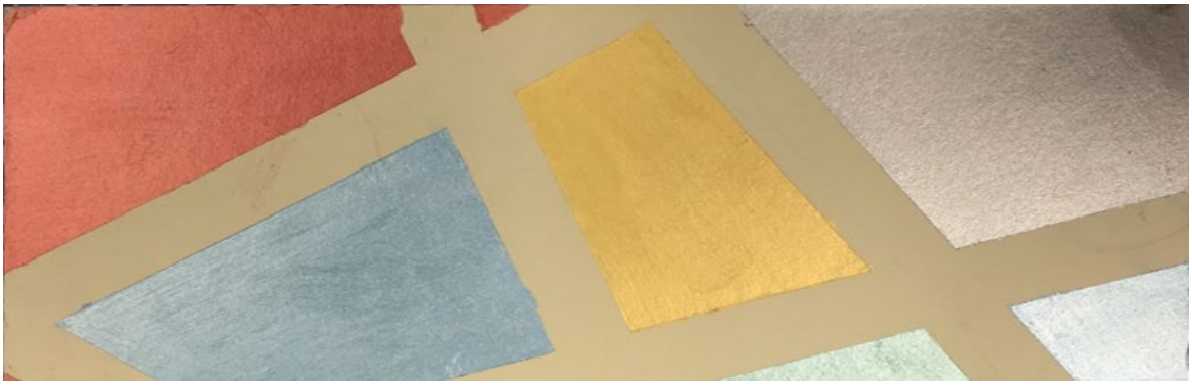
ASSESSING AND DETERMINING MENTAL CAPACITY

May 2025



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.

Editors
Alex Ruck Keene KC (Hon)
Victoria Butler-Cole KC
Neil Allen
Annabel Lee
Nicola Kohn
Katie Scott
Simon Edwards

The picture at the top, "*Colourful*," is by Geoffrey Files, a young autistic man. 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.

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. You may find it also to make use of the website www.capacityguide.org.uk, which draws upon both this guidance and research conducted by the Mental Health and Justice project to give further assistance to those thinking about capacity, especially in more difficult situations.

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 (P[4]) 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.

[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.

8. The assumption that P has decision-making 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 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). Precisely how the assumption 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 assumption 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 be satisfied that P lacks capacity. 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 a mental impairment). But it does mean that the decision-maker cannot outsource the determination of 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 outsource to a psychiatrist colleague the determination of capacity. You may – and in some complex cases may need – to get expert input from that psychiatric colleague during the assessment, 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 also 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 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

[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.
[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).

you are familiar with P's circumstances, incidents where risks have materialised etc.

12. For the vast majority of assessments, "*a prerequisite to evaluation of a person's capacity on any specific issue is at very least that they have explained to them the purpose and extent of the assessment itself*".[9] The only exceptional circumstance where non-disclosure of the assessment's purpose could be justified is on a *Montgomery*-type basis, whereby informing P of its purpose "would be seriously detrimental to the patient's health".[10] There may, separately, be situations in which it is necessary to proceed to reach a conclusion about the person's capacity where it has not been possible to engage with them: we discuss these at paragraphs 73-76 below.

13. The Court of Protection can proceed on an interim basis if there is reason to believe that P lacks capacity to make the relevant decisions.[11] 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 reason to believe that P lacks the relevant capacity and must, in particular, show what practicable steps they have taken to attempt to engage P 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.[12] The position in s.21A MCA 2005 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.[13]

14. 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.[14] We suggest that if there is legitimate doubt about someone's ability to decide a matter, an assessment may be called for.

15. 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:

---

[9] *The London Borough of Wandsworth v M & Ors* [2017] EWHC 2435 (Fam) at para 49 and 71. See also *DP v London Borough of Hillingdon* [2020] EWCOP 45 at para 61 where Hayden J remained "convinced that the failure to inform P as to what an assessment is actually addressing will probably be "fatal to" or, at least, "gravely undermine" the reliability of any conclusion."

