Derbyshire Healthcare NHS Foundation Trust v SSHSC & others [2023] EWHC 3182 (Admin)

Deborah Robinson, Consultant Solicitor

Cartwright King.

How did it start?

- Review of section papers – no issues
  - Forms CTO7/H5/G9
  - Date of examination, but not method
- Review of Tribunal reports
  - Reference to telephone call by RC when extending the CTO
  - (Also review notes, AMHP assessment report or ask the MHAA)
- Correspondence with the Trust

First-tier Tribunal proceedings

- First adjournment July 22
- Second adjournment Sep 22
  - Pending determination of the issue elsewhere
  - Trust issued Part 8 proceedings Nov 22
- Final hearing Dec 22
  - No jurisdiction to consider the issue
  - But if there was, 2020 CTO extension was valid

The Trust's approach:

- opposed argument being raised in First- tier tribunal
- brought proceedings in the High Court, seeking declarations that:

1. The responsible clinician is not required to undertake a face-to-face examination of the patient before making a community treatment order ("CTO") under section 17A(1);

2. The word "examine" in section 20A(4) should not be interpreted as meaning a face-to-face examination, so that a remote examination of the community patient by the responsible clinician before the latter extends the CTO may be sufficient; and/or

3. The word "examine" in section 20(3) and (6) should not be interpreted as meaning a face-to-face examination, so that a remote examination of the patient by the responsible clinician before the latter renews the authority for detention for hospital treatment of a patient under section 3 or guardianship in the community under section 7, may be sufficient.

What came next?

- Application for permission to appeal
  - On review: First-tier Tribunal not right to determine that the 2020 CTO extension lawful having decided had no jurisdiction to consider this issue
- Upper Tribunal appeal
  - First-tier Tribunal right to decide no jurisdiction to consider whether the extension of the CTO was lawful
  - Therefore no reason to determine the "substantive" issue (ie was the CTO extension lawful)
- Part 8 proceedings
  - Application to strike out prior to UT hearing – unsuccessful
  - Needed PQR's position not to be decided against him without his involvement.
  - Did not have funding for PQR to take part in the Part 8 proceedings - wanted it dealt with in Upper Tribunal if possible, to avoid expense
  - Final hearing

- The Trust's approach:
- Did not serve High Court proceedings on PQR and asserted through correspondence and witness statements that the proceedings in the High Court were nothing to do with PQR, despite the person bringing the proceedings on behalf of the claimant being the same person who had engaged in initial correspondence about the issue
- Did not inform the Court in the Part 8 claim of PQR and his position.

The links

PQR v Derbyshire Healthcare NHS Foundation Trust [2023] UKUT 195 (AAC)

https://www.gov.uk/administrative-appeals-tribunal-decisions/pqr-v-derbyshire-healthcare-nhs-foundation-trust-2023-ukut-195-aac

Derbyshire Healthcare NHS Foundation Trust v SSHSC & others [2023] EWHC 3182 (Admin)

https://www.bailii.org/ew/cases/EWHC/Admin/2023/3182.html

https://caselaw.nationalarchives.gov.uk/ewhc/admin/2023/3182

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GARDEN COURT
CHAMBERS

GARDEN COURT CHAMBERS: MENTAL HEALTH LAW

UPDATE

Derbyshire v Secretary of State: What was (and what was not) decided

Stephen Simblet KC, Garden Court Chambers

17 January 2024

Derbyshire v Secretary of State

- Case was decided by Lane J.
- Reference is [2023] EWHC 3182 (Admin), though is to be reported by the Weekly Law Reports and also the Business Law Reports
- From Garden Court Chambers, Stephen Simblet KC, Ollie Persey (instructed by Deborah Robinson for PQR), Roger Pezzani and Alex Schymyck (instructed by Rheian Davies, for Mind) were all involved.
- If the Trust had succeeded in their (misconceived) claim, it would have brought in extremely far- reaching changes to mental health law and procedure, and to clinical practice and procedure. This may be the reason that it is being properly reported in the Reports.
- For that reason, it is getting a talk of its own.

Application to strike out, and/ or to be joined with Claimants paying costs

- Lost (most of) the battles, won the war
- Claimants eventually agreed to letting PQR join proceedings, but still issue with costs
- We took the view (wrongly as court decided, but rightly still in our heads) that in addition to having no proper legal case, and purely theoretical claim, that (a) High Court should leave it to Upper Tribunal and (b) their failures to inform court of PQR position such that claim should be struck out.
- Application came before Cranston J 4th July 2023. Declined to strike it out, joined PQR as "Interested Party"; no order as to costs. Claimants also amended declarations sought to reflect correct statutory position!
- Appeal proceeded to Upper Tribunal (before UTJ Jacobs)
- Claim proceeded to final hearing before Lane J.

Upper Tribunal appeal

- By the time the case got to Upper Tribunal, First- tier Tribunal's decision that remote examinations could be done this way had been removed.

- Claimants sought to dissuade Upper Tribunal from hearing it.

- Secretary of State put in strong submissions on the substance, supporting the point that remote examinations could not be done.

- Upper Tribunal agreed with the Trust that there was no jurisdiction to decide the renewal point, with reasoning particularly in paragraph 12 and 14 -17.

- Judgment is at [2023] UKUT 195 (AAC)

Position at final hearing

- Secretary of State's opposition had hardened - indeed, PQR's skeleton argument quoted Secretary of State in Upper Tribunal.

- Mind had been joined to the claim and submitted evidence and written submissions

- Claimant relying on evidence (opinion) of its Assistant Legal Director as to the legal position, and still saying that legitimate to bring hypothetical claim.

- Not even attempted to file any clinical evidence (perhaps in part because in the battles, pointed out that in Part 8 claim, claimant confined to evidence that it places before the court.

Declarations sought

- Claimants sought declarations in these terms:

  1. The responsible clinician is not required to undertake a face-to-face examination of the patient before making a community treatment order ("CTO") under section 17A(1);

  2. The word "examine" in section 20A(4) should not be interpreted as meaning a face-to-face examination, so that a remote examination of the community patient by the responsible clinician before the latter extends the CTO may be sufficient; and/or

  3. The word "examine" in section 20(3) and (6) should not be interpreted as meaning a face-to-face examination, so that a remote examination of the patient by the responsible clinician before the latter renews the authority for detention for hospital treatment of a patient under section 3 or guardianship in the community under section 7, may be sufficient.

- It will be immediately seen how broad those are, and how this effectively removes any of the controls that Parliament placed on the way in which Responsible Clinician is to proceed. Becomes arbitrary medical decision.

Judge's decision on Trust's application

- 107. For the reasons I have given, it is evident that Parliament requires the highest degree of assurance that the examination in question will be as effective as it can be. There is no mandate for assuming that, in enacting sections 20 and 20A, Parliament intended to leave the matter to be determined by the responsible clinician. If that had been the intention, then Parliament can be expected to have said so. This is particularly true of section 20A where, as the claimant points out, at the time of its insertion into the 1983 Act, video conferencing facilities were in existence.
- 112. In short, on the state of the evidence, the claimant cannot show that there is the necessary societal consensus that an examination conducted by telephone or video conferencing will always be of the same high quality as one involving the physical co-location of clinician and patient. As I have sought to explain, Parliament's intention was to demand, as a general matter, an examination of such quality. Accordingly, the claimant cannot rely upon the "updating" or "always speaking" principle of statutory construction as a reason for this court to grant the remaining two declarations.

What the judge refused to decide - but what happened next…

- Despite the fact that it was Deborah Robinson's letter that had generated these proceedings (and see history at paragraph 44), the Judge said this:
    - *"118. Finally, I return to PQR's submission that I should say something specific in this judgment about the legality or otherwise of the examination undertaken in his case in May 2020. ..... Mr Simblet said that the juridical basis of PQR's position was plain and should be reflected in my judgment.*
    - *119. I disagree. The factual basis of what happened in May 2020 may be entirely as PQR asserts; but the present proceedings have not provided any opportunity for this to be interrogated. .....In the circumstances of the present case, where PQR is not being detained, the proper course, given the outcome of the proceedings in the Upper Tribunal, would be for PQR to pursue his case by way of judicial review."*
- BUT THE VERY SAME DAY that the final judgment was handed down, PQR's CTO was discharged.

What might happen next

- CTO has been discharged. PQR been subject to an unlawful CTO for several years, since once a CTO expires, it cannot be resuscitated.
- Derbyshire Trust plainly was concerned about that.
- There are plenty of other people in that position. Even within Derbyshire, and within Deborah's client base, aware of several other cases.
- This is not just a claimant lawyer viewpoint: https://www.dacbeachcroft.com/es/es/articles/2023/december/remote-renewals-rejected/
- *"Where remote renewals/extensions had been carried out and/or have continued post Devon, then organisations will now need to take appropriate steps to:*
  - *Ensure no further renewals/extensions are carried out remotely;*
  - *Take the necessary steps to ensure that any ongoing detentions, guardianships and CTOs are lawful."*

CTOs extended by remote examinations are unlawful.

- In our skeleton we put it this way:
  - A Community Treatment Order lasts for six months (section 20A (1)) unless it is extended by the procedure set out in section 20A (4);
  - By section 20B, the Community Treatment Order expires at the end of the community treatment period;
  - The community treatment period could only be extended if the Responsible Clinician took the steps in section 20A (4), which require (section 20A(4)(a)) that he "examine" the patient and if he considers that the criteria for compulsory treatment listed in section 20A (6) pertain, (section 20A (4)(b)) to issue a report to that effect;
  - A remote examination by telephone does not comply with section 20A (4)(a).
  - Since such conduct does not comply with section 20A (4), the report furnished to the hospital managers in section 20A (4)(b) in purported compliance with the duty under section 20A (4) cannot have operated to extend the community treatment period. the completed form CTO7 impliedly falsely represented that the Responsible Clinician had carried out a lawful examination of PQR, rather than one that does not comply with the law.

CTO renewal unlawful?

- Derbyshire, by objecting to the judge deciding the point in our claim, may well have to face the point (and potential costs liability) in another claim.
- It may NOT just be about judicial review. If there was no legal authority to take the step to renew the CTO, the CTO was not renewed, and never could be brought into existence.
- Although the decision of the Supreme Court in **R (Majera) v Secretary of State for the Home Department** [2021] UKSC 46, [2022] AC 461 (and see UTJ Jacobs analysis in the Upper Tribunal proceedings in this case), if the order has not been renewed and has lapsed, then subsequent CTOs cannot be brought into existence.
- However, se *Re S-C (Mental Patient: Habeas Corpus)* [1996] QB 599

Extensions of expired orders

- It has long been established that either a misrepresentation or a failure to comply with the statutory pre- conditions for an admission renders the admission unlawful: see *Re S- C (Mental Patient: Habeas Corpus)* QB 599.

- In *Re S- C*, the admission form completed by an approved social worker on which the hospital proceeded to admit and detain the patient pursuant to section 3 Mental Health Act 1983 wrongly recorded that the (AMHP) had consulted with the patient's nearest relative, when in fact the (AMHP) had consulted with a different relative.

- That was sufficient for the admission to be unlawful and for S-C to be released.

- To what extent can the production of a report which contains a falsity that is sufficient to vitiate the authority to make the order *affecting* the liberty of the subject, be different from an order removing the liberty of the subject?

Damages claims

- Someone subject to compulsory treatment against their will may have a claim for damages for assault and breach of human rights, obviously Article 8 ECHR and possibly Article 3 ECHR, depending on intrusiveness and unpleasantness of the treatment.

- They may have to proceed (out of time with judicial review) or, if the time limit had already expired and was a nullity, then the new order could not come into existence.: re S-C.

