Neutral Citation Number: [2023] EWCOP 58

Case No: 14107818

IN THE COURT OF PROTECTION

Sessions House,
Lancaster Road,
PRESTON PR1 2PD
Date: 21 December 2023

Before :

HIS HONOUR JUDGE BURROWS
Sitting as a nominated judge of the Court of Protection

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Between:

STOCKPORT METROPOLITAN BOROUGH COUNCIL	**Applicant**
- and -	
(1) KB	**Respondents**
(by her litigation friend, the Official Solicitor)	
(2) STOCKPORT LOCAL MEDICAL COMMITTEE	
(3) GREATER MANCHESTER ICB	

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Neil Allen (instructed by **the local authority solicitor**) for the **Applicant**
Ben McCormack (instructed by **Simpson Millar** by the **Official Solicitor**) for the **First Respondent**
Matthew Stockwell (instructed by **BMA Law**) for the **Second Respondent**
Nicola Kohn (instructed by **Hempsons**) for the **Third Respondent**

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JUDGMENT

This judgment was delivered in public, and the proceedings are subject to the Transparency Order dated 21 July 2023. The anonymity of KB must be strictly preserved, and nothing must be published that would identify KB, either directly or indirectly. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

HIS HONOUR JUDGE BURROWS:

OUTLINE & SUMMARY

1. This case is about KB. In many ways KB's case is an archetypal *Re-X* case for which the COPDOL11 procedure was invented. She is a middle-aged woman with what is said to be a lifelong learning disability that deprives her of her capacity to make decisions about her residence and care. Furthermore, the package of care necessarily deprives her of her liberty. No one has any doubts that she lacks capacity, and that her arrangements are in her best interests. However, actual evidence of her mental disorder appears not to be available. Certainly, no professional medical evidence was placed before me.

2. There are two closely related issues that have practically prevented the *Re-X* route being taken in this case. The first is whether, in order to satisfy the requirement under Article 5§1(e), namely that P suffers from "unsoundness of mind", the evidence upon which that conclusion is based has to say so in those terms? Secondly, whether the Court, either in its guise as a judge considering a COPDOL11 application on the papers, or via an application under the COP1 procedure, has to be in possession of evidence from a medical doctor?

3. Although I have treated this case as a COP1 brought before me and I have in no way sought to provide more general guidance, what I conclude may be of wider application.

4. In summary, my conclusions are:

   (1) In the context of applications to authorise a package of care, which inevitably results in P being deprived of his or her liberty, the Court must be satisfied that P

suffers from unsoundness of mind. However, these words have no mystical powers; they are not an "open sesame" giving access to the Article 5 cave. They refer to a mental disorder. It is for the court to be satisfied that P is of unsound mind on the basis of the evidence before it. Provided that evidence satisfies the Court that P has a mental disorder, and subject of course to the other essential requirements also being satisfied, the Court may authorise detention.

(2) The European Court of Human Rights (ECtHR) jurisprudence is clear that "unsoundness of mind" has to be proved by those seeking to assert it on sound medical evidence. Usually that evidence will come from a medical doctor, generally a psychiatrist or General Practitioner. Whether, in appropriate circumstances that evidence could come from a psychologist, mental health nurse, or other similar specialist clinical expert may be a moot point. It is one I do not have to decide in this case. I simply direct that the Applicant needs to commission and instruct a registered medical doctor, either a psychiatrist or a GP, to review KB's case and provide a report dealing with her diagnosis as well as whether that condition causes her to lack capacity to make relevant decisions, as well as the likely duration of that condition.

THE GENERAL BACKGROUND TO THIS APPLICATION

5. It is exactly ten years ago that the Supreme Court was considering its decision in the Cheshire West case: P v Cheshire West & Chester Council; P & Q v Surrey County Council [2014] UKSC 19. Having heard argument in October 2013 the judgment was eventually handed down in March 2014. It is debatable whether the final formulation to be applied when deciding whether an incapacitous person receiving social care is deprived of their liberty should have come as a surprise. However, three important points came out of the judgment.

(1) First, the objective definition of deprivation of liberty followed on very closely to that given by the ECtHR in HL v United Kingdom (2004) 40 EHRR 761. P had to be under continuous supervision and control and not be free to leave their place of residence.