[10] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 at para 87–88.

[11] Section 48 MCA 2005. It must also be in P's best interests to make the order, or give the directions, without delay.

[12] On the interface between s.48 MCA 2005 and the inherent jurisdiction, see *Hywel Dda University Health Board v P & Anor* [2024] EWCOP 70 (T3) at paras 14-18.

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

[14] 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.

- Whilst the assumption of capacity is a foundational principle, you should not hide behind it to avoid responsibility for a vulnerable individual.[15] 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.[16]

- If you have legitimate doubt or good cause for concern for thinking 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 an assumption of capacity, [X's] decision was the person's choice."[17] 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.

16. Useful guidance on how to think about the assumption can be found in this passage from the judgment in *Royal Bank of Scotland Plc v AB*:[18]

> *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.*

17. 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?

18. 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 in s.2(1) MCA 2005, [19] which provides

[15] 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.
[16] See, for instance, the cases discussed in *Learning from SARS: A report for the London Safeguarding Adults Board* (July 2017)
[17] 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); see also *Pindo Mulla v Spain* [2024] ECHR 753, in which the Grand Chamber of the European Court of Human Rights considered the balance between Articles 2 and 8 in the medical treatment context, and emphasised the need for consideration of capacity.
[18] [2020] UKEAT 0266_18_2702. The judgment relates to capacity to conduct proceedings before the Employment Tribunal, but the principles are of broader application.
[19] Referred to as the "core determinative provision" in *PC and NC v City of York Council* [2013] EWCA Civ 478 at paragraph 56. See also *A Local Authority v JB* [2021] UKSC 52 at paragraph 65.

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.*

19. To apply the test, it can best be broken down into two questions:

    (1) Is the person able to make a decision? If they cannot:

    (2) Is that because of an impairment or disturbance in the functioning of the person's mind or brain?[20]

20. The Supreme Court in *A Local Authority v JB* confirmed that it is necessary to start with the first question.[21] The Court of Appeal has subsequently made clear that the current Code of Practice at paragraph 4.11:

> *is in direct contradiction to the judgment in Re JB and stipulates the two-stage test of capacity should be approached with the first stage being to establish whether someone has an impairment (i.e. the diagnostic test) and only then to move onto the functional test. A new draft Code dated June 2022 but yet to be implemented, adopts the Re JB approach. Regardless of the fact that the new Code has not yet been implemented, all assessments should comply with the Supreme Court approach.*[22]

21. In addition to it being the law, there are also three sound 'policy' reasons why this order should be followed:

    (a) If you start with the ordering in the Code, 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;[23]

    (b) Linked to this, there is also a risk that the structuring perpetuates the discriminatory approach to those with mental disorders, as it is 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] As discussed below, this second question can usefully be broken down further into identification of whether there is a mental impairment at all, and, if there is, whether the functional inability is caused by that impairment.
[21] See *A Local Authority v JB* [2021] UKSC 52 at paragraph 79.
[22] *MacPherson v Sunderland City Council* [2024] EWCA Civ 1579 at paragraph 36.
[23] This risk was identified by the Court of Appeal in *PC* at paragraph 58.

22. 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 decision in question.

23. In all cases, though, both 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.

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

24. 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).

25. Section 3 is phrased in the negative, so P is unable to decide if unable to do x, y, or z. This means that having capacity means being able to do x, y, and z. So both using *and* weighing relevant information is required, which can make a difference in those complex cases where perhaps a person can weigh but not use. Before looking at each of these limbs, we need to emphasise six cardinal points applying across the board.