- WATCH THIS SPACE

That’s all, folks

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2023 Upper Tribunal Caselaw Update

Roger Pezzani and Alex Schymyck, Garden Court Chambers

18 January 2024

PC v Cornwall Partnership NHS Foundation Trust [2023] UKUT 64 (AAC)

- The FTT decided to proceed in the patient's absence
- A useful explanation of rule 39 of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 (SI No 2699)
- Paragraph 14 is of general application and importance: the special importance of the FTT operating within its rules of procedure in mental health cases

ML v Priory Healthcare Limited [2023] UKUT 237 (AAC)

- Yet another case about the infamous interface between the MHA and the MCA

- In essence, the FTT must deal with the potential availability of a less restrictive alternative to continued detention under MHA even in context of uncertainty as to the availability of an MCA authorisation (*MC v Cygnet Behavioural Health Ltd and Secretary of State for Justice* [2020] UKUT 230 (AAC) approved)

- An important statement of principle about what s.72(1)(b)(ii) MHA means, at paras 30 & 31

- And a significant concession by the Secretary of State for Justice at para 32

SF v Avon and Wiltshire MHP NHS Trust [2023] UKUT 205 (AAC)

- In essence, the distinction between detention for treatment and containment
- The dual purpose of detention under *both* the Art 5(1)(e) exception *and* the domestic statutory scheme: paras 52-54
- The logic of there being *three* (and not two) criteria in s.72(1)(b)(i), (ii) and (iia): para 41
- Hotel California, warehousing, Victorian asylums, and non-therapeutic (or counter-therapeutic) stasis
- The problem with *Manchester University Hospitals NHS Foundation Trust v JS & Anor (Schedule 1A Mental Capacity Act 2005)* [2023] EWCOP 33

MB v SLAM NHS Foundation Trust [2023] UKUT 261 (AAC)

- Patient had withdrawn their application to allow for a further period of 'testing' before applying to reinstate. The FTT refused to reinstate the application.
- UT determined that FTT had erred by:
  - 1) Failing to properly consider whether the period during which the patient had been tested could amount to a change in circumstances.
  - 2) Alternatively, failing to give adequate reasons.

SS v Cornwall Partnership NHS Foundation Trust [2023] UKUT 258 (AAC)

- FTT had adjourned to acquire evidence about aftercare, but then at the next hearing when it had not been provided decided to proceed anyway and refused the application.
- UT restated how to apply the principle in *AM v West London Mental Health NHS Trust and Secretary of State for Justice* [2012] UKUT 382 (AAC)
- UT robustly concluded that aftercare information only unnecessary where it would not make any difference to the decision the FTT has to make.

Thank you

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R (on the application of Worcestershire County Council) (Appellant) v Secretary of State for Health and Social Care (Respondent) Maher, R (On the Application Of) v First-tier Tribunal (Mental Health) & Ors [2023] EWHC 34 (Admin)

Ollie Persey, Garden Court Chambers

18 January 2024

Worcestershire

Issue?
Which local authority was responsible for the after-care of a service-user who had been detained in hospital under the Mental Health Act 1983? The case turns on the issue of where the service-user had been "ordinarily resident…immediately before being detained" for the purposes of s.117(3)(a) of the 1983 Act.

Facts
JG suffers from treatment-resistant schizoaffective disorder. In early 2014, she lived in Worcestershire. In March 2014, she was detained under section 3 of the 1983 Act for treatment in hospital (the "First Detention"). In April 2014, it was decided that it was in JG's best interests for her to move to a residential placement closer to her daughter in Swindon. In July 2014, JG was discharged and was released to a care home in Swindon for after-care bringing her First Detention to an end. Her after-care services were funded by Worcestershire Council County ("Worcestershire CC").

In February 2015, Worcestershire CC moved JG to a second care home in Swindon because the first care home could no longer adequately meet her needs. The placement was also funded by Worcestershire. In June 2015, JG was detained under section 3 of the 1983 Act for treatment in a hospital in Swindon (the "Second Detention"). In November 2015, JG was discharged, however, she remained an in-patient in the Swindon hospital, because she lacked decision-making capacity. In August 2017, JG was discharged to after-care.

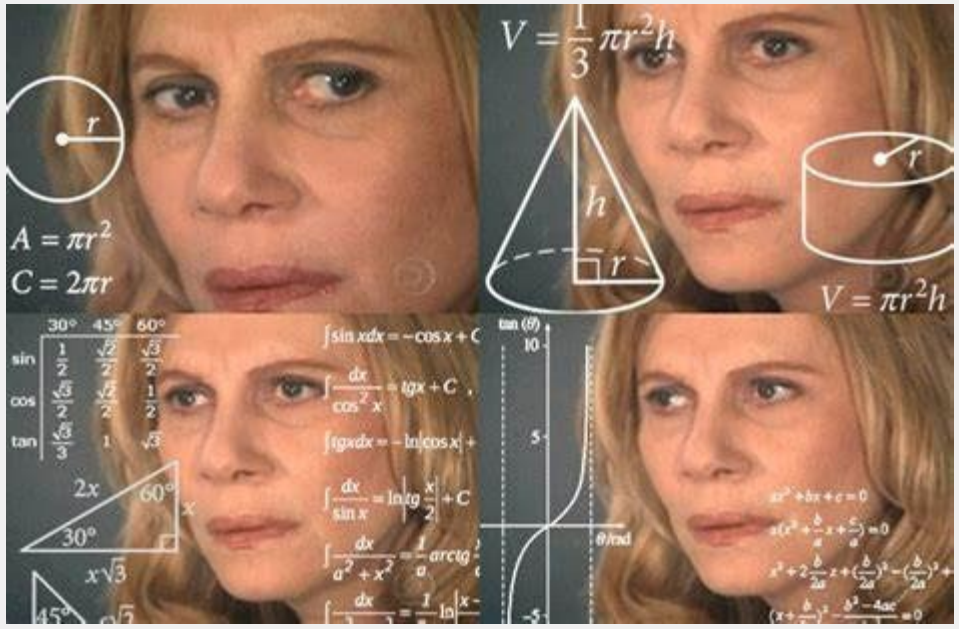
A dispute arose as to where JG was "ordinarily resident" immediately before her Second Detention which would determine which local authority should pay for her after-care services. The Secretary of State held that JG was ordinarily resident in Swindon because that was where she was living just before her Second Detention. Swindon sought a review of that decision. The Secretary of State reversed his decision and decided that JG was ordinarily resident in Worcestershire for fiscal and administrative purposes. Worcester applied for judicial review of this decision. The High Court held that JG was ordinarily resident in Swindon immediately before her second period of detention. On appeal, the Court of Appeal held JG was ordinarily resident in Worcestershire before her second period of detention.

Outcome:

- The Supreme Court unanimously:
  - *"It declares that, following the second discharge, Swindon, and not Worcestershire, had a duty to provide after-care services for JG under section 117 of the Act.*

- How did it get to this conclusion?

- WELL…



Brief recap: what is s117 afterrcare and who is eligible?

- Free care and support if a (former) mental patient was detained
- for treatment under section 3
- under a hospital order under section 37
- following transfer from prison under section 47 or 48
- under a hospital direction under section 45A
- Or…
- Patient has been discharged onto a CTO for the entire period of your CTO, or
- you are a restricted patient on a conditional discharge.

Ordinary residence…

- S117 (3) In this section 'the clinical commissioning group (now ICB) or Local Health Board' means the clinical commissioning group or Local Health Board, and 'the local social services authority' means the local social services authority —

  - (a) if, immediately before being detained, the person concerned was ordinarily resident in England, for the area in England in which he was ordinarily resident;

The conundrum

- After discharge, following detention 1 in Worcestershire = common ground that Worcestershire owed the duty as had been ordinarily resident there beforehand, and Worcestershire hadn't found that s117 aftercare had come to an end.

- Where it gets tricky:
  - JG moved to a care home in Swindon when she lacked capacity to make decisions on residence- so did she become ordinarily resident in Swindon?
  - She was then detained again having been (ordinarily resident?) in Swindon.
  - Common ground that 2 aftercare duties can't co-exist… so what happened?

The answer…

- 49. As a matter of linguistic analysis, the answer to this argument, in our view, is that the duty under section 117(2) is to provide after-care services "for any person to whom this section applies". The duty will therefore cease not only if and when a decision is taken that the person concerned is no longer in need of after-care services but, alternatively, if the person receiving the services ceases to be a person to whom section 117 applies. As Mr Sharland KC pointed out, that would be the case if, for example, the person concerned were to die or was deported or imprisoned. Although there is nothing in section 117(2) which says that the duty will cease in that event, there would then be no person to whom section 117 could apply. That is also true if the person concerned ceases to fall within the class of persons specified in section 117(1). For the reasons given, interpreted in the context of section 117 as a whole and its purpose, the class of persons specified in section 117(1) does not include persons who are currently detained in a hospital under section 3 for treatment. Upon such detention an individual therefore ceases to be a "person to whom this section applies"

The answer (part 2…)

- 87. We conclude that the courts below were right to decide that, in circumstances where Parliament has deliberately chosen not to apply a deeming (or equivalent) provision to the determination of ordinary residence under section 117 of the 1983 Act, the words "is ordinarily resident" must be given their usual meaning, so that JG was ordinarily resident in Swindon immediately before the second detention"

Modified Shah test focusing on the capacity of the person making decisions on JG's behalf:

- "R v Barnet London Borough Council, Ex p Shah [1983] 2 AC 309, 343. After reviewing earlier authorities, he concluded: "Unless, therefore, it can be shown that the statutory framework or the legal context in which the words are used requires a different meaning, I unhesitatingly subscribe to the view that 'ordinarily resident' refers to a man's abode in a particular place or country which he has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being, whether of short or of long duration.

Maher

- The Claimant's son, Kyle, had been killed by a man named Richard Wilson-Michael.
- Wilson-Michael was convicted of manslaughter by reason of diminished responsibility. He was found to be suffering from paranoid schizophrenia at the time and so rather than being sent to prison, he was given a Hospital Order and Restriction Order under sections 37 and 41 of the Mental Health Act 1983.
- 4 years after the offence, the MHT decided to discharge Wilson-Michael into the community.
- Claimant v concerned about this decision – and not involved in decision or provided with reasons in contrast to procedure in parole board.
- MHT was operating an unlawful blanket policy of never providing reasons for its judgments to victims. When the issue was considered by the Tribunal's Deputy Chamber President a year later, that decision was also unlawful because it failed to correctly balance Mr Wilson-Michael's right to privacy with Ms Maher's rights and the principles of open justice.
- New guidance: PRACTICE GUIDANCE ON PROCEDURE FOR HANDLING REPRESENTATIONS FROM VICTIMS IN THE MENTAL HEALTH JURISDICTION OF THE HEALTH, EDUCATION AND SOCIAL CARE CHAMBER

Judgments

Neutral Citation Number:[2023] EWCOP 33

Case No: COP14053021

IN THE COURT OF PROTECTION

ON APPEAL FROM HHJ BURROWS

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 10/08/2023

Before :

MRS JUSTICE THEIS DBE

- -

Between :

	MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	**Appellant**
	- and -	
	JS (by her Litigation Friend, the Official Solicitor)	**1st Respondent**
	- and -	
	MANCHESTER CITY COUNCIL	**2nd Respondent**
	- and	
	MIND	**1st Intervener**
	- and	
	SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE	**2nd Intervener**

- -

Ms Helen Mulholland K.C. and Ms Aisling Campbell (instructed by **Hill Dickinson LLP**) for the **Appellant**
Mr Neil Allen (instructed by the **Simpson Millar LLP** for the **1st Respondent**
Ms Eliza Sharron (instructed by **Weightmans LLP)** for the **2nd Respondent**
Mr Alex Ruck Keene K.C. (Hon) (instructed by **MIND)** for the **1st Intervener**
Ms Arianna Kelly (instructed by **SHSC)** for the **2nd Intervener**

Hearing date: 20 July 2023
Judgment: 10 August 2023

- -

Approved Judgment

This judgment was handed down remotely at 10.30am on 10 August 2023.

.....

MRS JUSTICE THEIS DBE

This judgment was delivered in public and the proceedings are subject to the Transparency Order dated 21 June 2023. The anonymity of JS must be strictly preserved and nothing must be published that would identify JS, 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.

