UA-2022-000151-HM

THE UPPER TRIBUNAL
(ADMINISTRATIVE APPEALS CHAMBER)

UPPER TRIBUNAL CASE NO: UA-2022-000151-HM
[2022] UKUT 166 (AAC)
DD v SUSSEX PARTNERSHIP NHS FOUNDATION TRUST AND SECRETARY OF STATE FOR JUSTICE, MIND INTERVENING

Decided following an oral hearing on 12 May 2022.

Representatives

DD	Roger Pezzani of counsel, instructed by Adam Marley of GT Stewart Solicitors and Advocates
The Trust	Dr Roddy Ley, formerly DD's responsible clinician
Secretary of State	Took no part
MIND	Stephen Simblet QC instructed by Rheian Davies, Head of Legal, MIND

DECISION OF UPPER TRIBUNAL JUDGE JACOBS

THE UPPER TRIBUNAL ORDERS that:

Pursuant to rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008 (SI No 2698), no one shall, without the consent of the Upper Tribunal, publish or reveal:

(a) the name or address of DD, who is the Appellant in these proceedings,

(b) or any information that would be likely to lead to the identification of him or any member of his family in connection with these proceedings;

but the decision itself may be made public.

On appeal from the First-tier Tribunal (Health, Education and Social Care Chamber)

Reference:	MP/2021/25440
Decision date:	25 November 2021

Although the decision of the First-tier Tribunal involved the making of an error on a point of law, it is NOT SET ASIDE under section 12(2)(a) of the Tribunals, Courts and Enforcement Act 2007.

REASONS FOR DECISION

1. The issue that originally arose in this case was whether the First-tier Tribunal retained jurisdiction on an application made by the patient who was subject to hospital and restriction orders when the application was made, but who had been conditionally discharged before the hearing. Before the hearing of the appeal to the Upper Tribunal, the patient ceased to be subject to the Mental Health Act 1983. That rendered the outcome of the appeal academic, which raised the question whether I should decide the issue. I did so and have decided that the First-tier Tribunal retained jurisdiction.

A. The background

2. The background is complicated and confusing. What follows is not complete, but it is sufficient to the purposes of this appeal. I am grateful to counsel and DD's solicitor for their joint efforts at unravelling what happened.

3. On 20 September 2016, DD was convicted of offences and sent to prison.

4. He was later charged with further offences. In order to follow what happened next, it is necessary to understand the Criminal Procedure (Insanity) Act 1964. In 2019, the issue arose whether he was fit to be tried on those further offences. The decision that he was unfit was made by a judge without a jury under section 4(5). Section 4A then provided for the jury to decide whether he did the act or made the omission in the charge:

> (2) The trial shall not proceed or further proceed but it shall be determined by a jury—
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> (a) on the evidence (if any) already given in the trial; and
>
> (b) on such evidence as may be adduced or further adduced by the prosecution, or adduced by a person appointed by the court under this section to put the case for the defence,
>
> whether they are satisfied, as respects the count or each of the counts on which the accused was to be or was being tried, that he did the act or made the omission charged against him as the offence.
>
> (3) If as respects that count or any of those counts the jury are satisfied as mentioned in subsection (2) above, they shall make a finding that the accused did the act or made the omission charged against him.

The jury's decision led to the making, on 18 October 2019, of hospital and restriction orders under the Mental Health Act 1983, as authorised by section 5 of the 1964 Act:

> (1) This section applies where–
>
> …
>
> (b) findings have been made that the accused is under a disability and that he did the act or made the omission charged against him.
>
> (2) The court shall make in respect of the accused–

(a) a hospital order (with or without a restriction order); …

5. I will need to refer to the 1964 Act again, but meanwhile back to the history. On 27 September 2021 with the hospital and restriction orders still in force, DD applied to the First-tier Tribunal. A few weeks later, on 15 October 2021, the Secretary of State directed that he be conditionally discharged; the only condition was that he 'reside at HM Prison'. I was told that the Parole Board considered that this condition prevented the Board from considering parole in respect of the earlier offences.

6. On 29 November 2021, the First-tier Tribunal decided that, following and as a result of the conditional discharge, it no longer had jurisdiction to hear DD's application. On 18 February 2022, the tribunal gave DD permission to appeal to the Upper Tribunal.

