.

¹⁸ See *PC and NC v City of York Council* [2013] EWCA Civ 478 at paragraph 58 and *Kings College NHS Foundation Trust v C and V* [2015] EWCOP 80 at paragraph 35.

¹⁹ This risk was identified by the Court of Appeal in *PC* at paragraph 58.

decision in question.

21. In all cases, though, all three elements of the single test must be satisfied in order for a person properly to be said to lack capacity for purposes of the MCA 2005.

22. We now look at these elements in turn.

(1): Is the person able to make a decision?

23. Section 3(1) states that P is unable to make a decision for himself if he is unable:

- to understand the information relevant to the decision; or
- to retain that information; or
- to use or weigh that information as part of the process of making the decision; or
- to communicate his decision (whether by talking, using sign language or any other means).

24. Before looking at each of these elements in turn, we should emphasise a number of cardinal principles that apply to all of them.

25. First, capacity is decision-specific. The statement 'P lacks capacity' is, in law, meaningless. You must ask yourself "what is the actual decision in hand"²⁰? If you do not define this question with specific precision before you start undertaking the assessment, the exercise will be pointless. By way of example, where a person needs medical treatment to address gangrene in their leg, the decision in respect of which you need to assess capacity is whether they have the capacity to consent to treatment. It is not whether they have capacity to consent to one of a number of potential operations that could be carried out to provide that treatment (assuming that each of the operations carries materially similar risks to the patient).²¹

26. Second, and linked to the first, as obvious as it may sound, it is also vitally important to ensure that, having framed the question with sufficient precision to yourself, you actually then ask P the question (in whatever manner is appropriate) during the assessment (and record the answer). If, unusually, it is not appropriate to ask the precise question, the reasons why it was not asked should be spelled out carefully.

27. Third, before you can determine whether P is able or unable to decide, you must identify what the information relevant is to the particular decision. This includes the reasonably foreseeable consequences of deciding one way or another, or failing to make the decision. You should record this information and explain which aspect(s) of it P is unable to understand, or retain, or use and

²⁰ See PC at paragraph 40.

²¹ This was the position that was addressed in *Heart of England NHS Foundation Trust v JB* [2014] EWHC 342 (COP).

weigh.

28. Fourth, to comply with s.1(3) MCA 2005, you must take all practicable steps to help P before concluding that they are nevertheless unable to make a decision.²² And, importantly, consider why is it that you were unsuccessful in enabling P to decide despite those steps having been taken? This will include asking yourself – and being in a position to record – the answers to questions such as:

- What is the method of communication with which P is most familiar (is it, for instance, a pointing board, Makaton or visual aids)?
- What is the best time of day to discuss the decision in question with P?
- What is the best location to discuss the decision in question with P?
- If you do not know P, would it assist to have another person present who does (and, if they do, what role should they play)?
- Has P made clear (in whatever fashion) that there is someone that they would like to be present, or someone they would really like not to be present?
- What help does P require to learn about and understand the information relevant to the decision? For instance, does P need to be taken to see different residential options? Have you explained to P all the pieces of information that you have identified as being relevant to the decision?
- Is it possible to complete the assessment in one go, or is it necessary to come back and see P on more than one occasion, even if only to put P at their ease and help them engage with the process?²³
- And, perhaps above all, is there something that you can do which might mean that P would be able to make the decision? Depending upon the circumstances, this could range from simply waiting to undergo work with P to assist them: see for a good example, *Re DE* [2013] EWHC 2562 (Fam), in which (whilst Court of Protection proceedings were ongoing), an intensive programme of education was provided to a learning disabled man, in consequence of which he gained the capacity to consent to sexual relations.

Is P able to understand the relevant information?

29. It is not necessary that P understands every element of what is being explained to them. What is

²² See also here Chapter 2 of the Code of Practice to the MCA 2005.

²³ For an example of the difference that this can make, see the contrasting assessments of P's capacity to make decisions as to residence and care in *Re FX* [2017] EWCOP 36.

important is that P can understand the 'salient factors'²⁴: the information relevant to the decision. This means that the onus is on you not just to identify the specific decision (as discussed above) but also what the information is that is relevant to that decision, and what the options are that P is to choose between. We give examples of the kind of information that has been held by the courts to be relevant (and irrelevant) in our separate guidance note.