(2) Secondly, Article 5 applied not just to those in Hospitals and registered care homes, but to those in less- or non- institutional placements, even in their own

home. That meant that Schedule A1 of the Mental Capacity Act 2005 (MCA), the "Deprivation of Liberty Safeguards" (or DOLS), an administrative process for the authorisation of deprivation of liberty, would not cover many of the cases identified as deprivations of liberty post-Cheshire West. Applications would have to be made to the Court of Protection.

(3) Finally, the reason why the Supreme Court approved of this approach was because above all, this "acid test" prevented an approach being taken to a particularly vulnerable cohort of people, those who lacked capacity as per the MCA, which was inherently and unjustifiably discriminatory. In other words, the proper comparator when considering the living arrangements and restrictions imposed on a person with a mental disorder and lacking capacity was an ordinary member of the public, not another person with those characteristics. That latter approach had been taken by the Court of Appeal, applying the test to be taken with children to incapacitated adults: see Cheshire West & Chester Council v P [2011] EWCA Civ. 1257, per Munby, L.J.

6. There were, of course, consequences that followed from this definition. One of them was the anticipated and dramatic increase in the number of cases coming before the Court of Protection to authorise packages of care that fell outside the statutory regime. This prompted the then President of the Court of Protection and Family Division, Sir James Munby to list a number of these cases before him in order to fashion a fast-track procedure which would take uncontentious cases out of the COP1 application procedure and allow the Court to deal with these cases on the papers: see Re X (Court of Protection; Deprivation of Liberty)(Nos 1 & 2) [2015] 1 WLR 2454). After an uncertain start (see the Court of Appeal in Re X (Court of Protection Procedure) [2015] EWCA Civ 599, per Black, L.J.) the Re-X procedure was brought into existence, largely due to the efforts of the then Vice President, Mr Justice Charles: see Re NRA [2015] EWCOP 59.

7. In that case, Charles, J. recognised that the Supreme Court's application of Article 5 to the living arrangements of those receiving essentially social care in a community environment seemed not be in accordance with other ECHR jurisdictions. Furthermore, many found it difficult to characterise such arrangements as a deprivation of liberty: see [9]. However, the Court of Protection had to follow the

Supreme Court's decision in Cheshire West. Furthermore, at [7], his Lordship said that if one took Articles 5§1(e) and 4 together "it should always be remembered that the process that renders deprivation of liberty lawful also protects those who provide, or arrange the provision of, the care package". In other words, clarity protected the detained person, but it also protected those detaining them.

8. The streamlined procedure, often referred to as the "Re X procedure" is commenced by the issuing of an application using form COPDOL11. That form contains the information necessary for the Court to decide whether to authorise P's deprivation of liberty.

9. The form includes Annex A "Evidence in support of an application to authorise a deprivation of liberty". That comprises (with tick boxes):

> "**1. Assessment of capacity**
>
> [ ] I confirm that P has been assessed as having an impairment or disturbance in the functioning of the mind or brain and lacks the capacity to consent to the measures proposed and the deprivation of liberty which is identified within the application"

There is a tick-box indicating that a COP3 (the capacity asessment) or equivalent evidence is attached.

10. Then comes the critical part:

> **2. Mental Health Assessment- Unsoundness of mind**
>
> [ ] I confirm that P has been medically diagnosed as being of 'unsound mind' and I attach written evidence from a medical practitioner.
>
> If your assessment of capacity on form COP3 has not been completed by a registered medical practitioner, you must attach written evdeince from a registered medical practitioner containing a diagnosis that P suffers from a diagnosis of 'unsoundness of mind'.

(There then follow boxes confirming the attachment of the relevant documentation).

11. There are notes attached to the Form providing "General Information for completing form". The relevant notes for Annex A "Evidence in Support of Application" (emphasis added):

> In most cases the allocated social worker with the relevant skill and knowledge, involved with the care arrangements may complete the form. However, if one or

more of the trigger factors apply, someone independent (who may still be employed by the applicant public authority) to the allocated social worker should provide the evidence.

- The purpose of the mental health assessment is to establish that P has been **diagnosed as being of 'unsound mind'**, and therefore comes within the scope of article 5 of the European Convention on Human Rights.
- The evidence may be provided by a registered medical practitioner or psychiatrist, evidence from a social worker or other non-medical practitioner listed in the notes to form COP3 will not be accepted. **The practitioner does not need to be approved under section 12 of the Mental Health Act 1983.**
- The mental health assessment **may** take the form of a letter **setting out the diagnosis, including reference to whether P is of 'unsound mind', the name of the practitioner and their qualifications**. If it is not possible to provide the original letter, a copy certified by the applicant as a true copy of the original will be acceptable. The evidence should not be more than 12 months old.
- In cases where suitable mental health evidence is not readily available, then it would be acceptable to provide the assessment of capacity and mental health assessment as a single document using form COP3, but the combined evidence must be provided by a registered medical practitioner or psychiatrist…..