7. The Secretary of State was later satisfied that DD could properly be tried. Section 5A(4) of the 1964 Act then applied. This provides for the orders to cease to have effect after a person's mental health has improved sufficiently to be tried:

> (4) Where–
>
> (a) a person is detained in pursuance of a hospital order which the court had power to make by virtue of section 5(1)(b) above, and
>
> (b) the court also made a restriction order, and that order has not ceased to have effect,
>
> the Secretary of State, if satisfied after consultation with the responsible clinician that the person can properly be tried, may remit the person for trial, either to the court of trial or to a prison. On the person's arrival at the court or prison, the hospital order and the restriction order shall cease to have effect.

Once the orders ceased to have effect, the proceedings in the Upper Tribunal became academic in the sense that DD's discharge and the issue of the First-tier Tribunal's jurisdiction no longer arose for decision. Just to complete the history, DD was acquitted at the Crown Court on 1 April 2022, on the Crown offering no evidence.

B. Why I dealt with the issue although it had become academic

8. As I have explained, DD ceased to be subject to the Mental Health Act 1983 after he had been given permission to appeal by the First-tier Tribunal and had lodged his appeal with the Upper Tribunal. In that sense, his appeal became academic. That does not mean that this tribunal ceased to have jurisdiction. Permission is merely a threshold condition, meaning that it does not lapse if the grounds on which it was given cease to obtain. The Upper Tribunal retains jurisdiction so long as there is a point of law arising from the decision under appeal: section 11(1) of the Tribunals, Courts and Enforcement Act 2007 and *Secretary of State for Work and Pensions v Robertson* [2015] CSIH 82 at [42]-[45]. In this case, there is a point of law, so the question is whether I should exercise my jurisdiction and decide it.

9. The courts have recognised that they retain jurisdiction to decide issues that are academic and have developed criteria to control the exercise of that jurisdiction. Those criteria differ according to whether the case involves private or public law. The latter

are the more relevant to the work of the Administrative Appeals Chamber. Mr Pezzani conveniently referred me to what Singh LJ said in *Unite the Union v McFadden* [2021] EWCA Civ 199:

> 36. The fact that permission to appeal was granted does not mean that this Court is bound to consider it: indeed this was common ground between the parties. The Court retains a discretion to determine an appeal in such circumstances if it would be in the public interest to do so. The position was summarised by Simler LJ in *Rehoune v London Borough of Islington* [2019] EWCA Civ 2142, at paras. 18-19:
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> > 18. There is no dispute that the court has discretion to determine an appeal that has become academic. The leading authority on the exercise of that discretion remains the decision in *R v Secretary of State for the Home Department ex parte Salem* [1999] 1 AC 450 (HL) where at 456-457 Lord Slynn held:
> >
> > > … in a cause where there is an issue involving a public authority as to a question of public law, your Lordships have a discretion to hear the appeal, even if by the time the appeal reaches the House there is no longer a *lis* to be decided which will directly affect the rights and obligations of the parties *inter se* … The discretion to hear disputes, even in the area of public law, must, however, be exercised with caution and appeals which are academic between the parties should not be heard unless there is a good reason in the public interest for doing so, as for example (but only by way of example) when a discrete point of statutory construction arises which does not involve detailed consideration of facts and where a large number of similar cases exist or are anticipated so that the issue will most likely need to be resolved in the future.
> >
> > 19. Subsequent cases have emphasised how narrow the discretion is. In *Hutcheson v Popdog Ltd (News Group Newspapers Ltd, third party) (Practice Note)* [2012] 1 WLR 782 (which was not a public law case and did not involve a public authority) Lord Neuberger of Abbotsbury MR held that the 'mere fact' that an appeal might raise a point of significance did not mean that it should be allowed to proceed where it is academic as between the parties (paragraph 12). He identified the following propositions (at paragraph 15):
> >
> > > Both the cases and general principle seem to suggest that, save in exceptional circumstances, three requirements have to be satisfied before an appeal, which is academic as between the parties, may (and I mean 'may') be allowed to proceed: (i) the court is satisfied that the appeal would raise a point of some general importance; (ii) the respondent to the appeal agrees to it proceeding, or is at least completely indemnified on costs and is not otherwise inappropriately

> prejudiced; (iii) the court is satisfied that both sides of the argument will be fully and properly ventilated.