Mrs Justice Theis DBE :

Introduction

1. The court is concerned with the appeal by Manchester University Hospitals NHS Foundation Trust ('the Trust') from the decision of HHJ Burrows ('the Judge') on 18 April 2023, when he refused the application by the Trust for orders in the Court of Protection. Permission to appeal was granted on 21 June 2023 on all grounds.

2. The respondents to the appeal are the young person who is the subject of these proceedings, JS, age 17 years, through her litigation friend the Official Solicitor, and Manchester City Council ('the local authority'). The respondents oppose the appeal. In addition, there are two interveners, MIND and the Secretary of State for Health and Social Care ('SHSC'). JS's mother was notified of this appeal but did not take any steps to participate. The proceedings regarding JS are continuing to be heard by the Judge in which the mother takes an active part.

3. In summary, the appeal concerns the interpretation of Schedule 1A to the Mental Capacity Act 2005 (MCA 2005) and the basis upon which the court sitting in that jurisdiction should determine ineligibility. In one sense this appeal is academic as the situation has moved on for JS, she is now detained pursuant to s3 Mental Health Act 1983 (MHA 1983). However, the issues in this appeal may arise again in this case and, in any event, there is a wider interest in the appeal.

4. In accordance with rule 20.14 Court of Protection Rules 2017 (COPR) the appeal will only be allowed if the decision of the judge was wrong or unjust due to a procedural error. The appellant submits the judge was wrong.

5. The court has had the benefit of detailed written and oral submissions from counsel for each of the parties and two interveners, MIND and SHSC. The court is extremely grateful for the depth and eloquence of those submissions.

6. The wider issues that arise in this case are, sadly, not unusual and have been highlighted in a number of judgments, most recently by the President of the Family Division, Sir Andrew McFarlane in *Re X (Secure Accommodation: Lack of Provision)* [2022] EWHC 129 (Fam) a judgment designed, as he set out in paragraph 1, to *'shout as loud as [the court] can'* about the shortfall in provision '*in the hope that those in Parliament, Government and the wider media will take the issue up'.* Although that case concerned an application for secure accommodation under s 25 Children Act 1989 (CA 1989), the shortages of suitable accommodation to meet the needs of young people who are being deprived of their liberty applies in a wider context. It is not a new issue (see former President of the Family Division, Sir James Munby, in *Re X (A Child) (No 3)* [2017] EWHC 2036 (Fam). Much of what was said in that case applies today, nearly six years later with little, if any, evidence of change.

7. As the President observed in *Re X (Secure Accommodation: Lack of Provision) (ibid)* at [42] *'Despite the regular flow of judgments of this nature over recent years, it is, at least from the perspective of the experienced senior judges who regularly deal with these cases, a matter of genuine surprise and real dismay that the issue has, seemingly, not been taken up in any meaningful way in Parliament, in Government or in wider public debate.'*

8. In this case no party suggested that JS was in a placement that met her needs, including those who cared for her. There are repeated references in the records of a mixed adult acute mental health ward being wholly unsuitable for her. Those caring for her were ill equipped to manage her extreme behaviours that not only put JS but also others at high risk of serious harm. There was no other placement for her.

9. I agree with the observations made by other judges as set out between [28] – [41] in *Re X (Secure Accommodation: Lack of Provision) (ibid).* The situation remains very difficult and challenging for the young people concerned and their families; for the staff in the hospitals who are having to manage these difficult and dangerous situations, when they are ill equipped and not trained to do so; and for the wider community, as it can often bring whole wards and departments in hospitals to a standstill due to the drain on resources and the disruption these situations cause. In addition, these cases take up scarce judicial court time and resources, with consequent delays for other cases being heard.

10. In *Re X (Secure Accommodation: Lack of Provision) (ibid)* at [59] the court was informed the Secretary of State for Education accepted that cross government action was required. I understand the government has in the past month set up a high-level cross departmental group to look at this, drawn from Departments of Education and Health. It is hoped this step will help improve the situation which is causing so much harm to some of the most vulnerable young people in society.

Relevant background

11. JS has a diagnosis of autistic spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), learning disability and an attachment disorder.

12. JS was admitted to a Tier 4 CAMHS unit on 16 December 2022, age 17 years. The admission was initially an informal admission. JS was assessed as having capacity and became an informal patient under s131 MHA 1983. That admission was changed on that day to be for assessment under s 2 MHA 1983.

13. JS was discharged home on 4 January 2023. Two days later she absconded from home on 6 January 2023 and ran in front of moving traffic. She was taken to A&E, absconded again and was taken to a place of safety under section 136 MHA 1983.

14. Following a review by the relevant assessment centre and a discussion with Dr A she was not considered suitable for inpatient admission and was discharged home.

15. On 7 January 2023 JS stole a large amount of paracetamol and took these in overdose. JS's mother called the police who took her to hospital under s136 MHA 1983 where she was admitted.

16. JS was detained under s 2 MHA 1983 on 8 January 2023 and admitted to a general hospital. That lapsed on 5 February 2023 and JS remained on the ward subject to the same restrictions.

17. An application to the Court of Protection was made by the Trust on 10 February 2023 to seek authorisation for her continued deprivation of liberty.

18. At that time, JS was represented within those proceedings by her mother as litigation friend.

19. The application was listed on 21 February 2023. The Judge heard the oral evidence of Dr K, consultant psychiatrist, who was JS's treating clinician. Declarations were made under s15 MCA 2005 that JS lacked capacity to make decisions as to whether or not to remain in hospital, the restrictions in place, medical treatment including medication and where she should live. The Judge ordered under s16 MCA 2005 that it was in her best interests to remain and be cared for in the hospital and authorised the deprivation of her liberty under s4 MCA 2005.

20. At that hearing the Judge raised the issue of whether JS was ineligible under the MCA 2005 and sought further submissions from the parties. Pending his determination of that issue he accepted the court had jurisdiction.

21. On 24 February 2023 the court re-authorised the deprivation of liberty until 27 February 2023, when JS was discharged from hospital, and directed written submissions by 13 March 2023.

22. On 2 March 2023 JS was taken to the hospital by the police pursuant to s136 MHA 1983, following an attempt to harm herself.

23. On 6 March 2023 the Trust confirmed that JS had been detained under s 2 MHA 1983. JS remained in hospital for two weeks before being transferred to the Tier 4 placement on 16 March 2023.

24. JS's s 2 was due to lapse on 31 March 2023. The Tier 4 placement arrangement was that JS would remain as an informal patient pursuant to s5(2) MHA 1983, which gives the doctors the ability to detain her for up to 72 hours.

25. On 18 April 2023 JS was further detained following her causing damage to the ward. JS was placed in holds and taken to the intensive nursing suite and later returned to the ward. As JS was expressing her wish to leave a decision was made for JS to be placed on s5(2) MHA 1983.

26. In his judgment dated 18 April 2023 the Judge determined JS was ineligible to be deprived of her liberty under the MCA 2005.

27. On 19 April 2023 JS was reviewed and detained under s 2 MHA 1983.

28. On 5 May 2023 JS was placed on s 3 MHA 1983 and moved placement. The case has continued to be considered by the Judge, with the next review due on 4 September 2023.

Relevant legal framework

The context

29. The purpose of introducing Schedule 1A MCA 2005 was, in part, to promote a consistent framework for detention of people in hospital for medical treatment of mental disorders who were objecting to that treatment. The policy behind Schedule 1A is such patients, with or without capacity, who were considered to require detention for the purposes of medical treatment for mental disorders should be treated in the same manner.

30. As regards the interface between the MHA 1983 and MCA 2005 neither Act is to have primacy over the other. The choice as to which Act is used will turn on the relevant decision-maker's consideration of the options that are available.

31. There are different frameworks to prevent the arbitrary deprivation of someone's liberty including:
    (1) MHA 1983, which can authorise a person's confinement in a hospital for the purpose of assessing and treating mental disorder.
    (2) The MCA 2005, which can take place in two ways, namely (i) the administrative process of the deprivation of liberty safeguards whereby a supervisory body can authorise the confinement of an adult in a hospital or care home; (ii) the judicial process of the Court of Protection whereby a judge can authorise the confinement of someone age 16 years and over in any care setting.
    (3) The inherent jurisdiction of the High Court, including for those who are under 18 years and some adults in certain circumstances, such as those who do not lack capacity, but are in some respect considered vulnerable.

32. In the SHSC's written submission he provided a very helpful overview of the scope of s 2 and 3 MHA 1983 which is set out below:
    a. *The vast majority of people with mental disorders are treated in the community, without any form of detention being used in their care or treatment. Many individuals who require treatment in hospitals for mental*

disorders and are not objecting to that treatment are treated on an 'informal' or 'voluntary' basis, residing in hospital, but not being detained. This is in keeping with the 'least restrictive' principle under the MHA. (See s.13(2) MHA, MHA Code of Practice at 1.1-1.6) Any decision to detain a person for the purposes of assessment or treatment of a mental disorder under ss.2 and 3 MHA should only be taken where it is necessary to do so and in accordance with the MHA.

b. *If a patient is not objecting to inpatient treatment but lacks the capacity to consent to it and is deprived of their liberty, it may be appropriate to authorise this detention under the MCA. (See MHA Code of Practice at 13.49-13.70; the SHSC would note in particular paragraph 13.60).*
c. *An application for admission to hospital under ss.2 or 3 MHA must be made to a named hospital. An application for admission to hospital under the MHA should only be made where it has been confirmed that the hospital has the capacity to admit the person. A person may be transferred to a different hospital while remaining under a ss.2 or 3 MHA detention.*
d. *The 'least restrictive' principle exists under both the MCA and MHA. Detentions under both the MCA and MHA should be tailored to eliminate unnecessary restrictions on the person, and in particular, avoid 'blanket' restrictions which are not related to the person's particular needs where possible. (Paras 8.9-8.14 MHA Code of Practice)*
e. *The MCA and MHA both have frameworks to facilitate a person's right to challenge a deprivation of liberty pursuant to Article 5(4) ECHR, though the frameworks operate differently.*
f. *Inpatient treatment may occur in a variety of settings, and hospitals and wards may have different specialisms or patient populations. Individual hospitals or categories of hospitals may have their own criteria for admission, which exist alongside the MHA framework.*
g. *'Gatekeeping' assessments are notably a feature of admission to inpatient settings which serve children and adolescents, known as Children and Adolescent Mental Health Services (CAMHS) Tier 4 units. Acceptance to a Tier 4 CAMHS service takes place through the National Referral and Access Process; this process was recently described in the judgement of MacDonald J in Blackpool Borough Council v HT (A Minor), CT, LT and Lancashire and South Cumbria NHS Foundation Trust [2022] EWHC 1480 (Fam). A child or young person will not be admitted to a Tier 4 CAMHS service unless <u>both</u> the requirements of the MHA are met, and the child's admission is recommended by the Gatekeeping service.*
h. *An individual who is considered to require admission to hospital for medical treatment for a mental disorder may not be able to immediately access the full range of inpatient options, as they may not be available at the time the person is considered to require detention. A person may be admitted to a hospital under ss.2 or 3 MHA which is not necessarily seen as a long-term option for the person's care and treatment because the person is considered to need care immediately, a bed is immediately available to the person at the hospital and the hospital provides the most appropriate treatment for the person's mental disorder which is available <u>at the time.</u>*
i. *Detentions under ss.2 or 3 MHA may be of long or short duration, and any s.2 detention can last a maximum of 28 days. Per the MHA Code of Practice at*

1.4, '[i]f the [MHA] is used, detention should be for the shortest time necessary in the least restrictive hospital setting available.'

j. A detention under ss. 2 or 3 MHA can be ended at any time by the person's responsible clinician if they consider that detention is no longer required to achieve the person's treatment. The appropriateness of continuing a detention under the MHA should be kept under continuous review by treating clinicians.

k. The question of whether it is necessary to detain a person under the MHA for treatment is not determined by absolute descriptions or metrics, but will depend on whether there is a less restrictive means available to deliver the person's treatment. If treatment for the person's mental disorder is actually available without the person being detained in hospital, this is likely to be highly relevant in any consideration as to the use (or continuation) of ss.2 or 3 MHA.

l. Appropriate care and treatment in the community may take time to arrange, and may not be immediately available to the person outside of hospital. If no appropriate care and treatment for the person's mental disorder is yet available in the community because care planning is ongoing, this is also likely to be relevant to the consideration of the use of ss.2 and 3 MHA, and the appropriate duration of the person's detention under the MHA.