THE PROBLEM

12. Although I am not concerned in this case with a COPDOL11 application, the reason this case comes before me as a COP1 application is because a number of applications made by Stockport MBC have not been accepted because of the requirements of this form seemingly not having been met.

13. A statement from the social worker in this case, Ms Zammit, explains the problem facing this Applicant. They commission services for around 800 individuals with either learning disability or autism under either the Care Act 2014 or s. 117 of the Mental Health Act 1983 (MHA, and many of those receive care in the community living either with their families or in either shared lives or supported living arrangements. Many of those people lack the capacity to consent to their arrangements. Very few have ongoing contact with a consultant psychiatrist. The only contact they will generally have with a registered medical practitioner will be their GP. It is good practice for members of this cohort to have an annual health check from their GP. Quite sensibly, in these circumstances, the Applicant formulated a

letter asking the relevant person's GP to certify (or not) that P was "of unsound mind".

14. There was concern on the part of GPs about the wording to be used in their letter in response. The term "of unsound mind" is not one contemporary GPs are happy to use as a diagnostic label. I will deal with this concern below.

15. Secondly, the GPs were understandably unwilling to carry out an assessment they did not feel qualified to carry out. If the letter in response was going to be used in any way as a mental health assessment it was thought they would need to have been section 12 approved doctors under the MHA'83. In fact, s.12 MHA approval is relevant only to the process of authorising detention within that Act, often referred to as "sectioning". As the COPDOL11 form makes clear, s. 12 approval is not required for an assessment to be made in this process. Notwithstanding that, however, any clinician who does not consider themselves able to certify that a patient has a mental disorder or is "of unsound mind", must not do so.

16. There was a further concern that to undertake such work would be additional to what is normally expected of them. Indeed, on 15 December 2022, the Honorary Secretary of the Second Respondent wrote a letter to the local GPs about requests to provide evidence in response to the Applicant's letters. The LMC urged GPs "to think about the possible medicolegal implications of putting their name to such a statement". Furthermore, they would "advise practices to consider the impact of the time spent responding to such a request may have on practice workload hen there is a nationally recognise[d] workload crisis….".

17. It was further explained to me by the ICB that none of the three forms of standard contract, GMS Contract, PMS Agreements, or APMS contract, all heavily regulated by statute, and complex, oblige GPs to provide medical evidence to public bodies for Court of Protection applications. Clearly, because the ICB had no direct involvement in KB's care they were unable to provide such evidence themselves.

18. The Applicant had changed the wording in their letter from "unsound mind" to "mental impairment". However, in their first position statement I was told that in three cases issued under COPDOL11, using that language, the Court rejected the applications.

19. Apparently for that reason, when this application was brought, the Applicant submitted no medical evidence of unsound mind at all. The order sought was to clarify "the requirements for the court to make a declaration that [KB] lacks capacity to decide on care and accommodation in circumstances where neither [KB] nor anyone concerned with her welfare object[s] to the care arrangements…" Along with that the Court was asked to authorise KB's undoubted deprivation of liberty.

20. HHJ Berkley made the first order on 21 July 2023 which contained interim declarations as to KB's incapacity to litigate, make decisions about care and residence and to sign a tenancy agreement. He also appointed the Official Solicitor to act as KB's litigation friend. The matter was then referred to me because it was submitted by the parties that it ought to be allocated either to the Senior Judge, HHJ Hilder or even to the Vice President, Theis, J. In all the circumstances, I decided that I should hear the matter and give a decision.

UNSOUND MIND &THE CORRECT PROFESSIONAL EVIDENCE

21. I was fortunate to have very helpful submissions both in writing and orally from counsel. I was pointed in the direction of the relevant caselaw in the ECtHR. Since ss.64(5) and (6) MCA imports the ECHR meaning of deprivation of liberty directly into the Act, that is essential. I have considered a number of cases, as well as the ECHR Guide on Article 5 from which Ms Kohn quoted.

