

# The Mental Capacity Act 2005



July 2022 Why should we use it? What difference does it make?

## 1. Consent and the MCA are linked



NHS guidance: *'For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision. The meaning of these terms are:*

- **voluntary** – the decision to either consent or not to consent to treatment must be made by the person, and must not be influenced by pressure from medical staff, friends or family
- **informed** – the person must be given all of the information about what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments, and what will happen if treatment does not go ahead
- **capacity** – the person must be capable of giving consent, which means they understand the information given to them and can use it to make an informed decision'

*'If an adult has the capacity to make a voluntary and informed decision to consent to or refuse a particular treatment, their decision must be respected.'* <https://www.nhs.uk/conditions/consent-to-treatment/>

## 2. We want to safeguard adults (and save lives)



### Analysis of Safeguarding Adult Reviews

April 2017 – March 2019

December 2020: The first national review of SARs analysing 231 SARs involving the deaths of 188 people. The SARs cover all types of care providers and professional groups (ambulance staff, police, nurses, doctors, social workers etc)

*'For direct practice, attention to mental capacity was the most prevalent theme. The majority of the observations in this theme were related to poor practice...'*

*'Failure to assess: There were numerous mentions of failure to assess mental capacity when to do so was warranted.'*

[www.local.gov.uk/analysis-safeguarding-adult-reviews](http://www.local.gov.uk/analysis-safeguarding-adult-reviews)

## 3. We want to save lives (Coroner's reports)



### 5 May 2021: Laura Booth, Coroner's report (prevention of future deaths)

Laura Booth died aged 21 whilst a patient at the Royal Hallamshire Hospital. She had a learning disability and was in hospital for a routine eye operation. The coroner found she: *'...developed **malnutrition** due to inadequate management of her nutritional needs. Her death was **contributed to by neglect.*** Matters of concern raised by the coroner included:

- *'I remain **gravely concerned that Senior Clinicians have limited or no understanding of the Mental Capacity Act and apply it in a way which undermines the principles and requirements of the legislation.***

<https://www.judiciary.uk/publications/laura-booth/>

### 4 October 2021: Jude Daryl Lloyd, Coroner's report (prevention of future deaths)

Jude Daryl Lloyd had chronic schizo-affective disorder and diabetes. He was admitted to a mental health NHS Trust and detained under Section 3 of the Mental Health Act. The Coroner found he died of *'Natural Causes **contributed to by Neglect***' and identified the following concern: *'During the course of the admission he refused to take his diabetic medication or agree to blood sugar testing. He denied having Diabetes or mental health problems...**No formal mental capacity assessment was undertaken or recorded.*** He died of diabetic ketoacidosis at home after his discharge.

<https://www.judiciary.uk/publications/jude-lloyd-prevention-of-future-deaths-report/>

### 3 December 2021: Terence Talbot, Coroner's Report (prevention of future deaths)

Terence suffered a rare and severe reaction to Olanzapine and Risperidone prescribed for Bipolar Affective Disorder whilst he was detained under the MHA 1983. The Coroner found the care provided by both a mental health NHS Trust and an acute NHS Trust: *'...amounted to a **gross failure to provide basic medical care...*** and *'Issues relating to capacity to make specific decisions in relation to Terence Talbot's care and treatment **were not all subjected to formal Mental Capacity Act assessments** when he was refusing medical interventions that were in his best interests...'*

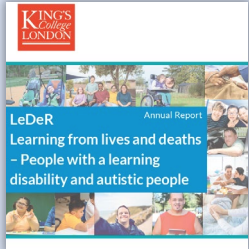
<https://www.judiciary.uk/publications/terence-talbot-prevention-of-future-deaths-report/>

## 16 March 2022: Billy Longshaw, Coroner's Report (prevention of future deaths)

Billy Longshaw died aged 22, he had significant learning disabilities. He was taken to A&E following sudden abdominal pain and vomiting. He was allowed to discharge himself without basic blood tests being taken and no assessment of his mental capacity to make this decision (this was described in the records as 'self-discharged against medical advice'). He died 24 hours later. The coroner found: *'Mr Longshaw's death raises issues as to the **adequacy of education provided to medical students as to the Mental Capacity Act 2005, and doctors' of all levels familiarity with the practical application of this legislation...***'

<https://www.judiciary.uk/publications/billy-longshaw-prevention-of-future-deaths-report/>

## 4. We want to save even more lives



**July 2022:** Kings College London (commissioned by NHS England and NHS Improvement), *LeDeR, Learning from lives and deaths – people with a learning disability and autistic people, 2021.*

This review of **2,553 deaths** found: *'In primary and community care the main concern in the responses was **lack of adherence to the Mental Capacity Act (MCA)**, in that the Act was sometimes not clearly discussed when decisions were made, or that its principles were not followed.'* and *'Similar issues were flagged in hospital in-patient care with a number of reviewers commenting on the Mental Capacity Act "not being referred to," or being poorly understood and implemented.'*

## 5. We want to act legally (and not be taken to court)



**Court of Appeal – Master of the Rolls, Lord Dyson:**

*'As I have said, the Mental Capacity Act does not impose impossible demands on those who do acts in connection with the care or treatment of others. It requires no more than what is reasonable, practicable and appropriate.'*

The failure of police officers to use the Mental Capacity Act when dealing with a man with autism in a public swimming pool. The Court of Appeal agreed with the lower judge that the officers were liable for trespass to the person, assault, battery and false imprisonment. Case of: *ZH v Commissioner of Police for the Metropolis* [2013] EWCA Civ 69

<https://www.bailii.org/ew/cases/EWCA/Civ/2013/69.html>

## 6. We want to meet CQC standards of care



**Regulation 11: Need for consent**

**Providers must have regard to the following guidance:** *'Where a person lacks mental capacity to make an informed decision, or give consent, staff **must** act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.'*

**Note:** This regulation applies to all CQC registered care providers.

[www.cqc.org.uk/regulations-11-need-consent](http://www.cqc.org.uk/regulations-11-need-consent)

Inadequate

**Barnsley Hospice, June 2022, Inadequate rating**

CQC inspectors found: *'Capacity was not recorded at the point of referral and was not considered until the patient was admitted. In addition, capacity was not formally assessed until a significant event occurred.'*

<https://www.cqc.org.uk/location/1-106225323>

**Lorna House, residential care home, June 2022, Inadequate rating**

CQC inspectors found: *'Care was not always provided with the consent of the relevant person or in accordance with the Mental Capacity Act 2005. This was a breach of regulation 11 (Need for consent)...'*

<https://www.cqc.org.uk/location/1-137550986>

## 7. We want to meet our professional standards of practice

**Nursing & Midwifery Council: The Code: Professional standards of practice and behaviour for nurses and midwives**

*'4.2 make sure that you get **properly informed consent** and document it before carrying out any action'*

*'4.3 keep to all relevant **laws about mental capacity that apply** in the country in which you are practising'*

**General Medical Council: Good medical practice**

*17. 'You must be satisfied that you have **consent or other valid authority\*** before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research.'*

**Health & Care Professions Council: Standards of conduct, performance and ethics**

*1.4 'You must make sure that you have **consent from service users or other appropriate authority\*** before you provide care, treatment or other services.'*

\* *Other authority* when a person is unable consent = the MCA (assessment of mental capacity and best interests)

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From the authors of: [Working with the Working with the Mental Capacity Act \(3rd edition\) S. Richards & AF. Mughal](#)  
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