Schedules 1A and A1 MCA 2005

33. These were introduced into the MCA 2005 through the Mental Health Act 2007. This was in order to close the gap in the law where incapacitated compliant mental health patients were being unlawfully deprived of liberty in hospital because they did not meet the MHA 1983 criteria but were not free to leave.

34. Schedule A1 provides the administrative procedure to authorise such confinement in hospitals and CQC registered care homes. In circumstances that do not fall within that procedure, the Court of Protection's powers to deal with deprivation of liberty in other circumstances are under s 4A, 16, 16A MCA 2005.

35. Both the judicial and administrative procedures are subject to the provisions under Schedule 1A MCA 2005 which provides the framework for the interface between detention under the MCA 2005 and MHA 1983.

36. Schedule 1A MCA 2005 establishes that certain categories of people cannot be deprived of their liberty under the MCA 2005, or places restrictions on what deprivations of liberty may be authorised under the MCA 2005. These provisions determine whether that person is eligible or not.

37. Schedule 1A sets out five situations, referred to as 'cases', where arrangements which deprive a person of their liberty may be considered between the MCA 2005 and MHA 1983. Cases A-D concern those already detained under the MHA 1983, which did not apply in this case. This case concerns Case E.

    Part 1

    INELIGIBLE PERSONS

Determining ineligibility

2. A person ("P") is ineligible to be deprived of liberty by this Act ("ineligible") if—

(b) P falls within one of the cases set out in the second column of the following table, and

(b) the corresponding entry in the third column of the table—or the provision, or one of the provisions, referred to in that entry—provides that he is ineligible.

	Status of P	Determination of ineligibility
Case A	P is— (a) subject to the hospital treatment regime, and (b) detained in a hospital under that regime.	P is ineligible.
Case B	P is— (a) subject to the hospital treatment regime, but (b) not detained in a hospital under that regime.	See paragraphs 3 and 4.
Case C	P is subject to the community treatment regime.	See paragraphs 3 and 4.
Case D	P is subject to the guardianship regime.	See paragraphs 3 and 5.
Case E	P is— (a) within the scope of the Mental Health Act, but (b) not subject to any of the mental health regimes.	See paragraph 5.

For someone to be "*ineligible*" under Case E the relevant person:

(a) has to be within the scope of the MHA 1983, and
(b) paragraph 5 has to be satisfied. [i.e., the patient must object to some or all of the mental health treatment].

"Within the scope of the Mental Health Act" is defined by paragraph 12 of Schedule 1A as (emphasis added):

"(1) P is within the scope of the Mental Health Act if-

(a) an application in respect of P **could** be made under s.2 or s.3 of the Mental Health Act, and

(b) P **could** be detained in a hospital in pursuance of such an application, were one made.

Paragraphs 5, 12, 16 and 17 Schedule 1A provide:

Objects to being a mental health patient etc (paragraph 5)

5(1)This paragraph applies in cases D and E in the table in paragraph 2.

(2)P is ineligible if the following conditions are met.

(3)The first condition is that the relevant instrument authorises P to be a mental health patient.

(4)The second condition is that P objects—

(a)to being a mental health patient, or

(b)to being given some or all of the mental health treatment.

(5)The third condition is that a donee or deputy has not made a valid decision to consent to each matter to which P objects.

(6)In determining whether or not P objects to something, regard must be had to all the circumstances (so far as they are reasonably ascertainable), including the following—

(a)P's behaviour;

(b)P's wishes and feelings;

(c)P's views, beliefs and values.

(7)But regard is to be had to circumstances from the past only so far as it is still appropriate to have regard to them.

P within scope of Mental Health Act (paragraph 12)

12(1)P is within the scope of the Mental Health Act if—

(a)an application in respect of P could be made under section 2 or 3 of the Mental Health Act, and

(b)P could be detained in a hospital in pursuance of such an application, were one made.

(2)The following provisions of this paragraph apply when determining whether an application in respect of P could be made under section 2 or 3 of the Mental Health Act.

(3)If the grounds in section 2(2) of the Mental Health Act are met in P's case, it is to be assumed that the recommendations referred to in section 2(3) of that Act have been given.

(4)If the grounds in section 3(2) of the Mental Health Act are met in P's case, it is to be assumed that the recommendations referred to in section 3(3) of that Act have been given.

(5)In determining whether the ground in section 3(2)(c) of the Mental Health Act is met in P's case, it is to be assumed that the treatment referred to in section 3(2)(c) cannot be provided under this Act.

Expressions used in paragraph 5 (paragraphs 16 and 17)

16(1)These expressions have the meanings given—

- "donee" means a donee of a lasting power of attorney granted by P;

- "mental health patient" means a person accommodated in a hospital for the purpose of being given medical treatment for mental disorder;
- "mental health treatment" means the medical treatment for mental disorder referred to in the definition of "mental health patient".

(2)A decision of a donee or deputy is valid if it is made—

(a)within the scope of his authority as donee or deputy, and

(b)in accordance with Part 1 of this Act.

Expressions with same meaning as in Mental Health Act

17(1)"Hospital" has the same meaning as in Part 2 of the Mental Health Act.

(2)"Medical treatment" has the same meaning as in the Mental Health Act.

(3)"Mental disorder" has the same meaning as in Schedule A1 (see paragraph 14).".

38. As Schedule 1A governs both the judicial and the administrative authorisation procedures it applies to
    (1) Young people (16+) and adults subject to welfare orders (ss4A, 16-16A MCA 2005);
    (2) Adults subject to deprivation of liberty safeguards framework (MCA 2005 Schedule A1).

39. Schedule 1A does not govern s4B MCA 2005 which, if the conditions in that section are satisfied, authorise a person to deprive P of their liberty while a decision is *'being sought from the court'* (s4B(7) MCA 2005).

40. The MHA Code of Practice, which is a statutory guidance issued under s.118 MHA, discusses the definition of 'medical treatment for mental disorder' and 'appropriate medical treatment' as follows:

    23.3 In the Act, medical treatment for mental disorder means medical treatment which is for the purpose of alleviating, or preventing a worsening of, a mental disorder or one or more of its symptoms or manifestations.
    23.4 Purpose is not the same as likelihood. Medical treatment must be for the purpose of alleviating or preventing a worsening of mental disorder even if it cannot be shown, in advance, that a particular effect is likely to be achieved…

    23.6 Even if particular mental disorders are likely to persist or get worse despite treatment, there may well be a range of interventions which would represent appropriate medical treatment. It should never be assumed that any disorders, or any patients, are inherently or inevitably untreatable. Nor should it be assumed that likely difficulties in achieving long-term and sustainable change in a person's underlying disorder make medical treatment to help manage their condition and the behaviours arising from it either inappropriate or unnecessary…

    23.13 Medical treatment must always be an appropriate response to the patient's condition and situation and indeed wherever possible should be the most appropriate

treatment available. It may be that a single medical treatment does not address every aspect of a patient's mental disorder.
23.14 Medical treatment must actually be available to the patient. It is not sufficient that appropriate treatment could theoretically be provided.
23.15 What is appropriate will vary greatly between patients. It will depend, in part, on what might reasonably be expected to be achieved given the nature and degree of the patient's disorder.
23.16 Medical treatment which aims merely to prevent a disorder worsening is unlikely, in general, to be appropriate in cases where normal treatment approaches would aim (and be expected) to alleviate the patient's condition significantly. However, for some patients with persistent and severe mental disorders, management of the undesirable effects of their disorder may be the most that can realistically be hoped for.
23.17 Appropriate medical treatment does not have to involve medication or psychological therapy – although it very often will. There may be patients whose particular circumstances mean that treatment may be appropriate even though it consists only of nursing and specialist day-to-day care under the clinical supervision of an approved clinician in a safe and secure therapeutic environment with a structured regime.

Section 3 MHA 1983

41. Section 3 MHA 1983 provides:

3(1) A patient may be admitted to a hospital and detained there for the period allowed by the following provisions of this Act in pursuance of an application (in this Act referred to as "an application for admission for treatment") made in accordance with this section.
(2) An application for admission for treatment may be made in respect of a patient on the grounds that—
(a) he is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and
(b) [. . .]
(c) it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section; and
(d) appropriate medical treatment is available for him.
(3) An application for admission for assessment shall be founded on the written recommendations in the prescribed form of two registered medical practitioners, including in each case a statement that in the opinion of the practitioner the conditions set out in subsection (2) above are complied with; and each such recommendation shall include
(a) such particulars as may be prescribed of the grounds for that opinion so far as it relates to the conditions set out in paragraphs (a) and (d) of that subsection; and
(b) a statement of the reasons for that opinion so far as it relates to the conditions set out in paragraph (c) of that subsection, specifying whether other methods of dealing with the patient are available and, if so, why they are not appropriate.

(4) In this Act, references to appropriate medical treatment, in relation to a person suffering from mental disorder, are references to medical treatment which is appropriate in his case, taking into account the nature and degree of the mental disorder and all other circumstances of his case.

GJ v The Foundation Trust [2009] EWHC 2974 (Fam) Charles J

42. The provisions in Schedule 1A were the subject of careful scrutiny by Charles J in *GJ v The Foundation Trust* [2009] EWHC 2972 (Fam).

43. In that case GJ was the subject of a Standard Authorisation, and detained in a hospital against his will under the authorisation. Whilst there, he was treated for diabetes and for his mental disorder. The treatment for his mental disorder took the form primarily of care and support. He was also prescribed various medications for his mental disorder but was never forced to take them against his will whilst subject to the Standard Authorisation.

44. The question was whether he was ineligible to be dealt with via the MCA 2005 on the ground that his circumstances fell more properly within the scope of the MHA 1983 and that he objected. Charles J made it clear at paragraph 59 that *'it is not lawful for medical practitioners referred to in [the MHA 1983], decision makers under the MCA, treating doctors, social workers or anyone else to proceed on the basis that they can pick and choose between the two statutory regimes as they think fit having regard to general considerations (e.g. the preservation or promotion of a therapeutic relationship with P) that they consider one regime preferable to the other in the circumstances of a given case'.*

45. In *GJ* the primary focus of argument was on the court's approach to the proper application of the word *'could'* in paragraph 12 (1) of Schedule 1A MCA 2005 and its meaning in the phrase *'an application in respect of P could be made under s3 or s3 MHA 1983'.* He set out the rival contentions and his conclusions as follows:

71. The rival contentions cover the possible range of meaning of the word. They were:

(a) On behalf of the Applicant (GJ or P), a "possibility test" was advanced to the effect that the decision maker should ask himself whether it is possible for such an application to be made, or more generally whether detention of P under the MHA 1983 is a possibility or (as put in reply) is it possible that P could be detained under the MHA 1983.

(b) On behalf of the First and Second Respondents, it was argued that "could" should be construed as meaning that no reasonable psychiatrist, or s. 12 approved doctor, could come to the view that the patient did <u>not</u> meet the s. 2 or s. 3 criteria, rather than a wider construction that a reasonable psychiatrist, or s. 12 approved doctor, might find that the patient did meet the relevant grounds. This is a "high probability or effective certainty" test.

(c) The Secretary of State argued that in determining whether an application "could" be made the decision maker should ask himself whether the criteria set by, or the grounds in, s. 2 or s. 3 of the MHA 1983 are met. This is a "what the decision maker thinks" test.