30. The level of understanding required must not be set too high.²⁵
31. Further, you must not start with a 'blank canvas.' In other words, you must present the person you are assessing with detailed options so that their capacity to weigh up those options can be fairly assessed.²⁶ This is particularly important where a person's particular impairment may make it more difficult for them to envisage abstract concepts. But it is also important to give the person sufficient information about the options that they are being asked to choose between that they are given the opportunity to understand (if they are capable of doing so) the reality of those options. In other words, and to take a common example, you should not simply seek to assess a person's ability to decide between living at home and living in a care home in the abstract, but rather by reference to what continuing to live at home would be like (for instance, what care package would the relevant local authority provide) and what living in an actual care home would be like.²⁷
32. The ability to understand also extends to understanding the reasonably foreseeable consequences of reaching a decision or failing to do so (s.3(4)).
33. When you are making an assessment of capacity it is vital that you ask yourself the questions set out at paragraph 64. Consider the responses, and record them in the assessment form or the COP3. Be in a position to explain to the court how questions have been put to P, where they have been put, what efforts have been made to ensure that P understands the information before him or her.

Is P able to retain the relevant information?

34. We repeat the need to be precise about the information in question.
35. P needs to be able to retain enough information for a sufficient amount of time in order to make a decision. The Act specifies at s.3(3), however, that 'the fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.'
36. This is an important consideration, particularly when dealing with the elderly or those with deteriorating memories. Capacity is the assessment of the ability to make a decision 'at the

²⁴ LBJ v RYJ [2010] EWHC 2664 (Fam).

²⁵ PH and A Local Authority v Z Limited & R [2011] EWHC 1704 (Fam).

²⁶ CC v KK & STCC [2012] EWHC 2136 (COP).

²⁷ CC v KK & STCC [2012] EWHC 2136 (COP).

material time.’ If information can be retained long enough for P to be able to make the relevant decision at the material time, that is sufficient, even if P cannot then retain that information for any longer period.

Is P able to use or weigh the relevant information?²⁸

37. Again, it is necessary to be clear what the information is (and how it is said to be relevant to the decision). This aspect of the test has been described as *‘the capacity actually to engage in the decision-making process itself and to be able to see the various parts of the argument and to relate the one to another.’*²⁹ As with understanding, it is not necessary for a person to use and weigh every detail of the respective options available to them, merely the salient factors. Therefore, even though a person may be unable to use and weigh some information relevant to the decision in question, they may nonetheless be able to use and weigh other elements sufficiently to be able to make a capacitous decision.³⁰
38. It is particularly important here to be aware of the dangers of equating an irrational decision with the inability to make one – P may not agree with the advice of professionals, but that does not mean that P lacks capacity to make a decision.³¹
39. Further, if a person is able to use and weigh the relevant information, the weight to be attached to that information in the decision making process is a matter for that person.³² This means you need to be very careful when assessing a person’s capacity to make sure – as far as possible – that you are not conflating the way in which they apply their own values and outlook (which may be very different to yours) with a functional inability to use and weigh information. This means that, as much as possible, you need as part of your assessment – your conversation – with P, to glean an idea of their values and their life story as it relates to the decision in question.
40. In some cases, it may be difficult to identify whether P is using a piece of relevant information but according it no weight, or failing to use the piece of information at all. Psychiatric expertise may be of assistance in such cases, as it may explain whether P’s ability to process information is impaired and if so, to what extent.

²⁸ Note that the statutory requirement is that P must be unable to use or weigh the relevant information. In practice, the two terms are usually used together, so we also refer here to “use and weigh.” However, we think that it is clear that P should be considered to lack capacity if they are able to use the information, but not able to weigh it.

²⁹ *The PCT v P, AH & the Local Authority* [2009] EW Misc 10 (COP).

³⁰ *Kings College NHS Foundation Trust v C and V* [2015] EWCOP 80 at paragraph 37.

³¹ *“there is a space between an unwise decision and one which an individual does not have the mental capacity to take and ... it is important to respect that space, and to ensure that it is preserved, for it is within that space that an individual’s autonomy operates”*: PC at paragraph 54.

³² *Kings College NHS Foundation Trust v C and V* [2015] EWCOP 80 at paragraph 38.

Is P able to communicate their decision?