22. It seems to me going back to Winterwerp v The Netherlands (1979) 2 E.H.R.R 387 is the natural place to start. At [37] the judgment states:

> The Convention does not state what is to be understood by the words 'persons of unsound mind'. This term is not one that can be given a definitive interpretation; was pointed out by the Commission, the Government and the applicant, it is a term whose meaning is continually evolving as research in psychiatry progresses, and increasing flexibility in treatment is developing and society's attitudes to mental illness change so that a greater understanding of the problems of mental patients is becoming more widespread".

In my judge this makes it clear that the term unsound mind is primarily a legal term and is not necessarily the term expected to be used by the expert giving the medical opinion. That legal term will develop as psychiatry and the public's attitude towards the mentally disordered changes.

23. In subsequent cases, it has become very clear that what is meant by "unsound mind" is mental disorder. In Ilnseher v Germany (10211/12 and 27505/14) from 4 December 2018 for instance at [129], the Court says (emphasis added):

> "as regards the first condition for a person to be deprived of his liberty as **being of "unsound mind", namely that a true mental disorder must have been established** before a competent authority on the basis of objective medical expertise, the Court recalls that, despite the fact that the national authorities have a certain discretion in particular on the merits of clinical diagnoses (see HL v the United Kingdom…….) the permissible grounds for deprivation of liberty listed in Article 5§1 are to be interpreted narrowly. **A mental condition** has to be of a certain severity in order to be considered as a 'true' mental disorder for the purposes of sub-paragraph (e) of Article 5§1 as it has to be so serious as to necessitate treatment in an institution for mental health patients"

Ilnseher was a case involving a forensic mental health detained patient, but the point would equally apply to any detained person under Article 5§1(e), including those in the community.

24. Finally, in Rooman v Belgium [2019] ECHR 105 (18052/11) from 31 January 2019 at [192] the term mental disorder is used interchangeably with the term unsound mind.

> As regards the deprivation of liberty of persons suffering from mental disorders, an individual cannot be considered to be of "unsound mind" and deprived of his liberty unless the following three minimum conditions are satisfied: firstly, **he must reliably be shown to be of unsound mind; secondly, the mental disorder must be of a kind or degree warranting compulsory confinement**; thirdly, the validity of continued confinement depends upon the persistence of such a disorder (see *Winterwerp*, cited above, § 39, and *Stanev*, cited above, § 145, with the cases cited therein).
>
> [1] With regard to the second of the above conditions, concerning in particular the detention of **a mentally disordered person**, this indicates that detention may be necessary not only where the person needs therapy, medication or other clinical treatment to cure or alleviate his condition, but also where the person needs control and supervision to prevent him, for example, causing harm to himself or other persons (see *Hutchison Reid v. the United Kingdom*, no. 50272/99, § 52, ECHR 2003-IV, and *Stanev*, cited above, § 146).

25. I would add that the definition of mental disorder applicable in England is that contained in the MHA at s. 1(2), namely "'mental disorder' means any disorder or disability of the mind". It seems clear to me that a person suffering from a learning disability has a mental disorder so defined. In the MHA there is a provision that

excludes those with learning disability from being detained under certain sections of the MHA without more; namely, their disability must be "associated with abnormally aggressive or seriously irresponsible conduct on [their] part". However, learning disability is a mental disorder and, under the MCA, which has no such exemption, a person can be detained without the conduct mentioned above.

26. It is the Court that must be satisfied that there is "unsoundness of mind". If the Court is satisfied there is a mental disorder, that may satisfy the criteria under Article 5§1(e), depending on the other circumstances, namely the "kind and degree" of the disorder, and whether it is causally connected to P's incapacity to make decisions.

27. I am only being asked to decide this case. I am not laying down guidance to other Court of Protection judges, including those determining COPDOL11/Re X applications. However, I do not consider that a judge making a decision as to whether P is of unsound mind has to see those exact words used by a clinician in the evidence given. What the Judge must receive is reliable evidence of mental disorder.

28. Of course, it is important to be clear, as those who appeared for the parties in front of me insisted, that the Court remembers that the mental disorder must be the cause of the mental incapacity. Does that mean that the expert certifying P to have a mental disorder must also express the opinion that it is the disorder that causes P to lack capacity? In my view, it is not necessary for that to be the case provided the Court is able legitimately to decide on all the evidence that there is a causal nexus between the disorder and P's incapacity.