10. The criteria set out in those cases cannot simply be transferred and applied to the work of the Administrative Appeals Chamber of the Upper Tribunal. Without intending to be comprehensive:

- Proceedings before this Chamber may not involve a *lis*, as Diplock LJ explained in *R v Deputy Industrial Injuries Commissioner ex p Moore* [1965] 1 QB 456 at 486:

  > . . . a claim by an insured person to benefit is not strictly analogous to a *lis inter partes*. Insurance tribunals form part of the statutory machinery for investing claims, that is, for ascertaining whether the claimant has satisfied the statutory requirements which entitle him to be paid benefit out of the fund. In such an investigation, neither the insurance officer nor the Minister (both of whom are entitled to be represented before the insurance tribunal) is a party adverse to the claimant.

- The Chamber has limited jurisdiction to award costs: rule 10 of the Tribunal Procedure (Upper Tribunal) Rules 2008 (SI No 2698).
- It is often unrealistic to expect full arguments on all sides as many of our cases involve unrepresented parties, and even public bodies may refrain from taking part in the argument, as the Trust and Secretary of State have done in this case.

11. I have already explained how the Upper Tribunal has retained jurisdiction in respect of the issue on which permission was given. I am now going to explain why I have exercised the jurisdiction to decide the issue despite it having become academic. I am not purporting to lay down principles that apply generally. It is their combination in the circumstances of this case that matter. What follows represents the combined efforts of Mr Pezzani and Mr Simblet, with a small contribution from me.

12. The appeal raised a point of law that arose at the time the appeal was lodged and will surely arise again. It is as yet undecided by the Upper Tribunal or the senior courts. The issue is one of jurisdiction and important as such. Being jurisdictional, the analysis will not depend on the facts of the particular case in which the issue is decided. Most importantly, it affects the availability of judicial protection for the liberty of the subject.

13. If the issue is not resolved now, it will have to be resolved at some time, and when that time comes, there will inevitably be delay and uncertainty about a subject's liberty. A decision now will avoid the delay and the consequences that may follow in the future. As Mr Simblet reminded me, the House of Lords refused to hear the issue in *Salem* and it was some years before it was resolved.

14. DD has legal aid, so he has been represented by solicitors and specialist counsel. I have joined MIND and thereby acquired the specialist expertise of its legal adviser and Mr Simblet.

15. The decision will be taken by a specialist judge. The courts have emphasised the importance of an issue being argued on all sides to allow a soundly-based decision. That cannot always be guaranteed in the Administrative Appeals Chamber, which

compensates for this through the expertise that its judges develop in their jurisdictions and by taking an inquisitorial and proactive approach to identifying and resolving issues. The Court of Appeal recently described this approach as 'commendably proactive' in *Carrington v Commissioners for Her Majesty's Revenue and Customs and Secretary of State for Work and Pensions* [2021] EWCA Civ 1724 at [10].

16. Finally, in this case, the lack of argument on all sides was offset by Mr Pezzani setting up a counter argument to the one he was advancing in order to assist the tribunal. I am grateful to him for taking that trouble.

C. Why the First-tier Tribunal retained jurisdiction

17. The simplest way to explain jurisdiction is to quote what I wrote in *AD'A v Cornwall Partnership NHS Trust* [2020] UKUT 110 (AAC):