41. It is very important to understand how this limb of the test works. It presupposes that the person has been able to make a decision: in other words, that they have been able to understand, retain, use and weigh the relevant information – the problem is that they cannot communicate the decision that they have made. It is therefore a limb of the test which only applies to a very limited group of people, for instance those with locked-in syndrome who may, despite all practicable steps, be unable to communicate.
42. If, therefore, you consider that the person is unable to understand, retain, use or weigh relevant information, but it is clear that they are communicating something, then:
- The record of your assessment should **not** say that they are unable to communicate their decision – it should say that they are unable to make a decision, and what they are communicating are wishes and feelings;
 - You should take into account what they are communicating for purposes of constructing the best interests decision: see further our guide to this process [here](#).
43. Any residual ability to communicate the decision is enough, so long as P can make themselves understood. This will be an area where it is particularly important to identify (and to demonstrate you have identified) what steps you should be taking to facilitate communication: for instance, reproducing as best as possible the manner by which they usually communicate, providing all necessary tools and aids, and enlisting the support of any relevant carers or friends who may assist with communication.

(2) Is there an impairment or disturbance in the functioning of the person's mind or brain?

44. In many cases, and especially if you are not medically qualified, you will be relying upon a clinician to provide an opinion as to whether P has an impairment or disturbance in the functioning of the mind or brain, and, if so, what precisely it is. As this is often a clinical question, we do not therefore address this aspect of the test in great detail here.
45. It is, though, important to make the following points:
- The impairment or disturbance in the functioning of the mind or brain can be temporary or permanent (s.2(2)): if temporary, be careful to explain why it is that the decision cannot wait until the circumstances have changed before the decision is taken.
 - It is important to remember that it is not necessary for the impairment or disturbance to fit

into one of the diagnoses in the ICD-11 or DSM-5.³³ It can include medical conditions causing confusion, drowsiness, concussion, and the symptoms of drug or alcohol abuse. To this extent, therefore, the term “diagnostic” test which is often used here is misleading – the important thing is that there is a proper basis upon which to consider that there is an impairment or disturbance.

- Finally, particular care needs to be exercised if you are considering a person who appears to have a very mild learning disability – this may well not be enough to constitute an impairment or disturbance of the mind or brain for these purposes.³⁴

(3): Is the person’s inability to make the decision because of the impairment or disturbance in the functioning of their mind or brain?

46. In all cases, it is important to be able to answer this third question – sometimes called identifying the ‘causative nexus.’³⁵ In other words, are you satisfied that the inability to make a decision is because of the impairment of the mind or brain? Any pro forma form for the assessment of capacity that does not include a final box asking precisely this question is likely to lead you astray. In *PC and NC v City of York Council* this issue made all the difference. The Court of Appeal found that a conclusion that PC’s inability to decide whether to resume married life with her husband upon release from prison “*significantly relate[d] to*” her mild learning disability was insufficient: the MCA requires the inability to be “because of” of the impairment, which is evidentially more stringent.

47. To reiterate, there has to be, and you have to show that you are satisfied why and how there is, a causal link between the disturbance or impairment and the inability to make the decision(s) in question. *JB*’s case, again, shows how easy it is to assume that merely because a person has schizophrenia, they are then unable to take decisions regarding surgical procedures – this is entirely incorrect. The disturbance or impairment in the functioning of the mind or brain must also not merely impair the person’s ability to make the decision, but render them unable to make the decision.³⁶

48. There will be situations in which it is not entirely easy to identify whether a person is unable to make what professionals consider to be their own decisions because of:

- An impairment or disturbance in the functioning of their mind or brain (for instance the effect of dementia);

³³ The COP3 form recognises this in section 7, where it requires the identification of the material impairment of or disturbance in the functioning of the mind or brain, and the identification of the specific diagnosis (or diagnoses) “[w]here this impairment or disturbance arises out of a specific diagnosis.”

³⁴ See *WBC v Z* [2016] EWCOP 4.

³⁵ *PC and NC v City of York Council* [2013] EWCA Civ 478 at paragraph 52.

³⁶ *Kings College NHS Foundation Trust v C and V* [2015] EWCOP 80 at paragraph 31.

- The influence of a third party (for instance an over-bearing family member); or
- A combination of the two.

49. Examples of such cases include:

- The older patient on the hospital ward who looks to their child for affirmation of the 'correctness' of the answers that they give to hospital staff;
- A person with mild learning disability in a relationship with an individual who (even when that individual is next door) is clearly still cautious about expressing any opinions that may go against what they think may be the wishes of that individual.