72. The First and Second Respondents argued, and I accept, that their interpretation reflects the approach taken in negligence cases by reference to the range of reasonable views of a reasonably competent professional and that this is a concept that those charged with determining eligibility are familiar with. Their approach is also similar to a test mentioned in the notes produced by the Department namely that the decision maker should ask himself whether "it is clear that the MHA 1983 will apply", which avoids the double negative.

73. The rival approaches of the Applicant and the First and Second Respondents produce results at different ends of the range of decision open to decision makers on the relevant value judgments. This is because the Applicant takes an approach that the test is at one end of a range from possibility to effective certainty and the First and Second Respondents' approach is at the other end (if not just outside it).

74. The First and Second Respondents' approach has the potential advantage that it reduces the risk that problems such as those that arose in Surrey CC v MB [2007] EWHC 3085 (Fam) will occur because it makes it unlikely that (a) the relevant decision makers under the MHA 1983 would decide not to make an application under the MHA 1983, and (b) the treating doctors would not support such an application and would prefer the court to deal with deprivation of liberty to promote their therapeutic relationship with P and their important relationship with P's family. This is what occurred in that case. In that case the expert evidence before the court was to the effect that P should be detained under the MHA 1983 and there was a risk that did not materialise that P would be evicted from his home and then arrested and kept in police custody. In the events that happened MB went to the hospital without objection and the need to rely on my declaration that it would be lawful to deprive him of his liberty to transport him to, and during his assessment at, the hospital did not arise.

75. However, in my view:

(a) it does not rule out problems arising from such a disagreement, and the primacy of the MHA 1983 reduces them,
(b) as a matter of the ordinary use of language it is the most strained of the interpretations,
(c) the gap which Parliament deliberately left by not providing that authorisations under the MCA covered taking a person to a hospital or care home can be filled by the Court of Protection because, in my view, an order that covered that transportation would not be within paragraph 5(3), and also
(d) an authorisation that provided for P to be in a care home (or anywhere other than a hospital) would not be within paragraph 5(3), so if in a care home P could be deprived of liberty by an authorisation (or an order) and if elsewhere P could be deprived of liberty by an order.

76. Further, this approach would lead to a situation in which a number of cases, that many practitioners would regard as ones that should be dealt with under s. 2 or s. 3 MHA 1983, might be dealt with under the MCA which would undermine the primacy of the MHA 1983.

77. I therefore reject the First and Second Respondents' argument on the construction of "could" namely, the high probability or near certainty test.

78. The more natural meaning of the word "could" favours the "possibility" test or the "what the decision maker thinks" test.

79. I reject the "possibility" test for the following reasons:

(a) it introduces into the test an exercise with involves an assessment of what others may think or conclude, on the question whether the criteria or grounds set by s. 2 or s. 3 MHA 1983 are met,
(b) it is more likely that Parliament intended that the decision makers under the MCA were to apply their own expertise to assess and decide whether those criteria or grounds are met in a given case,
(c) point (b) is supported by the opening words of paragraphs 12(3) and (4), namely - if the grounds in s. 2(2) / s. 3(2) MHA 1983 are met in P's case, and
(d) point (b) is supported by the deeming provisions in paragraphs 12(3) and (4) because it is likely to reduce the number of cases in which the assumption does not occur.

80. So, in my judgment the construction urged by the Secretary of State is the correct one, namely that the decision maker should approach paragraph 12(1) (a) and (b) by asking himself whether in his view the criteria set by, or the grounds in, s. 2 or s.3 MHA 1983 are met (and if an application was made under them a hospital would detain P).

46. Charles J continues, when considering paragraph 5(3) Schedule 1A, as follows:

87. I have concluded that the correct approach for the decision maker to take when applying paragraph 5(3) is to focus on the reason why P should be deprived of his liberty by applying a "but for" approach or test. And to do that he should ask himself the following questions, namely:

(a) what care and treatment should P (who will usually have a mental disorder within the MHA 1983 definition) have if, and so long as, he remains in a hospital:
(i) for his physical disorders or illnesses that are unconnected to, and are unlikely to directly affect, his mental disorders (the package of physical treatment), and
(ii) for (i) his mental disorders, and (ii) his physical disorders or illnesses that are connected to them and/or which are likely to directly affect his mental disorders (the package of treatment for mental disorder).

And then:

(b) if the need for the package of physical treatment did not exist, would he conclude that P should be detained in a hospital, in circumstances that amount to a deprivation of his liberty. And then, on that basis

(c) whether the only effective reason why he considers that P should be detained in hospital, in circumstances that amount to a deprivation of liberty, is his need for the package of physical treatment.

88. *If he answers part (b) in the negative and part (c) in the affirmative then the relevant instrument does not authorise P to be a mental health patient and the condition in paragraph 5(3) is not satisfied.*

89. *At part (a) of the question the decision maker must identify P's package of care for mental disorder (and thus the treatment for, or which will be likely to directly affect P's mental disorders as defined by the MHA 1983 and any physical disorders or illnesses that in his view are connected to them). It seems to me that if, having done so, the decision maker is of the view that the criteria set by, or the grounds in, s.2 or s.3 MHA 1983 are satisfied then on that "but for" approach he would have to answer part (b) and (c) differently. This is because he could not then conclude that the package of physical treatment was, on that "but for" approach, the only effective reason why he considers that P should be detained in hospital, in circumstances that amount to a deprivation of his liberty.*

90. *So, generally the application of this "but for" approach or test will effectively incorporate an application of the status test or gateway set by paragraph 12(1)(a) and (b) of Schedule 1A, applying the approach to it that I have concluded is the correct one (namely, that the decision maker should determine whether in his view the criteria set by, or the grounds in, s. 2 or s.3 MHA 1983 are met - and if an application was made under them a hospital would detain P).*

91. *To my mind this "but for" approach or test also recognises, and caters for the points, that:*

(a) it falls to be applied against a background that the Mental Health Requirement and the Best Interests Requirement will also have to be satisfied,

(b) it will not be uncommon that when P is in hospital (say for an operation) he will continue to receive the treatment for his mental disorder that he has been having in the community (e.g. medication),

(c) it will not be uncommon that there will be cases in which some care (e.g. nursing, monitoring and providing a safe environment) is the appropriate background for, or part of the treatment for, both P's mental disorders and his unconnected physical disorders or illness, and would therefore be included in both packages of treatment if and so long as, or to the extent that, they were to be given in a hospital, and

(d) the existence of such an overlap may not be decisive in determining whether the only effective reason why the decision maker concludes that P should be detained in a hospital, in circumstances that amount to a deprivation of liberty, is

his need for care and treatment for his physical disorders or illnesses that are (i) unconnected to, and (ii) are unlikely to directly affect, his mental disorders.

92. The point that the paragraph 5 test applies when the status test or gateway is satisfied (and thus when the decision maker has concluded that P could be, although he has not been, detained under s. 2 or s. 3 of the MHA) might be said to favour a wider approach to paragraph 5(3), based on say a consideration of the predominant, primary or significant purpose of the reason for deprivation of liberty because my approach effectively elides the status test or gateway with the paragraph 5 test.

93. But, in my view the primacy of the MHA 1983 supports my "but for" test albeit that I acknowledge that its application does not exclude the possibility of there being an overlap between the two statutory regimes because, as the authorities relating to whether treatment for physical disorder for illness can be considered as treatment for a mental disorder indicate, in some cases when the "but for" test is applied other decision makers might properly and lawfully reach different conclusions.

94. But those authorities also confirm that value judgments inevitably arise in borderline cases and I have concluded that a "but for" approach recognises the primacy of the MHA 1983 but also provide a practical approach that should help to minimise gaps and the potential for persons who lack capacity suffering harm by falling between the two statutory regimes, particularly in cases of emergency.

47. This was the test followed by the Judge and which is the subject of this appeal.

The key questions

48. In this appeal the parties have agreed the sequence of questions advanced by the Official Solicitor that distil the issues in Schedule 1A Case E, namely:

    (1) Is P a ‘mental health patient’?
    (2) Is P an ‘objecting’ mental health patient?
    (3) Could P be detained under s 3 MHA 1983?

49. I agree these key questions provide a useful structure to aid practitioners and judges who have to navigate these choppy waters within a legal framework that could have been expressed with more clarity.

Submissions

The Trust

50. Ms Mulholland K.C. seeks to challenge the Judge’s decision on two grounds (1) the judge wrongly concluded that P was ineligible within the meaning of Schedule 1A MCA 2005 on the basis that she was within the scope of the MHA 1983 and (2) the Judge wrongly concluded that there was a relevant instrument that authorised P to be a mental health patient.

51. In relation to the first ground her submissions can be summarised as follows:

(a) The decision in *GJ* is different and distinct from the case of JS and that in so far as the Judge followed it he was wrong to do so. Her submissions suggested that the different facts in *GJ* and Charles J describing it as a '*finely balanced case'* enable the court to distinguish it as to the facts. For example, in JS's case she only suffered from mental health conditions, not concurrent mental health and physical conditions as in *GJ.* In *GJ* they had expert evidence, in JS's case they didn't.

(b) The Judge fell into error when asking himself the question whether the treatment P was receiving in hospital (which included chemical and physical restraint) was, or could be said to be, treatment for her mental disorder. That focus by the Judge on the treatment meant he failed to consider properly section 3 MCA 1983.

(c) The Judge failed to give any weight to the opinion of the clinicians where, the evidence was that the psychiatric team did not consider JS was appropriate for detention under s3. The Judge should have been slow to depart from those views and if he did he ought to have given cogent reasons.

(d) In reaching his decision the Judge failed to consider and apply a number of aspects of s3(2) MHA 1983 namely that the patient (a) is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; (b) it is necessary for the health and safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detailed under this section; and (c) appropriate medical treatment is available for him.

52. The test contended for in *GJ* by the First and Second Respondents in that case is the more appropriate test where, Ms Mulholland submits, '*the Court is to pitch itself against the views of experienced clinicians',* it would have more certainty and could properly be referred to as the *'responsible clinician'* test.

53. Ms Mulholland submits the adoption of the decision maker test in accordance with *GJ* leads to a *'...counter-intuitive outcome. It cannot be right that a vulnerable young person who seeks the protection of the Court emerges with a decision which is contrary to her best interests and is, potentially, damaging to her'.*

54. Turning to the second ground of appeal; that the Judge wrongly concluded there was a relevant instrument that authorised P to be a mental health patient. Ms Mulholland submits that in reality JS was accommodated in hospital because it was considered unsafe for her to return home in the absence of a robust package of care.

55. The local authority required time to put that package of care in place and in the intervening period it was considered safer for JS to be in a hospital setting. That was the purpose, it was not so she could be given medical treatment for her mental health or otherwise. Any medical treatment was either consequent on her being in an unsuitable placement or would have been administered to her irrespective of where

she was residing. Her discharge was dependent on the availability of the package of care not the completion of any treatment plan.

56. Ms Mulholland submits this is demonstrated by the fact that JS *was 'accommodated on an acute adult medical ward (not a psychiatric or mental health ward) run by an NHS Trust that employed no mental health staff'.* She submits the order under s 16(2)(a) MCA 2005 authorised the Trust to prevent JS from leaving hospital through the use of supervision, physical restraint and oral sedative medication. It was not a mechanism, submits Ms Mulholland, for the court to authorise JS being accommodated in hospital so that she could receive medical treatment for a mental disorder.

57. Ms Mulholland agreed the three key questions posed by the Official Solicitor provides a useful framework; taking them in turn.

58. First, in considering whether JS is a mental health patient, Ms Mulholland submits it is necessary for the court to consider whether she was (a) receiving medical treatment for mental disorder, and, if so, what that treatment was and (b) what the purpose was of JS being accommodated in hospital.