> 7. A tribunal has authority only to operate within the jurisdiction conferred on it by statute. If it has no jurisdiction, it is under a duty to strike out the proceedings. In the case of the First-tier Tribunal's mental health jurisdiction, that duty is imposed by rule 8(3)(a).
>
> 8. The nature of jurisdiction was defined by Diplock LJ in *Garthwaite v Garthwaite* [1964] P 356 at 387:
>
> > In its narrow and strict sense, the 'jurisdiction' of a validly constituted court connotes the limits which are imposed on its power to hear and determine issues between persons seeking to avail themselves of its process by reference (i) to the subject-matter of the issue, or (ii) to the persons between whom the issue is joined, or (iii) to the kind of relief sought, or any combination of these factors.
>
> 9. This does not mean that a tribunal necessarily loses jurisdiction if one of those three factors is wrong or changes. Thinking of a typical civil proceeding, like a personal injury claim: (i) the pleadings may need to be amended – for example, to add an additional head of claim; (ii) a party may need to be removed or added – for example, the defendant may be changed from a doctor to the Trust for whom the doctor worked; and (iii) the relief sought may be altered – for example, to add a claim for interim relief. The rules under which these changes are permitted cover two possibilities: (a) they allow mistakes to be corrected in the way that the proceedings were originally constituted; and (b) they allow changes to be made in the light of developments. In other words, once a tribunal has acquired jurisdiction, it may be possible under its rules of procedure to make changes that allow it to retain jurisdiction.
>
> 10. A tribunal's jurisdiction is different from the powers it has within that jurisdiction. These may change if the law changes or if the circumstances of the case change.
>
> 11. These general points translate to the context of this case like this: as the proceedings were originally properly constituted, the rules of procedure may allow the parties to be changed and the substantive powers and duties available

to the tribunal may change to reflect the change in the patient's status. The issue therefore becomes whether those results would be consistent with the Mental Health Act 1983.

18. How did those principles apply in this case? The answer depends on the Mental Health Act 1983. The section that governs the First-tier Tribunal's jurisdiction is section 73, but that section refers back to some of the provisions of section 72:

> **72 Powers of tribunals**
>
> (1) Where application is made to the appropriate tribunal by or in respect of a patient who is liable to be detained under this Act or is a community patient, the tribunal may in any case direct that the patient be discharged, and—
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> …
>
> (b) the tribunal shall direct the discharge of a patient liable to be detained otherwise than under section 2 above if it is not satisfied—
>
> (i) that he is then suffering from mental disorder or from mental disorder of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or
>
> (ii) that it is necessary for the health of safety of the patient or for the protection of other persons that he should receive such treatment; or
>
> (iia) that appropriate medical treatment is available for him; …
>
> **73 Power to discharge restricted patients**
>
> (1) Where an application to the appropriate tribunal is made by a restricted patient who is subject to a restriction order, or where the case of such a patient is referred to the appropriate tribunal, the tribunal shall direct the absolute discharge of the patient if—
>
> (a) the tribunal is not satisfied as to the matters mentioned in paragraph (b)(i), (ii) or (iia) of section 72(1) above; and
>
> (b) the tribunal is satisfied that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment.
>
> (2) Where in the case of any such patient as is mentioned in subsection (1) above—
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> (a) paragraph (a) of that subsection applies; but
>
> (b) paragraph (b) of that subsection does not apply,
>
> the tribunal shall direct the conditional discharge of the patient.
>
> (3) Where a patient is absolutely discharged under this section he shall thereupon cease to be liable to be detained by virtue of the relevant hospital order, and the restriction order shall cease to have effect accordingly.
>
> (4) Where a patient is conditionally discharged under this section—

(a) he may be recalled by the Secretary of State under subsection (3) of section 42 above as if he had been conditionally discharged under subsection (2) of that section; and

(b) the patient shall comply with such conditions (if any) as may be imposed at the time of discharge by the tribunal or at any subsequent time by the Secretary of State.

(5) The Secretary of State may from time to time vary any condition imposed (whether by the tribunal or by him) under subsection (4) above.

(6) Where a restriction order in respect of a patient ceases to have effect after he has been conditionally discharged under this section the patient shall, unless previously recalled, be deemed to be absolutely discharged on the date when the order ceases to have effect and shall cease to be liable to be detained by virtue of the relevant hospital order.

(7) A tribunal may defer a direction for the conditional discharge of a patient until such arrangements as appear to the tribunal to be necessary for that purpose have been made to its satisfaction; and where by virtue of any such deferment no direction has been given on an application or reference before the time when the patient's case comes before the tribunal on a subsequent application or reference, the previous application or reference shall be treated as one on which no direction under this section can be given.

(8) This section is without prejudice to section 42 above.

19. When DD applied to the First-tier Tribunal, its jurisdiction was conferred by section 73(1) and (2). The issues were set out in those subsections and the relief available depended on which conditions were satisfied. Once DD was conditionally discharged, the relief sought narrowed to the conditions to be imposed. As I have said, the condition that DD reside in a prison effectively prevented the Parole Board from considering parole. Although DD's status had changed by reason of the conditional discharge, there was still an issue under section 73 over which the tribunal retained jurisdiction. It was, therefore, wrong to decide that it no longer had jurisdiction.