50. In such cases, there will sometimes a difficult judgment call to make as to whether the involvement of the third party actually represents support for the person in question, or whether it represents the exercise of coercion or undue influence. We strongly suggest that in any case where you have grounds for concern that you seek legal advice as soon as possible as to what (if any) steps should be taken. In particular, there are some cases in which the right route is not to go to the Court of Protection but rather to make an application to the High Court for declarations and orders under its inherent jurisdiction. More guidance can be found on the inherent jurisdiction in our guidance note [here](#).

D: Flashpoints: (1) Fluctuating capacity

51. Some people's ability to make decisions fluctuates because of the nature of a condition that they have. This fluctuation can take place either over a matter of days or weeks (for instance where a person has bipolar disorder) or over the course of the day (for instance a person with dementia whose cognitive abilities are significantly less impaired at the start of the day than they are towards the end).

One-off decisions

52. If it is a one-off decision, it may be possible to put it off until the impact of the person's condition upon their decision-making abilities has diminished. At that point, you should record the person's decision, and, at least in any case where there may be a challenge later to the decision on the basis that they lacked capacity, record why you consider that the person had capacity to make it.³⁷ Depending upon the context, you should also record what the person would want in the event that they lose capacity in future to make similar decisions. This means that, if further decisions then need to be taken in their best interests, they can be taken in knowledge of what they would want.

53. If it is not possible to put the decision off, then you should take the minimum action necessary to

³⁷ *A, B and C v X and Z* [2012] EWHC 2400 (COP) (grant of a will and grant of a power of attorney).

'hold the ring' pending the person regaining decision-making capacity.

Repeated decisions

54. Some decisions are not one-off and need to be repeated over a period of time. Examples include the management of property and affairs,³⁸ or the management of a physical health condition which requires a multitude of 'micro-decisions' over the course of each day. Although capacity is time-specific, in such a case, it will usually be appropriate to take a broad view as to the 'material time' during which the person must be able to take the decisions in question. If the reality is that there are only limited periods during the course of each day or week that the person is able to take their own decisions, then it will usually be appropriate to proceed on the basis that, in fact, they lack capacity to do so. This is particularly so where the consequences for the person are very serious if they are taken to have capacity when, in reality, this is only true for a very small part of the time. The courts have shown themselves increasingly willing to take this approach,³⁹ or, closely-linked, the approach of 'zooming out' to ask themselves a macro-question if appropriate.⁴⁰
55. If the approach taken here is adopted, you should keep the person's decision-making ability under review, and reassess if it appears that the balance has tipped such that they have, rather than lack, capacity to take the relevant decision(s) more often than not.

Deprivation of liberty

56. Precisely how to characterise the 'material time' in relation to the capacity assessment under DoLS is legally complicated at the level of principle.⁴¹ However, the Deprivation of Liberty Safeguards Code of Practice, in essence, suggests that the same approach as set out above in relation to repeated decisions should be taken in the context of deprivation of liberty.⁴²

E: Flashpoints (2): Executive functioning

57. Another common area of difficulty is where a person – often a person with an acquired brain injury – gives superficially coherent answers to questions, but it is clear from their actions that they are unable to carry into effect the intentions expressed in those answers. It may also be that there is evidence that they cannot bring to mind relevant information at the point when they might need to

³⁸ *A, B and C v X and Z* [2012] EWHC 2400 (COP) at paragraph 37.

³⁹ See *Cheshire West And Chester Council v PwK* [2019] EWCOP 57.

⁴⁰ See *Royal Borough of Greenwich v CDM* [2019] EWCOP 32 ('macro' decision about the management of diabetes in the context of rapidly fluctuating capacity to take all the many 'micro' decisions that might be required to bring about effective management of the condition).

⁴¹ For discussion, see the Law Commission's report on *Mental Capacity and Deprivation of Liberty* at paragraphs 9.38 and onwards.

⁴² See paragraphs 8.22-8.24.

implement a decision that they have considered in the abstract. Both of these situations are frequently referred to under the heading of 'executive dysfunction.' Executive function has also been described by Cobb J as *"the ability to think, act, and solve problems, including the functions of the brain which help us learn new information, remember and retrieve the information we've learned in the past, and use this information to solve problems of everyday life."*⁴³

58. It can be very difficult in such cases to identify whether the person in fact lacks capacity within the meaning of the MCA 2005, but a key question can be whether they are aware of their own deficits – in other words, whether they are able to use and weigh (or understand) the fact that there is a mismatch between their ability to respond to questions in the abstract and to act when faced by concrete situations. Failing to carry out a sufficiently detailed capacity assessment in such situations can expose the person to substantial risks.