59. The Trust accepts JS's diagnoses of autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD) and learning disability (LD) meet the criteria of JS having a mental disorder. It is accepted JS was receiving some medical treatment for her mental disorder while in hospital but Ms Mulholland submits that JS being required to remain in hospital with round the clock supervision could not amount to medical treatment for mental disorder. If anything, Ms Mulholland submits, the detention in hospital made JS's symptoms and manifestations worse as she continued to self-harm, express suicidal ideation, damage property and injure staff. Ms Mulholland submits the Judge failed to address the purpose for which JS was being accommodated in hospital.

60. Ms Mulholland contends the purpose was not to receive medical treatment for mental disorder and her date of discharge was dependent on when resources would be available for her in the community. She submits the physical and medical sedation was required because JS was in an unsuitable environment. The only reason JS was in hospital was due to the strain on resources, as was acknowledged by the Judge in his judgment below (at [44] – [45]). As a consequence, she submits, JS was not a mental health patient and there could not have been a relevant instrument authorising JS to be a mental health patient.

61. There is no issue between the parties as to the second question: is JS an 'objecting' mental health patient; JS did object.

62. The third question, could JS be detained under s3 MHA 1983? If not, she was not ineligible within the meaning of Schedule 1A MCA 2005 and the Court of Protection had jurisdiction. Ms Mulholland submits the court needs to consider first whether JS could be detained under s3 MHA 1983, and then whether the criteria for detention under s3 are met. She accepts for the purposes of MCA 2005 the decision maker is either the supervisory body for a standard authorisation or a Court of Protection judge for an order under section 16 MCA 2005. She submits the Judge considered the matter in the judgment below through the prism of JS's treatment rather than analysis of s 3 and as a result fell into error.

63. In her written submissions she raises the issue of a 'stalemate' where there is a dispute between the decision maker under the MHA 1983 and MCA 2005. She submits an adapted *GJ* test should be adopted where the MCA 2005 decision-maker interferes with the MHA 1983 decision maker only *'if their decision is not logical or rational'*. This is not a measure of negligence but much more akin to a public law test; it asks whether the decision should be interfered with. This would, she submits, avoid the stalemate situation. She invites the court '*not to overrule GJ but to distinguish it, and to equip decision makers with the tools to manage the inevitable 'stalemate' that arises from its application in cases such as this'*.

Official Solicitor

64. The Official Solicitor opposes the appeal. Mr Allen submits that the two grounds of appeal can be readily conflated to one ground: did the judge err in concluding that JS was ineligible by virtue of MCA 2005 Schedule 1A? He submits the leading case is *GJ* and Schedule 1A paras 5, 12, 16 and 17 determine case E eligibility.

65. Taking the key questions outlined above, he submits that in relation to the first question, is the person a 'mental health patient' this means in accordance with Schedule 1A paragraph 16 *'a person accommodated in a hospital for the purpose of being given medical treatment for mental disorder'*. It requires the MCA 2005 decision maker to determine what is the purpose of hospital confinement; is it to give treatment for physical or mental disorder? Often the treatment is for both physical and mental health issues, hence the rationale of Charles J to adopt the 'but for' test: 'but for' the need for the package of physical treatment should P be detained in hospital? If the answer is 'no', the person is a physical health patient and eligible. If the answer is 'yes' because of the need for treatment of mental disorder, the decision maker needs to proceed to the second question.

66. Mr Allen acknowledges that it is not always straightforward to distinguish between treatment for mental and physical ill-health. Paragraph 17 Schedule 1A assists, stating 'medical treatment' has the same meaning as in the MHA 1983. Section 145 (1) MHA 1983 provides that this includes *'nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care'* and explains at s145(4) *'medical treatment, in relation to mental disorder, shall be construed as a reference to medical treatment the purpose of which is to alleviate, or prevent, a worsening of the disorder or one or more of its symptoms or manifestations'*. 'Mental disorder' has the same meaning as in the MCA Schedule 1A paragraph 14 which refers to the meaning in the

MHA 1983, s1 MHA 1983 defines mental disorder as *'any disorder or disability of mind'* excluding drug or alcohol dependency.

67. As a consequence Mr Allen submits first, medical treatment is broadly defined but in relation to mental disorder it must have the purpose of alleviating or preventing a worsening of the disorder or one or more of its symptoms or manifestations. It requires the purpose of the treatment to be to alleviate or prevent a worsening. Chapters 23 and 24 of the MHA Code provide further explanation which, he says, supports his submission. Second, treatment for mental disorder is not limited to treating an 'underlying' or 'core' mental disorder. It includes addressing its manifestations, as summarised by Charles J in *GJ* in [52], demonstrating the breadth of the MHA 1983 and its purpose insofar as medical treatment for mental disorder is concerned. Examples from previous cases illustrate the point, such as feeding was considered treatment for autism, dialysis was treatment for personality disorder and why treating wounds self-inflicted as a result of mental disorder also falls within the definition.

68. Turning to the second key question whether JS is an objecting mental health patient, Mr Allen notes that Schedule 1A paragraph 5 (6) and (7) are broadly drafted and include consideration of P's behaviour. This breadth is reflected in both the DoLS Code (at paragraph 4.46) and the MHA Code (at paragraph 13.51). The reasonableness of the objection is irrelevant and decision makers should err on the side of caution, and if in doubt treat the person as objecting.

69. Finally, the third key question; 'could' the person be detained under MHA 1983? The Official Solicitor supports the *GJ* test as determined by Charles J. Parliament entrusted the eligibility decision to the Deprivation of Liberty Safeguards assessor and ultimately the Court of Protection judge. The suggested change contended by the appellant is not supported by the Official Solicitor as it risks greater uncertainty and satellite litigation. Mr Allen submits *'It also conflicts with the aim of case E which is to put P on an equal footing with their capacitous counterpart.'* It risks undermining the safeguards of the MHA 1983 as there is a risk they would be routinely denied to those lacking capacity. The 'what the decision-maker thinks' test adopted in *GJ* means each decision-maker must consider the circumstances and reach their own decision based on the situation and available evidence. The reasoning of each can legitimately be probed by the other but in the final analysis neither can be compelled to change their decision.

70. Mr Allen submits the risk of stalemate is reduced as the statutory assumptions in Schedule 1A paragraph 12 play a key role in ensuring such reasoning is properly based. As Charles J observed in *GJ* at paragraph 58 the statutory assumptions assume that an alternative solution is not available under the MCA 2005 and aim to equate the position of P with that of their capacitous counterpart.

71. Part of this includes requiring the MHA 1983 decision-maker to assume that the MCA 2005 is not available . In *GJ* Charles J dealt with this at [46]:

    46 This is because they point to the conclusion that <u>when the MHA 1983</u> is being considered by those who could make an application, founded on the relevant recommendations, under s. 2 or s. 3 thereof they, like the decision maker under the MCA, should assume that (a) the treatment referred to in s. 3(2)(c) MHA 1983 cannot be provided under the MCA, and (b) the assessments referred to in s. 2 cannot be provided under the MCA in circumstances that amount to a deprivation of liberty.

72. These assumptions are required only for mental health patients who are, or are to be, confined to hospital. As Mr Allen observed, removing the MCA 2005 presents the decision-maker with a stark choice: either the person is confined under the MHA 1983 or they are not confined at all. It provokes them to consider explicitly P's capacitous counterpart for whom similarly the MCA 2005 is not available. Based on the nature and degree of P's mental disorder, the risks arising, the options available, and P's objections: the question is does P meet the MHA 1983 grounds? If not, they cannot be deprived of their liberty in a hospital.

73. He submits the proper application of the statutory framework and statutory assumptions that apply to both sets of decision-makers serve to reduce, if not avoid, the risk of any gap developing between the two procedures.
74. In the event of a dispute, each decision-maker can legitimately probe the reasoning of the other. When a party, usually a hospital Trust, applies to the Court of Protection for authorisation to deprive liberty it will need to convince the judge that P is not ineligible. Evidence of the reasoning of the MHA decision-maker should be provided as part of the evidence in support of the application. In the interim, pending that decision, provided the stringent conditions are met, s4B MCA 2005 provides interim authority to deprive liberty whilst the court makes directions and determines P's eligibility. Subject to any appeal the parties are likely to accept the Court's determination on eligibility.

75. As Mr Allen notes, this case demonstrates how in practice some people have fallen through the gap in the procedures prescribed by Parliament and it is not limited to young people. The MHA Code paragraph 13.69 provides '*In the rare case where neither the Act nor a Dols authorisation nor a Court of Protection order is appropriate, then to avoid an unlawful deprivation of liberty it may be necessary to make an application to the High Court to use its inherent jurisdiction to authorise the deprivation of liberty'*.

76. In relation to this case Mr Allen submits JS was confined to a MHA registered hospital for the purpose of being given medical treatment for mental disorder. He submits this is clear from the care plan of restrictions dated 9 February 2023. As a result, JS was a mental health patient. JS was objecting to being accommodated and to treatment for her mental health disorder. Having considered the written and oral

evidence, the Judge correctly decided that based on the statutory assumptions JS 'could' be detained under s3 MHA 1983.

Local Authority

77. Ms Sharron, on behalf of the local authority, supports the Official Solicitor's analysis. She rejects the appellants' submission that the Judge failed to apply the criteria under section 3(2) MHA 1983 or that he failed to give sufficient weight to the clinical opinion when applying the statutory criteria.

78. She submits that at [81], [88], and [90] of the judgment the Judge addresses section 3(2) MHA 1983 dealing with JS's mental disorders, the nature and degree of those orders and why detention in hospital was appropriate for treatment of those disorders.

79. The Judge clearly weighed in the balance Dr K's written and oral evidence, in particular at [42], [69], [70], [71] and [88] of the judgment. He did not disagree what was appropriate in terms of JS's care and treatment, only in relation to what the legal implications of it were. Dr K's evidence was that what they were providing did not meet the threshold under the MHA. The Judge disagreed and gave his reasons.

80. At [91] the Judge addresses s 3(2)(c) MHA 1983 in terms of why detention in hospital was necessary, referring to JS's health and safety or the protection of others noting *'The medical treatment she did receive as a detained patient in hospital was necessary to keep her safe and to prevent her from absconding or harming herself'*. The treatment could not be provided unless JS was detained because, as noted by the Judge *'There was not a readily available alternative when she was receiving it'*.

81. Section 3 (2) (d) MHA 1983 is addressed by the Judge at [69] – [71], [92] and [97] of the judgment. The Judge sets out at [67] – [71] how the treatment that JS was receiving meets the definition of treatment in accordance with s145 MHA 1983. There was no issue before the court that the measures set out in the care plan were necessary and appropriate.

82. As Ms Sharron emphasises, the issue was whether the provisions in the care plan represent treatment for mental disorder which was necessary for JS to be detained in order to receive it. In addition to the provisions in s145 MHA 1983, Ms Sharron relies on the MHA 1983 Code of Practice:

    '*23.5 Symptoms and manifestations include the way a disorder is experienced by the individual concerned and the way in which the disorder manifests itself in the person's thoughts, emotions, communication, behaviour and actions…'*

    Further the Code addresses the breadth of what may be considered appropriate treatment under the MHA 1983 :

'23.17 Appropriate medical treatment does not have to involve medication or psychological therapy – although it very often will. There may be patients whose particular circumstances mean that treatment may be appropriate even though it consists only of nursing and specialist day-to-day care under the clinical supervision of an approved clinician in a safe and secure therapeutic environment with a structured regime.'

83. Ms Sharron submits the psychotropic medication, mental health reviews, nursing, restraint and therapeutic containment that the care plan provided, which should be considered holistically, was intended to alleviate or prevent a worsening of the symptoms and manifestations of JS's mental health disorders. As she observed, *'Whilst the treatment in the care plan may not have been the optimum treatment plan for [JS], no party sought to suggest that it was not, in and of itself, necessary and in [JS]'s best interests, given the lack of alternative available, and the risk to [JS] if she was discharged without suitable care being in place'.*

84. Ms Sharron referred the court to one entry to illustrate her point. On 28 January 2023 after a particularly difficult incident when JS tried to run off twice, she had to be restrained, additional security staff had to be called, medication was administered and the mental health team were called. The record notes *'they didn't turn up as they were short staffed'.* Additional medication was administered under physical restraint, there were '*10 security guards with a female support worker to hold and comfort her. She should be seen and cared for by MH team, as staff in assessment unit are not trained to handle mental health issues….'* There are similar entries on 29 and 31 January 2023 and the staff who cared for her recognised she was inappropriately placed in an acute ward area.