20. This result is not surprising. The Upper Tribunal has decided in other circumstances that First-tier Tribunal retains jurisdiction despite a change in the patient's status after the date of their application but before it is heard and decided. The decisions are:

- Detention changed from section 2 to section 3: *KF v Birmingham and Solihull Mental Health Foundation Trust* [2010] UKUT 185 (AAC), [2011] AACR 3.
- Detention under section 3 changed to a community treatment order: *AA v Cheshire and Wirral Partnership NHS Foundation Trust* [2009] UKUT 195 (AAC), [2011] AACR 37.
- Detention under section 3 (after a community treatment order had been revoked) changed to a new community treatment: *PS v Camden and Islington NHS Foundation Trust* [2011] UKUT 143 (AAC), [2011] AACR 42.

- Detention under section 3 changed to guardianship: *AD'A v Cornwall Partnership NHS Trust* [2020] UKUT 110 (AAC).
- Restrictions under sections 47/49 changed to restrictions under sections 37/41: *CS v Elysium Healthcare and the Secretary of State for Justice* [2021] UKUT 186 (AAC).

21. This outcome is not, though, inevitable. It will not apply if it is inconsistent with the structure of the Mental Health Act. That is what happened in *GM v Dorset Healthcare NHS Trust and the Secretary of State for Justice* [2020] UKUT 152 (AAC). I decided that the First-tier Tribunal lost jurisdiction on an application that had been made when the patient was liable to be detained under section 3 but was later made the subject of a hospital order without a restriction before the hearing. It is convenient to quote the summary of my reasoning:

> 7. The Act provides for judicial oversight of compulsory detention. Patients who are detained in pursuance of an application for treatment under section 3 are given the right to apply to the First-tier Tribunal within six months (section 66(1)(b) and (2)(b)), which is how long the initial authority to detain lasts (section 20(1)). That ensures that the *initial* detention is potentially subject to judicial oversight. Thereafter, patients are given the right to apply to the tribunal once within each period for which authority to detain is renewed under section 20 (section 66(1)(f) and (2)(f)). That ensures that the *subsequent* detention is potentially subject to regular judicial oversight. If the patient does not exercise those rights, the Act imposes protective duties on the hospital managers, requiring them to refer their case to the tribunal after six months (section 68(2) to (5)) and then after three years (section 68(6)). Those provisions are well-known, so I have not lengthened this decision by setting them out. I take them as read.
>
> 8. In the case of a patient under a hospital order but with no restriction order, the Act modifies the patient's right to apply for initial scrutiny and the hospital managers' duty to refer. The modifications are contained in Part I of Schedule 1 to the Act. In short, they remove the patient's right to apply to a tribunal within the first six months (by modifying section 66) and the hospital managers' duty to refer the patient's case to the tribunal if the patient has not exercised that right (by modifying section 68). Those provisions show a clear statutory policy that there should be no judicial oversight for the first six months following a hospital order. The rationale is the obvious one that as the order has been made by a court, there has been judicial oversight of the initial detention.
>
> 9. It would be contrary to that statutory policy, if the tribunal were to retain jurisdiction under an application or reference that was made before the date of the hospital order. This distinguishes the circumstances of this case from the decisions that have decided that an application survives a change in the status of the patient.
>
> 10. Moreover, the tribunal's jurisdiction when there has been a change in the status of the patient depends on the tribunal exercising the powers of discharge applicable to the patient's status at the time of the hearing. As the tribunal has no

> jurisdiction at all in the first six months of a hospital order, it cannot have any power of discharge that it can exercise. It is, therefore, conceptually impossible to apply the reasoning in the Upper Tribunal cases that have taken that approach to cases like the present.
>
> 11. Finally, I have considered the possibility that the reference might be in abeyance during the first six months that the hospital order was operative but then revive giving the tribunal jurisdiction. I can find no conceptual or legal basis for that result under the Act or the tribunal's rules of procedure.