59. Although there is a (strange) lack of determinative case-law on this point,⁴⁴ our view is that:

- You can legitimately conclude that a person lacks capacity to make a decision if they cannot understand or use/weigh the information, that they cannot implement what they will say that they do in the abstract, or (if relevant) that when needed, they are unable to bring to mind the information needed to implement a decision;

BUT

- You can only reach such a finding where there is clearly documented evidence of repeated mismatch.⁴⁵ This means, in consequence, it is very unlikely ever to be right to reach a conclusion that the person lacked capacity for this reason on the basis of one assessment alone.

AND

- If you conclude that the person lacks capacity to make the decision, you must explain how the deficits that you have identified – and documented – relate to the functional tests in the MCA. You need to be able to explain how the deficit you have identified means (even with all practicable support) that the person cannot understand, retain, use and weigh relevant

⁴³ *A Local Authority v AW* [2020] EWCOP 24.

⁴⁴ In *TB v KB and LH (Capacity to Conduct Proceedings)* [2019] EWCOP 14, the court found that P was unable to conduct the proceedings because the deficits in his executive function meant that he was unable to retain information (as he had short-term memory issues) or to use and weigh the information as part of making the decision; the court also found that while there were some compensatory strategies that could be deployed to assist P, they could not compensate for the deficits in his executive functioning. In *A Local Authority v AW* [2020] EWCOP 24, Cobb J found that AW's problems with executive functioning were such as to make him unable to understand the information relevant to residence and care).

⁴⁵ In *TB & KH*, noted above the court had before it evidence of *"glaringly obvious occasions when [P] has not been able to bring to mind information that it is important to know in the moment to make the relevant decision."*

information, or communicate their decision.

F: Flashpoints (3): Refusal to participate in capacity assessment

60. A problem that can be encountered in practice is where the person declines to take part in a capacity assessment.
61. It is important to distinguish between the situation where the person is **unwilling** to take part in the assessment, and the one where they are **unable** to take part. As Hayden J emphasised in *Re QJ*: “[i]t is important to emphasise that lack of capacity cannot be established merely by reference to a person’s condition or an aspect of his behaviour which might lead others to make unjustified assumptions about capacity (s.2(3) MCA). [In this case, a]n aspect of [the person’s] behaviour included his reluctance to answer certain questions. It should not be construed from this that he is unable to. There is a good deal of evidence which suggests that this is a choice.”⁴⁶ It is, though, not necessary mechanically to keep asking the person about each and every piece of relevant information if to do so would be obviously futile or even aggravating.⁴⁷ However, it is always important (1) to consider what steps could be taken to assist the person to engage in the process; and (2) record what steps were taken and what alternative strategies have been used.
62. It is also important to think of ways in which to seek to persuade the person to take part, for instance on the basis that helping the assessor will help them. It is often helpful to liaise with others about what alternative strategies might help. Solutions in reported cases have included identifying whether the reason for non-engagement is embarrassment about particular issues and finding ways which allow the assessing of capacity with requiring confronting the person with the issue,⁴⁸ and giving the person an element of choice as to who will carry out the assessment.⁴⁹
63. If there is reason to think that the person’s non-engagement is down to the actions of another person, it may be necessary to think about the use of inherent jurisdiction, although the Court of Protection could make orders requiring that person to allow access where it has reason to believe that the individual in question may lack capacity.⁵⁰
64. Ultimately, however, it is not possible to force a person to undergo a capacity assessment. It will therefore be necessary to consider whether there is enough surrounding evidence to come to a reasonable belief that the person lacks capacity, if steps are going to be taken on the basis of s.5 MCA 2005. If the stakes are high, for the person or others, then it will be necessary to make an application to court to decide whether the person has or lacks the capacity to make the relevant

⁴⁶ *QJ v A Local Authority & Anor* [2020] EWCOP 7.

⁴⁷ See *AMDC v AG & Anor* [2020] EWCOP 58 at para 28(h) per Poole J, talking about a report to the Court of Protection, but equally relevant to any other report, including for purposes of e.g. DoLS.