26. First, and emphasised by the Supreme Court in *A Local Authority v JB*,[24] capacity is decision-specific. The statement 'P lacks capacity' is, in law, meaningless. You must ask yourself "what is the actual decision in hand"?[25] 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 decide on 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).[26] Indeed, s.3(4), importantly, states that relevant information includes the reasonably foreseeable consequences of deciding *one way or another* (or failing to decide), for example consenting or refusing treatment, or whether or not to reside in a care home. It would be legally perverse were someone to *have* capacity to *consent* to treatment but *lack* capacity to *refuse*

[24] See *A Local Authority v JB* [2021] UKSC 52 at paragraph 79. The Supreme Court collapsed the second and third questions into one, but in practice, it is useful to break them down.
[25] See *PC* at paragraph 40.
[26] This was the position that was addressed in *Heart of England NHS Foundation Trust v JB* [2014] EWHC 342 (COP).

it.[27] The issue is whether P is able to decide one way or another.

27. 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. The only conceivable circumstance would be if to ask would be seriously detrimental to the patient's health.[28]

28. 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. Those reasonably foreseeable consequences can include not just the consequences for P but also, where relevant, the consequences for others.[29] You should record this information and explain which aspect(s) of it P is unable to understand, or retain, or use, or weigh.

29. Fourth, if the decision could have serious or grave consequences, you must test whether P can understand, retain, use and weigh those consequences. Testing in this way is not the same as confusing the outcome of the decision with the person's ability to make it, which the courts have made clear you cannot do. [30] Rather, it is an important safeguard to ensure that whatever decision is reached is reached on a proper basis.

30. Fifth, to comply with s.1(3) MCA 2005, you must take all practicable steps to help P make the decision before concluding that they are nevertheless unable to do so.[31] 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)?

[27] In *An NHS Trust v X* [2021] 4 WLR 11 at paragraph 78, Sir James Munby noted that "'*In relation to those falling within the scope of the Mental Capacity Act 2005, including those who have attained the age of 16, the courts do not examine separately capacity to consent and capacity to refuse medical treatment. Rather, the courts proceed by examining the question of whether the person has the capacity to make a decision in relation to the treatment*,"
[28] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 at paragraphs 87–88.
[29] See *A Local Authority v JB* [2021] UKSC 52 at paragraph 73.
[30] See *PC and NC v City of York Council* [2013] EWCA Civ 478 at paragraphs 53 and 54, *Kings College NHS Foundation Trust v C* [2015] EWCOP 18 at paragraph 29, and *A Local Authority v JB* [2021] UKSC 52 at paragraphs 58-61.
[31] See also here Chapter 2 of the Code of Practice to the MCA 2005.

- 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?[32]

- 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 undergoing work with P to assist them to understand the relevant information, to helping the person to understand that they can even make decisions: as an expert identified in one case observed "in order to make a decision, first one needs to be aware that one is in a position to do so"[33] – this is particularly important in situations where a person has never been given the opportunity to make decisions.

31. Sixth, it is important to be clear-eyed about the line between supporting a person to make a decision and making a disguised best interests decision. If the support required is, in truth, so integral to the decision-making process that the person is in effect carrying out the instructions of others rather than (for instance) responding to prompts, then it is likely that what is going on is best interests decision-making and should be recognised as such.[34]

Is P able to understand the relevant information?

32. It is not necessary that P understands every element of what is being explained to them. What is important is that P can understand the 'salient factors'[35]: 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.

33. The level of understanding required must not be set too high.[36]

34. 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.[37] 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

[32] 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.
[33] See *Re ZK (No 2)* [2021] EWCOP 61 at paragraph 19.
[34] See *C (Capacity to Access the Internet and Social Media)* [2020] EWCOP 73 at paragraphs 40-41.
[35] *LBJ v RYJ* [2010] EWHC 2664 (Fam).
[36] *PH and A Local Authority v Z Limited & R* [2011] EWHC 1704 (Fam).
[37] *CC v KK & STCC* [2012] EWHC 2136 (COP).

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.[38]

35. When you are making an assessment of capacity it is vital that you ask yourself the questions set out at paragraph 74. 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?

36. We repeat the need to be precise about the information in question.

37. 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.'