22. In this case, I can find nothing inconsistent with my analysis that the tribunal retains jurisdiction. Quite the reverse. If the First-tier Tribunal ceased to have jurisdiction when DD was conditionally discharged, he would not be able to apply to the tribunal again for 12 months (see section 75). And it is possible to construct scenarios in which a series of conditional discharges and recalls would operate to prevent the tribunal ever having jurisdiction to hear an application. That would remove any guarantee of judicial oversight. These scenarios are not fanciful. They are realistic ones for a patient with a fluctuating condition; Mr Simblet drew my attention of *R (MM) v Secretary of State for the Home Department* [2007] EWCA Civ 786 as an example of a patient's status changing swiftly in response to fluctuations.

23. Judicial oversight is an important matter. Lack of it undermines a central policy in the protection of patients. I mentioned it in the passage I have quoted from *GM* and identified it as a policy in *AD'A*:

> 15. The patient was admitted for treatment pursuant to an application under section 3. That application was supported by clinical recommendations under section 3(3). There is a clear policy in the Act that, when detention is based on clinical decision-making, the patient is given access to the tribunal for judicial supervision of their detention. That policy is effected by section 66(1)(b) and (2)(b), which provides for the patient to apply to the tribunal within six months. Section 68 then provides a back stop for the hospital managers to refer the case to the tribunal if the patient has not taken advantage of section 66. And section 67 confers a power on the Secretary of State to refer a patient's case to the tribunal at any time.
>
> 16. The tribunal's jurisdiction is essential for that process to work. It is integral to the operation of the Act and is conferred on the tribunal by section 66. It deals with applications to the tribunal. That is what the heading to the section says and that is what it does. The patient made an application on 16 May 2019. At that stage, she was detained under section 3. There is no doubt that the tribunal acquired jurisdiction. And it acquired the powers in exercise of that jurisdiction under section 72(1)(b).

Mr Pezzani identified the doctrinal underpinning for my approach in the modern emphasis on context in statutory interpretation, as explained by Leggatt LJ in *R (CXF) v Central Bedfordshire Council* [2019] 1 WLR 1862 at [19]-[21] and traced the history of this policy to the Lunacy Act 1890 and beyond to the Act for Regulating Private Madhouses 1774, which introduced inspections by Justices of the Peace.

24. As I have said, Mr Pezzani constructed a case against himself in order to test his argument. One factor he drew to my attention was the possibility that the Secretary of State would refer a patient's case to the First-tier Tribunal. I accept that that would go some way towards preventing indefinite detention without judicial oversight, but I do not consider that a discretionary power is sufficient to override my analysis of the tribunal's jurisdiction.

25. Just for completeness, Mr Pezzani also referred to the possibility of applying section 3 of the Human Rights Act 1998. I have not found it necessary to rely on that section, as no violation of a Convention right arises on ordinary principles of interpretation.

D. MIND's argument

26. I have already mentioned Mr Simblet's contributions, but I have yet to mention the submission he made on behalf of MIND. I record it as having been made in case it is relevant later. Mr Simblet argued that 'decisions such as the one taken by the judge in this case and which delay or deprive the speedy consideration of discharge, or the basis upon which it might be given, are likely to have a discriminatory effect. As the statistics attached to this submission show, there is a significant over-representation of black men among the section 37/41 cohort than one would expect from the population as a whole. There are also larger numbers of black men in prison than would be expected merely from the numbers of black men in the UK population. Accordingly, any judicial decision limiting the effectiveness of right of appeal of patients subject to orders under section 37/41 of the Mental Health Act 1983 is likely to have a significantly greater impact on black men.' This led to an argument based on the Convention right under Article 14 read in conjunction with Article 5, and on the Public Sector Equality Duty under section 149 of the Equality Act 2010.

27. As I have reached the outcome that MIND wanted on other grounds, I do not need to analyse these argument.

E. Disposal

28. The First-tier Tribunal made an error of law by deciding that it no longer had jurisdiction. There is, though, no point in setting the decision aside, because DD is no longer liable to be detained. That is why I have acknowledged that the tribunal made an error, but have exercised the power under section 12(2)(a) of the Tribunals, Courts and Enforcement Act 2007 and not set its decision aside.

Authorised for issue
on 23 June 2022

Edward Jacobs
Upper Tribunal Judge