⁴⁸ See *Re FX* [2017] EWCOP 36.

⁴⁹ *Wandsworth Clinical Commissioning Group v IA* [2014] EWCOP 990.

⁵⁰ See, for instance, *Re SA* [2011] EWCA Civ 128.

decision.

G: Flashpoints (4): Remote assessment

65. The COVID-19 pandemic has led to a dramatic change in the way that the majority of capacity assessments are carried out. Remote assessments are undoubtedly lawful: the Vice-President set out in *BP v Surrey*⁵¹ the guidance that he had issued on 19 March 2020 to the effect that:

'Can capacity assessments be undertaken by video when it is established that P is happy to do so and can be "seen" alone?

Suggested solution: In principle, yes. The assessor will need to make clear exactly what the basis of the assessment is (i.e. video access, review of records, interviews with others, etc.) Whether such evidence is sufficient will then be determined on a case by case basis. It is noted that GPs are rapidly gaining expertise in conducting consultations by video and may readily adopt similar practices for assessments. Careful consideration will need to be given to P being adequately supported, for example by being accompanied by a "trusted person." These considerations could and should be addressed when the video arrangements are settled. It should always be borne in mind that the arrangements made should be those which, having regard to the circumstances, are most likely to assist P in achieving capacity.⁵²

66. Remote assessment undoubtedly poses particular challenges, and requires considerable creativity. Some of those challenges, and ways in which it is proving possible to overcome those challenges, are discussed in this [webinar](#) led by Alex for the National Mental Capacity Forum. However, the following key points are crucial:

- None of the fundamentals set out above, or below, are altered by the need to conduct assessments remotely. However, preparation – including identification of the decision in question and the information relevant to the decision – becomes all the more important. Indeed, some DoLS assessors have identified that this process means that they are ultimately **more** confident that the assessment that they have reached is robust than might have been the case when they carried out such assessments previously;
- The requirement is always on the assessor to explain why, on the balance of probabilities, they have reached the conclusion that they have as to the person's capacity. Where assessments are taking place remotely, it may well be that the evidence that they take into account includes a considerable amount of 'triangulation' of the evidence that they have

⁵¹ [\[2020\] EWCOP 17](#).

⁵² The independent psychiatrist in fact declined to carry out the assessment remotely but Hayden J "*remain[ed] of the view that creative use of the limited options available can deliver the information required to determine questions of capacity. It may be that experienced carers well known to P and with whom P is comfortable can play a part in facilitating the assessment. Family members may also play a significant role in the process. I am aware that in many areas of the country innovative and productive approaches of this kind are proving to be extremely effective*" (*BP v Surrey (No 2)* [2020] EWCOP 22).

gained by way of the (remote) assessment of P themselves. In a limited number of cases, this surrounding evidence may have to do all the work because it is simply not possible to interact even in a limited way with P remotely;

- In some cases, assessors have identified that, in fact, providing P with technology and enabling a remote assessment constitutes a practicable step to supporting them to make their own decision – for instance, a person with autism who is more comfortable talking by video than face to face.

H: Good capacity assessment and recording

67. A judge has helpfully summed up what makes a good capacity assessment in this way (although this relates to medical treatment, the principles are equally applicable to other contexts):

*The fundamental principles of self-determination, freedom from non-consensual medical treatment and personal inviolability, and the equally fundamental principles behind the right to health, are most respected by **capacity assessments that are criteria-focussed, evidence-based, person-centred and non-judgmental**. Such assessments engage with the demand (or plea) of the person to be understood for who they are, free of pre-judgment and stereotype, in the context of a decision about their own body and private life. (emphasis added)⁵³*

68. A good record of a capacity assessment will show that you have:

- Been clear about the capacity decision that is being assessed;
- Ensured P (and you) have the concrete details of the choices available (e.g. between living in a care home and living at home with a realistic package of care);
- Identified the salient and relevant details P needs to understand/comprehend (ignoring the peripheral and minor details);
- Avoided the protection imperative;
- Demonstrated the efforts taken to promote P's ability to decide and, if unsuccessful, explained why;
- Recognised that assessment is not necessarily a one-off matter, and that you have taken the time to undertake to gather as much evidence as is required to reach your conclusion – including, for instance, returning to have a further conversation with P or obtaining corroborative evidence (particularly important in the case of deficits in executive functioning);

⁵³ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564. The judge in question is an Australian one, the case coming from Victoria, but applying a framework that looks very much like the MCA, and drawing on English case-law.