38. This is an important consideration, particularly when dealing with those with deteriorating memories. Capacity is the assessment of the ability to make a decision 'at the 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 the relevant information?

39. Using information, we suggest, involves being able to apply the information to the decision the person is facing in the real world. So in some cases it is necessary to focus on whether the person can use the information 'in the moment' and, if not, whether that inability is because of mental impairment. Importantly, 'the notional decision-making process attributed to the protected person … should not become divorced from the actual decision-making process carried out in that regard on a daily basis by persons of full capacity'.[39]

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. We consider the ability to use further below in the context of executive dysfunction.

Is P able to weigh the relevant information?

41. This aspect of the test has been described as *'the capacity actually to engage in the decision-making*

[38] *CC v KK & STCC* [2012] EWHC 2136 (COP).
[39] *JB v A Local Authority* [2021] UKSC 52 at para 75.

process itself and to be able to see the various parts of the argument and to relate the one to another.'[40] As with understanding, it is not necessary for a person to weigh every detail of the respective options available to them, merely the salient factors. Therefore, even though a person may be unable to weigh some information relevant to the decision in question, they may nonetheless be able to weigh other elements sufficiently to be able to make a capacitous decision.[41]

42. 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.[42] Or P may not believe the information provided, but that does not inevitably mean P is unable to weigh it. The Court of Appeal has held that there is no belief requirement in the statutory test, which requires no gloss:

> *The proper application of the statutory test does no more than reflect that, where there is an objectifiable verifiable medical consensus as to the consequences of having or not having medical treatment, if the patient does not believe or accept that information to be true, it may be that they are unable to understand and or use and weight the information in question.*[43]

43. Further, if a person is able to weigh the relevant information, the weight to be attached to that information in the decision making process is a matter for that person. [44] 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 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.

44. 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.

Is P able to communicate their decision?

45. It is important to understand how this limb of the test was intended to work. It was designed to address the situation where the person may well have been to make a decision: in other words, to understand, retain, use and weigh the relevant information, but cannot then communicate the decision that they have made. It is therefore a limb of the test which was meant only to apply to a very limited group of people, for instance those with locked-in syndrome, or after a stroke, who may, despite all practicable steps, be unable to communicate. In effect, it was a limb of the test

[40] *The PCT v P, AH & the Local Authority* [2009] EW Misc 10 (COP).
[41] *Kings College NHS Foundation Trust v C and V* [2015] EWCOP 80 at paragraph 37.
[42] "[T]*here 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.
[43] *Re Thirumalesh (dec'd)* [2024] EWCA Civ 896 at paragraph 129.
[44] *Kings College NHS Foundation Trust v C and V* [2015] EWCOP 80 at paragraph 38.

designed to provide a 'work around' for the fact that it is simply impossible to tell whether, in fact, the person is able to make a decision. In such a situation, the law provides that people can then proceed in the name of the person's best interests.

46. Care should therefore be used if you are relying upon the communication limb to check that it is actually doing 'analytical' work and not simply relying true but superfluous information. In other words, if 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.

47. 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.

48. Although the legislative history of the criterion suggests that it should only be used for a narrow category of cases set out above, research shows that the courts seem, to have broadened the criterion to also to include the situation where the person is unable to express a stable preference:[45] in such a situation, the assessor does not have access to the person's real choice. In any such situation, further probing should be done to see whether another rationale is not a better explanation for the apparent inability to express a choice.

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

(i) Mental impairment

49. 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. As a judge has put it, a formal diagnosis "*may constitute powerful evidence informing the answer to the second cardinal element of the single test of capacity, namely whether any inability of* [P] *to make a decision in relation to the matter in issue is because of an impairment of, or a disturbance, in the functioning of the mind or brain.*"[46] However, it is entirely legitimate to reach such a conclusion in the absence either of a formal diagnosis or without being able to formulate precisely the underlying condition or conditions.[47] To this extent, therefore, the

[45] Note, **inability** to express a stable preference is different to being **able** to, but **unwilling**. See the Flashpoint 'engagement challenges' below.
[46] *North Bristol NHS Trust v R* [2023] EWCOP 5 at paragraph 48.
[47] See also *Pennine Acute Hospitals Trust v TM* [2021] EWCOP 8 at paragraph 37.

term "diagnostic" test which is often referred to is misleading.