85. Ms Sharron submits 'appropriate treatment' under s 3(2)(d) is subject to the provisions in s3(4) MHA 1983 which provides *'In this Act, references to appropriate medical treatment, in relation to a person suffering from mental disorder, are references to medical treatment which are appropriate in his case, taking into account the nature and degree of the mental disorder and all other circumstances of his case'.*

86. The MHA 1983 Code of Practice provides further explanation

'23.11 The test requires a balanced and holistic judgment as to whether, medical treatment available to the patient is appropriate, given the nature of the patient's mental disorder, and all other circumstances of the patient's case. In other words , both the clinical appropriateness of the treatment and its appropriateness more generally must be considered'

One of the examples given at paragraph 23.12 of the Code as to what other circumstances may be considered is *'the consequences for the patient, and other people, if the patient does not receive the treatment available'.*

87. At the time of JS's detention, Ms Sharron submits, there were no alternatives available, the consequences to her would be severe, giving rise to a risk of significant

self-harm or even death, unless she was detained, until a safe discharge plan could be put in place. She submits it is not uncommon for patients to be detained under MHA 1983 to remain subject to s3 until such time as a suitable discharge placement is available.

88. Ms Sharron rejects the appellant's submission that the treatment JS received was coincidental to being in a safe environment. She submits the evidence shows little change in the care JS was receiving when her s2 lapsed. There was no obvious change to the care plan and rejects any suggestion that JS was being provided with 'hotel type' services in the hospital, illustrated by just one example, the steps that had to be taken by the staff on 6 February 2023 to prevent JS securing a ligature. The risks remained very high for JS, they were largely caused due to her mental disorders and she needed the provisions in the care plan and to remain in hospital due to the high level of risk to JS.

89. As regards the test in *GJ*, Ms Sharron submits the 'but for' test applies to the first question, namely whether JS is a mental patient. The 'decision maker' test refers to the third question, namely whether JS could be detained under the MHA 1983 s2-3.

SHSC

90. On behalf of the SHSC Ms Kelly limits her written and oral submissions to assist the court on the framework of Schedule 1A MCA 2005. In her helpful analysis she agrees with the submissions of the Official Solicitor and local authority as to the legal framework.

91. If it is proposed that a person should be detained in hospital but authorisation has not been given under the MCA 2005 or MHA 1983, she submits professionals should meet and discuss the position in the spirit of co-operation to seek a resolution. Consideration should be given to what can be put in place to support the person in the community pursuant to s117 MHA 1983 and/or Care Act 2014 duties. She submits *'It cannot be an appropriate outcome for people to remain de facto deprived of their liberty in hospital without legal authorisation'.*

MIND

92. The helpful submissions on behalf of MIND provided some important context and highlighted the difficulties in the application of the legal framework which could have been better expressed, taking into account the stretched resources in the community. There is a need for the construction of Schedule 1A that makes clear: (1) who is making the decision; (2) what test they are applying; and (3) what should happen when there is disagreement between professionals or organisations. MIND supports the test regarding Schedule 1A as determined by Charles J in *GJ* at least in respect of the test to decide which regime should be used for a person not currently subject to either the MHA 1983 or MCA 2005.

Discussion and decision

93**.** Sadly, the circumstances that exist in this case reflect the wider problem of an alarming number of cases which involve legal issues that arise when a young person

is deprived of their liberty where there are insufficient suitable places in the community. The Nuffield Family Justice Observatory has published research analysing data regarding applications under the inherent jurisdiction seeking orders that authorise deprivation of liberty relating to children. The latest data reveals that there are about 117 new applications per month, 60% relate to children who are 15 years and over, about 70 children a month within that age range.[1] Many of these cases involve significant difficulties about the suitability of placements the young people are in.

94. In this case the application was brought in the Court of Protection, which provides the legal framework for such orders for persons between the ages of 16 and 18 who lack capacity and who are not ineligible in accordance with Schedule 1A. Where a person is aged 18 and above, then the legal framework will be provided by the Deprivation of Liberty Safeguards regime, where it is applicable.

95. In her written submissions Ms Kelly provided a helpful summary regarding Case E under Schedule 1A MCA 2005, it applies **only**:

(1) where it is proposed that a person should be deprived of their liberty (para 2 Schedule 1A MCA 2005).
(2) where the proposed detention would take place in a hospital (paragraph 12(1) Schedule 1A MCA 2005; 'hospitals' is defined to have the same meaning as under Part 2 MHA 1983 (paragraph 17(1) Schedule 1A MCA 2005).
(3) where a detention in hospital is proposed for the purpose of giving medical treatment for mental disorder (Paragraphs5(3) and 16(1) Schedule 1A MCA 2005) . 'Mental disorder' and 'medical treatment' both have the same meaning as in the MHA (Paragraphs 17 (2)-(3) Schedule 1A MCA 2005). Case E is not relevant if the person is being detained for the purpose of treating physical health.
(4) where the person is objecting either to being a mental health patient or to be given some or all of the mental health treatment (paragraph 5(4) Schedule 1A MCA 2005). Objections are construed broadly, taking into account both statements and behaviours, wishes, feelings, views, beliefs and values (paragraph 5(6) schedule 1A MCA 2005).

96. The criteria in Case E to determine eligibility was the subject of careful and detailed examination by Charles J in *GJ*. As set out above, Case E applies where it is proposed that a person should be deprived of their liberty, in hospital, for the purposes of medical treatment for mental disorder, to which the person objects, but is not subject to detention under the MHA 1983.

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[1] **National deprivation of liberty court: Latest data trends - June 2023 – Nuffield Family Justice Observatory** (nuffieldfjo.org.uk)

97. Like this court, Charles J had the benefit of the SHSC intervening to assist the court. Charles J's conclusion and reasoning as to the test the court should apply is detailed in that judgment at [69] – [80] (as set out above).

98. I do not consider there is any reason or sound basis to depart from that test and analysis, as set out in *GJ*. Ms Mulholland sought to suggest that it has caused difficulties and uncertainty on the ground, and to avoid that the court should re-visit the arguments advanced in *GJ* by the First and Second Respondents in that case and rejected by Charles J for the reasons he gave at [75] and [76] of that judgment.

99. I agree with the other parties that the tests advocated by Ms Mulholland, where the MCA 2005 decision-maker interferes with the MHA 1983 decision-maker only if their decision is not *'logical and rational. This is not a measure of negligence, but much more akin to a public law test',* would probably lead to more uncertainty and risk undermining the purpose of the legislation. Such a development would not be welcome in this area, where the legal landscape needs stability rather than further uncertainty.

100. In the end it was far from clear whether the appellant was actually challenging the test. In her skeleton in response Ms Mulholland invites the court '*not to overrule* GJ *but to distinguish it, and to equip decision makers with the tools to manage the inevitable 'stalemate' that arises from its application in cases such as this'*. There was no basis to distinguish it. Charles J clearly set out the principles as to how the test should be applied, recognising that the application will be fact dependent on the circumstances of each case.

101. I agree with the Official Solicitor that the two grounds of appeal can sensibly be merged into one, namely: did the Learned Judge err in concluding that JS was ineligible by virtue of MCA 2005 Schedule 1A?

102. The focus of Ms Mulholland's submissions was the failure by the Judge to deal with the relevant parts of s 3(2) MHA 1983.

103. In his careful and well-reasoned judgment the Judge addressed each of the three key questions the parties agree provide a helpful framework to consider these issues, namely:

(1) Is P a 'mental health patient'?
(2) Is P an 'objecting' mental health patient?
(3) 'Could' P be detained under MHA 1983 s2-3?

104. Was JS a mental health patient? As the Judge noted in [22] of his judgment, her care plan remained the same as it had been when she was subject to s2 MHA 1983 noting *'with exactly the same purpose namely to treat [JS's] challenging behaviour, largely*

by physical containment and the use of restraint both by physical intervention and medication.' After detailing the medication the Judge stated [23] '*It seems entirely obvious to me those treating [JS] considered her behaviour to be a manifestation of her mental disorder. This pharmacological treatment was intended to combat it'.* Put simply, he concluded the purpose had not changed, she remained a mental health patient. As set out above, medical treatment is broadly defined but in relation to mental disorder it must have the purpose of alleviating or preventing a worsening of the disorder or one or more of its symptoms or manifestations. Treatment for mental disorder is not limited to treating an underlying or core mental disorder, it included addressing its manifestations. The conclusion the Judge reached was entirely justified on the evidence.

105. At [6] of his judgment the Judge identified her mental health diagnoses; ASD, ADHD, learning disability and an attachment disorder. He had evidence from the registered nurse that confirmed she was medically fit for discharge on 10 January 2023. The statement detailed evidence of what nursing was being provided to JS, that she continues to self-harm, wishes to end her life and the detailed incidents that had taken place since the s2 lapsed, including seeking to swallow a plastic cup and trying to self-ligature with a shower cord. The nurse's statement confirmed JS was not permitted to leave her room due to the risk of absconding and the severe risk of the consequences of that.

106. The statement from JS's treating psychiatrist, Dr K, confirmed at JS's review on 25 January 2023 the clinical view is that *'much of her difficulties relate to ASD, ADHD and LD'.* Later in the statement, he states these neurological disorders *'affect her ability to manage emotional, psychological distress, manage daily distress and relationships, changes to environment, limit her ability to adapt to changes. Her rigid thinking prevents her from considering other options…these therefore manifest in agitation and self-harm. She isn't able to identify triggers and cannot remember incidents of severe agitation. She is impulsive. All this makes her behaviour unpredictable. When she is in an agitated state she isn't able to think and consider the risks that her actions pose. She is not able to appraise her arousal and control herself and this therefore has required that restrictions are placed to maintain her safety in hospital'.* This evidence is all connected to JS's mental disorder. In the letter from the Trust to the social worker on 26 January 2023, it sets out how the risks relate to her neuro-developmental difficulties, again confirming that it is her mental disorder that gives rise to these risks and why the hospital needed to put in place the care plan.

107. The care plan includes medical treatment for the manifestation of her mental disorder, including physical and chemical restraint, regular room review by the nurse to remove any risky objects that JS could use to harm herself or others, restriction on leaving the hospital and a high level of supervision. The care plan provides detailed provision for sedative medication in the event JS's behaviour is not managed any other way. When undertaking the *GJ* 'but for' test the detail in this care plan is clearly not treatment for physical health but treatment for mental disorder.

108. The appellant submits the Judge did not ask the question regarding s3 MHA 1983, however the notes of Dr K's oral evidence make clear the Judge was probing this

issue in connection with the care plan and that the treatment in it relates to her mental disorder, which Dr K acknowledged. The Judge explored with Dr K in his oral evidence why the provisions of the MHA 1983 had not been used.

109. As regards the second key question, there is no issue between the parties that JS objected.

110. Turning to the third key question, could JS have been detained under the MHA 1983 s2-3, the Judge considered this issue in some detail.