-
- Evidenced each element of your assessment:
 - (i) Why could P not understand, or retain, or use/weigh, or communicate in spite of the assistance given?
 - (ii) What is the impairment/disturbance? Is it temporary or permanent?
 - (iii) How is the inability to decide caused by the impairment/disturbance (as opposed to something else)?
 - Answered the question: why is this an incapacitated decision as opposed to an unwise one?

69. Verbatim notes of questions and answers can be particularly valuable in the record of the assessment, because they can allow the reader then to get a picture of the nature of the interaction and judge for themselves both the nature of the questions asked and of the responses received.⁵⁴

70. If you are assessing a person's capacity to make a number of different decisions, it is important to take a step back and ask before reaching a conclusion as to the person's decision-making capacity in relation to each decision whether they all make sense logically together. This point was reinforced by the Court of Appeal in *B v A Local Authority*,⁵⁵ in which it emphasised the danger of approaching decisions in 'silos' and reaching mutually incompatible conclusions.

71. In addition to the specific points mentioned above, as with all documentation, the key general points to remember are:

- Contemporaneous documentation is infinitely preferable to retrospective recollection;
- Do not assert an opinion unless it is supported by a fact;
- "Yes/No" answers in any record are, in most cases, unlikely to be of assistance unless they are supported by a reason for the answer;
- What is reasonable to expect by way of documentation will depend upon the circumstances under which the assessment is conducted. An emergency assessment in an A&E setting of whether an apparently brain-injured patient has the capacity to run out of the ward into a busy road will not demand the same level of detail in the assessment or the recording as an assessment of whether a 90 year old woman has the capacity to decide to continue living in her home of 50 years where the concerns relate to her declining abilities to self-care.

⁵⁴ As a judge has noted (in relation to expert reports, but equally relevant to other reports): "[t]he interview with P need not be fully transcribed in the body of the report (although it might be provided in an appendix), but if the expert relies on a particular exchange or something said by P during interview, then at least an account of what was said should be included." See *AMDC v AG & Anor* [2020] EWCOP 58 at para 28(g) per Poole J.

⁵⁵ [2019] EWCA Civ 913.

I: Conclusion

72. As the court memorably put it in *JB*, “do not allow the tail of welfare to wag the dog of capacity”. An extremely foolish or irrational decision is still a decision and one that P is entitled to make if they have capacity to make it. An action can only be taken either in reliance on the general defence in s.5 MCA 2005 (or a decision made by the court) if and when it is proved on the balance of probabilities that (1) P is in fact unable to take the decision in question and (2) this inability is because of an impairment or disturbance in the functioning of the mind or brain.
73. And finally: it is possible to overcomplicate capacity assessments. Especially in the context of those with learning disability and dementia, the key to a successful assessment is patience and empathy. Those are not skills that are the province of particular professionals, but they are ones that can be taught, and need to be nurtured in settings in which it is understood that assessment of capacity to take complex decisions necessarily takes time.

J: Useful resources

74. Useful free websites include:

- www.39essex.com/resources-and-training/mental-capacity-law – database of guidance notes (including as to capacity assessment) case summaries and case comments from the monthly 39 Essex Chambers Mental Capacity Law Report, to which a free subscription can be obtained by emailing marketing@39essex.com.
- www.mclap.org.uk – website set up by Alex with forums, papers and other resources with a view to enabling professionals of all hues to ‘do’ the MCA 2005 better.
- www.mentalhealthlawonline.co.uk – extensive site containing legislation, case transcripts and other useful material relating to both the Mental Capacity Act 2005 and Mental Health Act 1983. It has transcripts for more Court of Protection cases than any other site (including subscription-only sites), as well as an extremely useful discussion list.
- www.scie.org.uk/mca-directory/ - the Social Care Institute of Excellence database of materials relating to the MCA.
- www.nice.org.uk/NG108: - the NICE guideline on decision-making and mental capacity
- www.gmc-uk.org/learningdisabilities/ - extremely useful resource designed in the first instance for doctors, but of much wider application, with particularly useful practical guidance upon communication techniques.
- www.assessright.co.uk/ - a website developed in conjunction between NHS Aylesbury CCG and NHS Chiltern CCG to help health and social care professionals assess capacity for purposes of the MCA 2005.

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