50. An impairment or disturbance can include medical conditions causing confusion, drowsiness, concussion, and the symptoms of drug or alcohol abuse. It 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.

51. Sometimes there will be no pre-existing medical evidence which helps you answer the questions of whether P has an impairment or disturbance in the functioning of the mind or brain, and, if so, what precisely it is. If you are not, yourself, a medical practitioner, this does not always mean that you have to seek medical evidence at that point: depending on the circumstances, you may well be able to give a sufficient explanation as to what you consider the impairment or disturbance is which means that the person is unable to make their own decision. However, the more serious the implications of the decision or the more complex the situation, the more likely that it is that you will need to consider whether you can appropriately say that you have a reasonable belief as to P's decision-making capacity without medical evidence which can help you explain what the impairment or disturbance is.

52. Note that 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.[48]

(ii) Causative nexus

53. If P cannot make a decision (i.e. they cannot do one or more of the functional things identified above), it is important to explain why: is it "because of" a mental impairment – sometimes called the 'causative nexus.'[49] Any pro forma form for the assessment of capacity that does not include a 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 resumed 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.

54. 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.[50]

55. There will be situations in which it is not entirely easy to identify whether a person is unable to make

[48] See *WBC v Z* [2016] EWCOP 4.
[49] *PC and NC v City of York Council* [2013] EWCA Civ 478 at paragraph 52.
[50] *Kings College NHS Foundation Trust v C and V* [2015] EWCOP 80 at paragraph 31.

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

56. 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.

57. In such cases, there will sometimes be 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

58. The consequences of fluctuating capacity will depend upon the context. There may be situations in which a person's fluctuating capacity will solely impact upon the extent to which they can be held to the legal consequences of their actions (for instance in relation to property and affairs); there may also be situations in which their fluctuating capacity will impact upon the ability of others to rely upon their consent. 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).

59. Two main problems present themselves in the context of fluctuating capacity:[51]

- A person is misidentified as having the material decision-making capacity, purports to refuse the act, and the act is not carried out on the basis of the apparently capacitous refusal, and the

[51] Another problem is where the person in fact lacks capacity to make the decision but incapacitously assents to whatever it is that the professional is proposing. That gives rise to other issues, but for present purposes, our focus is on where there is not this alignment.

person either suffers serious adverse consequences or dies;

- A person is misidentified as lacking the material capacity, and an act is carried out in the face of what is, in fact, a capacitous refusal, giving rise to a breach of their Article 8 ECHR rights and liability on the part of the professionals concerned.

60. Outside the court setting, it will always be for relevant professionals to determine whether the person has, or lacks, the relevant capacity at the time that care or treatment is being recommended or offered. In a situation of risk, and given the operational duties imposed by Articles 2, 3 and 8 ECHR, there is likely to be an obligation in a case of fluctuating capacity on the relevant professional to explain why in relation to any given decision they determined that the person in question had capacity to refuse a necessary intervention.[52]

61. Especially if the stakes are high, legal advice should be sought to help think through:

- Whether is really a case of fluctuating capacity, or a situation where there is a temporary problem with which the person can be supported (as required by s.1(3) MCA 2005);

- If it is a case where the person's capacity fluctuates, what measures can be taken to support them undertake advance planning to help work out what course of action should be taken at the points when they do not have the capacity to make the decision(s) in question;

- If is genuinely a case of fluctuating capacity, whether it is appropriate to rely upon the informal approach set out above (combined with advance planning) or whether the Court of Protection should be involved; or

- Whether – unusually – this is a 'contingency' case where the person currently **has** capacity to make the relevant decision but is likely to lose it under very specific circumstances. An example of this is the case of *GSTT v R* [2020] EWCOP 4 (involving birth arrangements): it is extremely important in such a situation that the court is involved as early as possible.