29. Of course, the Re X procedure was introduced for those cases for which there was little complexity, disagreement or uncertainty on the essential requirements for the authorisation of P's deprivation of liberty. There are wide case management powers for a Judge dealing with COPDOL11. Important here is that the Court must be guided by Practice Direction 11A. Also the Court must be guided by the comprehensive judgment of HHJ Hilder, the Senior Judge of the Court of Protection, on the issue of which cases should and should not be dealt with on COPDOL11 in Bolton Council v KL (by his litigation friend, the Official Solicitor) [2022] EWCOP 24.

30. This case concerned whether the applications for authorisation of deprivation of liberty of those who are 16 or 17 should be dealt with under COPDOL11, to which the

Senior Judge's answer was invariably "no". At [56] she says:

> The streamlined application was devised to meet the *minimum* requirements for compliance with Convention and domestic law, by abbreviating the procedural requirements of the standard COP1 application process. The difference between the standard and the streamlined court procedures is the intensity of scrutiny. The COPDOL11 process is very definitely not a 'rubber-stamping' procedure but it relies on judicial antennae alone to identify from paperwork if/where further enquiry is required.

Critical pointers to the case being taken off the Re X route included [86]:

> In my judgment, KL's age at the time of the application, his being subject to a Care Order at the time of the application, his absence of family contact and the imminence of transition to adult services **were** all reasons which clearly led to the conclusion that he should be independently represented, by joinder as a party and appointment of a Litigation Friend for him. As Litigation Friend of last resort, the appointment of the Official Solicitor was required.

It seems clear to me in addition, where there are complex issues over diagnosis or the causal nexus, or where there is a substantial disagreement over best interests, the COPDOL11 route is inappropriate.

31. It will be clear by now from the quotes from the cases that what is required is reliable medical evidence of mental disorder. The word "medical" connotes that the evidence is of and pertaining to the science of medicine. It is clear to me that means a registered medical practitioner. There is no need to elaborate on that in this case. Here it means either a psychiatrist or a GP. Whether a wider net can be cast for other clinicians, such as clinical psychologists, learning disability nurses, or occupational therapists, may be a moot point. However, in this case the evidence needed is from a medical doctor.

32. That is what I direct. The Applicant will ensure that the court is furnished with a report from a registered medical practitioner competent in giving his or her opinion on KB's condition. It does not have to be a psychiatrist, although it may be. It could be a GP. I am not directing a Court of Protection visitor to be instructed. I am not directing a s. 49 report. Finally, I am not directing a jointly instructed expert. None of those are appropriate in this case, at least not at this stage.

33. Having looked at this case as a whole, I regret to say that the Applicant has the burden of ensuring that the MCA and Article 5 of the ECHR is complied with. They have not discharged that burden at the present time. They issued proceedings without a vital

component for their case. Pragmatically and quite rightly, the Court made interim declarations on the evidence before it. The matter was then listed for a decision as to what evidence was needed. It would have been disproportionate and frankly absurd if the Court had dismissed the Applicant's application for want of evidence. However, in future it is for the Applicant to ensure that there is evidence of unsoundness of mind as well as incapacity before commencing proceedings. I hope that in future in a case that is an archetypal Re X case that will be done, and the matter started by way of COPDOL11.

34. I hope directions can be agreed without the need for a hearing before the report is commissioned and available.

KB AND HER FAMILY

35. Finally, despite all the words above, this case is about KB. From what I have read she is contented where she is and receiving entirely excellent care. She is able to maintain her relationship with her family who clearly love her and care about her very much. I can only imagine how difficult it is for parents of highly vulnerable adults as they become older and less able to care directly for their child, and increasingly fearing what will happen to their child once they are gone. At the first hearing over which I presided, KB's father was on the remote link. Unfortunately, due to a breakdown in communication with him he had travelled into Manchester for an in person hearing, not knowing that it had been transferred to me, sitting remotely at Preston. He was a little flustered as well as somewhat bewildered at why four barristers, a team of solicitors and people from the various parties were appearing before a Judge because of his daughter's living arrangements. He clearly is entirely happy with his daughter's arrangements. I hope I dispelled any concerns he had that the Court was there to judge him or his family.

36. However, I did emphasise why the Court of Protection is in place. It is there to ensure that the most vulnerable people are not treated in a way that is less favourable than they would be if they were not disabled. If KB's is a straightforward and uncontroversial case, then no doubt some will wonder what all the fuss was about. But it is important that a fuss is made about KB to ensure she is in the right place with the right package of care.

37. That completes this judgment.