One-off decisions

62. 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.[53] 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

[52] This reflects, amongst other things, the concern expressed by the House of Lords Select Committee conducting post-legislative scrutiny of the MCA 2005 (HL Paper 139 (March 2014)): "[t]*he presumption of capacity, in particular, is widely misunderstood by those involved in care. It is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm. In some cases this is because professionals struggle to understand how to apply the principle in practice. In other cases, the evidence suggests the principle has been deliberately misappropriated to avoid taking responsibility for a vulnerable adult*" (para 105). For an analysis of the position in relation to the presence of suicide risk, see this blog post by Alex.

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

need to be taken in their best interests, they can be taken in knowledge of what they would want.

63. If it is not possible to put the decision off, then you should take the minimum action necessary to 'hold the ring' pending the person regaining decision-making capacity.

Repeated or continual decisions

64. Some decisions are not one-off and need to be repeated or continue over a period of time. So the 'material time' for the decision is longer. Examples include the management of property and affairs,[54] 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 longer 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.

65. When determining capacity on this longitudinal basis, factors such as the unpredictability of the loss of capacity, as well as the seriousness and breadth of its impact, are likely to be relevant to the determination.[55] The courts have shown themselves increasingly willing to take this approach,[56] or, closely-linked, the approach of 'zooming out' to ask themselves a macro-question if appropriate.[57]

66. If a longitudinal approach is taken, you should make clear why that is by reference to the decision in question and 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

67. Precisely how to characterise the 'material time' in relation to the capacity assessment under DoLS is legally complicated at the level of principle.[58] However, the Deprivation of Liberty Safeguards Code of Practice, in essence, suggests that the same approach as set out above in relation to repeated/continual decisions should be taken in the context of deprivation of liberty.[59]

[54] *A, B and C v X and Z* [2012] EWHC 2400 (COP) at paragraph 37.
[55] *Cheshire West And Chester Council v PWK* [2019] EWCOP 57 at paragraphs 25. For a more recent summary of the principles, see Calderdale Metropolitan Borough Council v LS & Anor [2025] EWCOP 10 (T3), at paragraphs 9-12.
[56] See *Cheshire West And Chester Council v PWK* [2019] EWCOP 57.
[57] 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).
[58] For discussion, see the Law Commission's report on *Mental Capacity and Deprivation of Liberty* at paragraphs 9.38 and onwards.
[59] See paragraphs 8.22-8.24.

E: Flashpoints (2): Executive functioning

68. 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. Such scenarios typically sit on the horns of the capacitous unwise decision versus incapacity dilemma. It may also be that there is evidence that they cannot bring to mind relevant information at the point when they might need to implement a decision that they have considered in the abstract.

69. Both of these situations are frequently referred to in clinical practice under the heading of 'executive dysfunction.' Particularly in the context of brain injury, reference is often made to 'frontal lobe paradox', which describes situations where those with damage to the frontal lobe can perform well in interview settings despite significant impairments in everyday life.[60] In such cases, it is important to gather the real-world evidence before putting it to the person whose capacity is being questioned. Executive functioning 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."*[61] But it is important to recognise that the two are not synonymous: executive dysfunction derives from clinical practice; mental capacity is the test prescribed by the 2005 Act.[62]

70. People often say one thing and do another without their capacity being doubted. But where there is sufficient evidence of conflict or divorce between what a person says and what they do which they cannot rationalize or otherwise explain, this may call for a deeper enquiry into their (in)ability to 'use' and/or weigh relevant information. Failing to carry out a sufficiently detailed capacity assessment in such situations can expose the person to substantial risks.

71. If the person can account for the evidential differences, these may simply be unwise decisions. If, however, there is documented evidence of a glaring disparity between knowing and doing which cannot be explained – which is likely to require more than one assessment – this could be evidence of incapacity if it is because of a mental impairment. However, in such a case, explaining how the conflict between a person's understanding and a failure to follow through or convert to action is 'because' of the mental impairment will require particular explanation and justification.[63] It is also a situation in which it is likely that specialist assessment will be required before a final conclusion can be reached.

72. Like any capacity assessment, but of particular importance in these scenarios, a 3-dimensional

[60] For example, see MS George and SJ Gilbert, 'Mental Capacity Act (2005) Assessments: Why Everyone Needs to Know about the Frontal Lobe Paradox' (2018) 1(5) The Neurologist 59–66; S Newstead et al, 'The Paradox of the Frontal Lobe Paradox: A Scoping Review' (2022) Frontiers in Psychiatry 13: 913230.
[61] *A Local Authority v AW* [2020] EWCOP 24.
[62] Warrington BC v Y *& Ors* [2023] EWCOP 27 at paragraph 45.
[63] For example, see *Warrington BC v Y & Ors* [2023] EWCOP 27, where there was a dispute between a neuropsychologist and a neuropsychiatrist as to whether the person's dissociation was pathological or part of her normal everyday behaviour.

assessment is required. In other words, your assessment should draw evidence not just from what the person says but also from the real world and from speaking with those who know the person best. Your focus may be on whether P is unable to use the information 'in the moment' because of the mental impairment. P's 'notional decision-making process … should not become divorced from the actual decision-making process carried out in that regard on a daily basis by persons of full capacity'.[64] Any determination of incapacity on this basis must, as always, be based upon clearly documented evidence of repeated conflict which is unlikely to be available on the basis of one assessment alone.

F: Flashpoints (3): Engagement challenges

73. A problem that can be encountered in practice is where it is difficult to engage the person in the capacity assessment. 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*."[65] 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.[66] 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.

74. 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,[67] and giving the person an element of choice as to who will carry out the assessment.[68]

75. 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 lacks capacity.[69]

76. Ultimately, however, it is not possible to force a person to undergo a capacity assessment. It will

[64] *JB v A Local Authority* [2021] UKSC 52 at para 75. See also *TB & KH*, noted above where the court had 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.*"
[65] *QJ v A Local Authority & Anor* [2020] EWCOP 7.
[66] 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.
[67] See *Re FX* [2017] EWCOP 36.
[68] *Wandsworth Clinical Commissioning Group v IA* [2014] EWCOP 990.
[69] See, for instance, *Re SA* [2011] EWCA Civ 128.

therefore be necessary to consider whether there is enough surrounding evidence from the other sources 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 decision.

G: Flashpoints (4): Remote assessment

77. Remote assessments are undoubtedly lawful: the then-Vice-President, Hayden J set out in *BP v Surrey*[70] 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.'*[71]

78. Remote assessment undoubtedly poses particular challenges and requires considerable creativity if it has to be undertaken. It should never be undertaken simply for administrative or professional convenience. 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

[70] [2020] EWCOP 17.
[71] 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).

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 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

79. The Vice President helpfully provided a checklist as to what makes a good capacity assessment, and explained the difference between the clinical concept of insight and the legal concept of capacity:[72]

> *(1) The first three statutory principles in s 1 MCA 2005 must be applied in a non-discriminatory manner to ensure those with mental impairments are not deprived of their equal right to make decisions where they can be supported to do so.*
>
> *(2) In respect of the third principle regarding unwise decisions, particular care must be taken to avoid the protection imperative and the risk of pathologising disagreements.*
>
> *(3) As set out in A Local Authority v JB [2021] UKSC 52, whether the person is able to make the decisions must first be addressed. Only if it is proven that one or more of the statutory criteria are not satisfied should the assessor them proceed to consider whether such inability is because of a mental impairment.*
>
> *(4) Those assessing capacity must vigilantly ensure that the assessment is evidence-based, person-centred, criteria-focussed and non-judgmental, and not made to depend, implicitly or explicitly, upon the identification of a so-called unwise outcome.*
>
> *(5) Insight is a clinical concept, whereas decision making capacity is a legal concept. Capacity assessors must be aware of the conceptual distinction and that, depending on the evidence, a person may be able to make a particular decision even if they are described as lacking insight into their general condition.*
>
> *(6) In some cases, a lack of insight may be relevant to, but not determinative of, whether the person has a mental impairment for the purposes of s2 MCA 2005.*
>
> *(7) When assessing and determining the legal test for mental capacity, all that is required is the application of the statutory words in ss2-3 MCA 2005 without any gloss; having 'insight' into mental impairment is not part of that test.*

[72] *CT v London Borough of Lambeth & Anor* [2025] EWCOP 6 (T3).

(8) Relevant information will be different in each case but will include the nature of the decisions, the reason why the decision is needed, and the likely effects of deciding one way or another, or making no decision at all.

(9) The relevant information is to be shared with the individual and the individual should be supported to understand the relevant information. The individual is not required to identify relevant information him/herself.

(10) If a lack of insight is considered to be relevant to the assessment of capacity, the assessor must clearly record what they mean by a lack of insight in this context and how they believe it affects, or does not affect, the person's ability to make the decision as defined by the statutory criteria, for example to use/weigh relevant information.

80. Another judge has equally helpfully summarised judicial expectations as to the recording of capacity assessments:

Given the number of capacity assessments that are required to be carried out on a daily basis in multiple arenas, it would obviously be too onerous to require a highly detailed analysis in the document in which the capacity decision is recorded. However, a careful and succinct account of the formulation of the matter to be decided and the formulation of the relevant information in respect of that matter, together with a careful and concise account of how the relevant information was conveyed and with what result, would seem to me to be the minimum that is required.[73]

81. In more detail, a good record of a capacity assessment will show that you have:

- Been clear about the 'matter' that P is being asked to decide upon, and what decision they are being asked to take;
- Identified why you have reason to doubt their capacity to make this decision (nb, this is just as important where the outcome of the assessment is that you consider that they have capacity);
- Identified the salient and relevant details P needs to understand/comprehend (ignoring the peripheral and minor details);
- 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);
- 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 –

[73] *North Bristol NHS Trust v R* [2023] EWCOP 5 at paragraph 65.

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);

- Evidenced each element of your assessment:

  (i) Why could P not understand, or retain, or use, or weigh, or communicate in spite of the assistance given?

  (ii) 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?

82. 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.[74]

83. 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*,[75] in which it emphasised the danger of approaching decisions in 'silos' and reaching mutually incompatible conclusions.

84. 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 factual evidence;
- "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.

I: Conclusion

85. As the court memorably put it in *Heart of England NHS Trust v JB*, "*do not allow the tail of welfare to*

[74] 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.
[75] [2019] EWCA Civ 913. See also *Liverpool City Council v CMW* [2021] EWCOP 50.

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 (1) P is 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.

86. 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. These 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

87. 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.capacityguide.org.uk – a website which draws upon both this guidance and research conducted by the Mental Health and Justice project to give further assistance to those thinking about capacity, especially in more difficult situations.
- www.lpslaw.co.uk – a website set up by Neil which includes videos, papers and other materials (much of them free) relating both to the Liberty Protection Safeguards and the MCA 2005 more widely.
- 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.
- https://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/ - an extremely useful resource designed in the first instance for doctors, but of much wider application, with particularly useful practical guidance upon communication techniques.

.

Sheraton Doyle
Senior Practice Manager
sheraton.doyle@39essex.com

Peter Campbell
Senior Practice Manager
peter.campbell@39essex.com