111. At [67] and [68] he set out s 3(2) and (4) MCA 1983. At [69] the Judge analysed the purpose of JS's care plan, concluded at [71] that JS's behaviours were '*manifestations of her mental disorder'*. As he states *'...put another way, [JS's] mental disorder causes her to abscond from safe environments, such as her home or hospital. It causes her to place herself at great risk of danger. It causes her to injure herself using sharp objects or taking overdoses. She has done this with alarming regularity. Nothing that those responsible for her care have been able to do has prevented her from doing so. However, that is what they were trying to do, and their treatment was aimed at that'.*

112. The Judge set out his reasoning at [90] – [97] as follows:

> *90. Firstly, that she was accommodated at the Hospital as a place of safety because there was nowhere else for her to go and, once the physical damage caused by her overdose was successfully treated, she needed no in patient medical treatment. The answer to that is: of course, she did. She was a danger to herself. She needed to be nursed safely and medicated to address the effects of her mental disorder (viz. to injure herself and abscond away for safety).*
>
> *91. It was submitted that although [JS] suffers from a mental disorder it was not of a nature or degree to make it appropriate for her to receive medical treatment for that disorder in a hospital. This is clearly wrong. The medical treatment she did receive as a detained patient in hospital was necessary to keep her safe and to prevent her from absconding or harming herself. There was no readily available alternative when she was receiving it.*
>
> *92 It is submitted that the outcome of the MHA Assessments was that inpatient care for [JS's] condition was neither available nor desirable because she could be treated in the community under the MCA. This too is plainly wrong. She could only be treated in the community once a suitable package of care was available for her. Until then she could not safely leave hospital. That was the situation with which I was confronted at the first hearing. At that point hospital was the only option.*
>
> *93. This is quite a familiar situation for those who practise mental health law. Patients who have been detained under the MHA (like [JS]) can theoretically be discharged into the community with a suitable package of care, but only when that package is actually available. Many weeks or months can be spent putting such packages together (funding, placement, support etc) and in place. During*

which time patients remain detained. The whole s. 117 process is designed to speed that up so as to ensure detained patients get out and stay out of hospital. Of course, because [JS] was never detained under s. 3 of the MHA, s. 117 aftercare was not available to her.

94. The hospital thought that utilising the MHA to detain [JS] would be harmful to her mental health, as would her remaining in Hospital. This is an invalid argument which contains two fallacies. First, she was detained by her care plan which I have summarised above. What jurisdictional label is placed on the care plan is immaterial to its restrictive nature, whether that be MHA, MCA, "common law", the High Court's inherent jurisdiction is irrelevant to whether she was detained for treatment. That was the care plan's doing.

95. Secondly, keeping her in Hospital for a day longer than was necessary was also nothing to do with the regime she was subject to. Good clinical practice and the operation of Article 5 of the European Convention requires a patient to be detained only for so long as is necessary. The MHA does not prolong detention. In fact, as I have already said, proper use of s. 117 should reduce the overall time a patient spends in Hospital because professionals inside and out of Hospital concerned with health and social care should all work together to put together an effective discharge plan speedily.

96. There seems to be a belief, not just in this case but in others which I have heard recently, that the decision to use the MHA should be viewed in isolation from what is available elsewhere at the time the decision to detain or not detain is taken. Ideally, a 17-year-old vulnerable young person would not be detained in a psychiatric facility, let alone a mixed adult general ward. However, where there is literally no option in which that young person will be safe, or as safe as possible in the circumstances, I cannot see how the MHA decision maker can avoid the decision I have had to make in this judgment. If the patient has to be detained for treatment for their mental disorder, and there is no alternative outside the hospital setting, and no other treatment plan available, then it seems clear to me the patient should not be detained under the MCA but rather under the MHA.

97. In my judgment, [JS] was receiving medical treatment for her mental disorder. The order I was asked to make in the Court of Protection was intended to authorise that care plan which inevitably led to [JS] being deprived of her liberty for that purpose.

113. The Judge was entitled to reach the conclusions he did on the evidence he had. He anxiously considered the provisions of s3, the evidence he had available to him and clearly set out his conclusions with admirable clarity and reasons in support. He was not wrong, did not fall into error and there is no other basis upon which this appeal should be allowed. Accordingly, the appeal is dismissed.

Wider issues

114. The court has had written and oral submissions about what has been termed 'the stalemate' that could arise in these situations. The Official Solicitor, the local authority and the SHSC submit that if the legal framework is applied correctly there should be no stalemate or gap. If there is it relates to a gap in practice, rather than the legal framework.

115. Any judge who sits in this area will have encountered these difficult cases involving young people where an issue has arisen as to the appropriate legal framework under which the deprivation of liberty is sought to be authorised. There remain some misunderstandings, as there was in this case. The Trust case record referred to the continued authorisation of JS's deprivation of liberty when the s 2 lapsed prior to issuing these proceedings was under common law. Ms Mulholland rightly accepted that was incorrect.

116. A practical step that could be taken in cases where Schedule 1A Case E issues are likely to arise, is for evidence to be provided to address that issue, utilising the *GJ* framework. That would not only assist the court and the parties, but also focus the minds on what needs to be addressed both in terms of any decisions to date under the MHA 1983, the basis of the application in the Court of Protection and addressing the key questions outlined above.

117. As regards the issue of stalemate more generally, the practical suggestions outlined by Ms Kelly on behalf of the SHSC provide a useful road map for the parties to resolve any issues. They are set out below. Ms Kelly takes issue with what Ms Mulholland stated was one of the issues that caused the stalemate in this case, that the Trust did not have any approved mental health professionals ('AMHPs') to proceed with any application under the MHA 1983. This perhaps illustrates Ms Kelly's first point below, as far as Ms Kelly is aware there is no evidence in this case that any attempt was made to contact an AMHP to try and resolve this issue.

118. Ms Kelly's practical suggestions are:

(1) The MHA and MCA decision-makers should arrange for discussions between the relevant professionals. They should be undertaken in what Ms Kelly describes as *'the spirit of cooperation and appropriate urgency'*. This will ensure the relevant professionals have reviewed and considered relevant evidence and if required further inquiries can be made.

(2) If these discussions do not result in a detention being authorised under the MCA the hospital has a number of choices:

(i) It can seek the person's admission under the MHA 1983 to authorise the deprivation of liberty, including on a short term basis while it seeks to advance the person's discharge;

(ii) It can seek for the person to be detained in an alternative setting, such as a care home, in which Case E has no application, with consideration being given to what can be put in place to support the person in the community under s 117 MHA 1983 and/or Care Act 2014 duties.

(iii) It can stop depriving the person of their liberty if it considers the person should not be detained under MHA 1983, even with the knowledge that the person will not be detained under the MCA 2005.

(iv) If the hospital does not consider that an application for assessment or treatment under MHA 1983 is warranted but does consider it is in the person's best interests to be detained in hospital for treatment of a mental disorder, it should consider carefully its reasons for drawing this distinction. The hospital could apply to the Court of Protection for a determination of whether the person is eligible for detention under the MCA 2005.

119. I can see the sense in the suggestion of an application to the Court of Protection for a determination being a possible route to resolve these issues, but that is not said with any encouragement for such applications to be made unless it is necessary, and only after all other options have been explored. It will be a matter for each individual judge whether such an application is accepted, depending on the particular circumstances of the case.

120. Although not advocated by the SHSC or MIND, the other parties submitted the inherent jurisdiction could, in certain circumstances, be resorted to. For those under 18 years that happens within the principles outlined by the Supreme Court in *Re T (A Child) (Appellant)* [2021] UKSC 35. Against the chronic shortage of provision of secure children's homes in England and Wales, it was determined in that case that the inherent jurisdiction of the High Court can be used to authorise the deprivation of liberty of a child who meets the criteria in s 25 Children Act 1989 (CA 1989) in a place other than approved secure accommodation, subject to safeguards.

121. For 16 and 17 year olds there is concurrent jurisdiction with the Court of Protection. There is provision in The Mental Capacity Act 2005 (Transfer of Proceedings) Order 2007 (SI2007/1899) for the transfer of proceedings in relation to such children between the Court of Protection and a court having jurisdiction under the CA 1989.

122. As Senior Judge Hilder noted in *Bolton Council v KL* [2022] EWCOP 24 at [46] the Court of Protection has been receiving and determining applications for authorisation of deprivation of liberty in the living arrangements of 16 and 17 year olds both with and without a care order in place. A recent increase has been noted of applications being made for this cohort of young people, as well as applications which begun as proceedings under the inherent jurisdiction that are transferred to the Court of Protection.

123. Drawing these threads together the following matters may provide a guide in these difficult cases:

(1) In any application seeking authorisation to deprive the liberty of a 16 or 17 year old, the applicant should carefully consider whether the application should be made in the Court of Protection and, if not, why not.

(2) If a Schedule 1A Case E issue is likely to arise any evidence filed in support of an application should address that issue, so the relevant evidence is available for the court, thereby reducing any delay.
(3) In the event that the Court of Protection determines that P is ineligible the professionals should urgently liaise in the way outlined above.

124. I do not underestimate the challenges these cases cause in circumstances where there is a lack of appropriate placements for these vulnerable young people, however it is important there is a clear understanding about the respective legal frameworks that govern these decisions so that the obligations under the ECHR are complied with, in particular Article 5.

ML -v- (1) Priory Healthcare Limited and (2) SSJ
[2023] UKUT 237 (AAC)

IN THE UPPER TRIBUNAL **Appeal No. UA-2022-000640-HM**
ADMINISTRATIVE APPEALS CHAMBER

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

Between:

ML

Appellant

- v –

Priory Healthcare Limited

First Respondent

Secretary of State for Justice

Second Respondent

Before: Upper Tribunal Judge Church

Following a remote video hearing held on 16 May 2023

Representation:

Appellant:	Mr Roger Pezzani of counsel, instructed by Mrs Yesim Hall of TV Edwards, Solicitors
First Respondent:	Not represented
Second Respondent:	Mr Alex Cisneros of counsel, instructed by the Government Legal Service

DECISION

This decision may be made public (rule 14(7) of the Tribunal Procedure (Upper Tribunal) Rules 2008 (SI No 2698)).

The decision of the Upper Tribunal is to allow the appeal.

The decision of the First-tier Tribunal made on 25 February 2022 with case reference number MP/2021/20568 involved the making of an error in point of law. It **is SET ASIDE** under section 12(2)(a) of the Tribunals, Courts and Enforcement Act 2007

and the case is **REMITTED** to the First-tier Tribunal for rehearing by a differently constituted panel under section 12(2)(b)(i).

REASONS FOR DECISION

What this appeal is about

1. This appeal is about ML, a 63 year old man who is a restricted patient detained at Kneesworth House Hospital under sections 47 and 49 of the Mental Health Act 1983 (the **"1983 Act"**). He has been detained for over 35 years, the last 15 years of which have been spent in secure psychiatric hospitals. His tariff expired more than 30 years ago. This appeal arises out of his application to the First-tier Tribunal to review his section. In practical terms, he wanted to secure a conditional discharge by the Secretary of State. The first step towards this was to seek a notification from the First-tier Tribunal under section 74(1)(a) of the 1983 Act (see paragraph 11 below).

2. Legally speaking, the appeal is about the interplay between two different statutory regimes: the 1983 Act and the Mental Capacity Act 2005 (the **"2005 Act"**). The 1983 Act is concerned with the provision of medical treatment of people suffering from mental disorder, and when they should be liable to be detained in hospital for treatment, while the 2005 Act is concerned with the making of decisions in the best interests of those who lack relevant mental capacity. There are inevitably areas of overlap between the two regimes, and this case raises issues about what consideration the First-tier Tribunal must give to the mechanisms available under the 2005 Act when deciding whether the statutory conditions to detention under the 1983 Act are met, and whether continued detention represents the "least restrictive option" for the patient's care.

3. The main thrust of the appeal was that the First-tier Tribunal heard evidence that the Appellant lacked capacity to make decisions in relation to various matters, including whether he should take prescribed psychotropic medication, and evidence that he could be made subject to a care plan which involved a deprivation of liberty that could be authorised under the 2005 Act in accordance with the principles set down in *MC v Cygnet Behavioural Health Ltd and Secretary of State for Justice (Mental Health) (Rev 1)* [2020] UKUT 230 (AAC) (**"*MC v Cygnet*"**).

4. It was argued before the First-tier Tribunal that, in light of this evidence:

   a. continued detention in hospital was not necessary;

   b. section 72(1)(b)(ii) of the 1983 Act was not satisfied; and

   c. section 73 of the 1983 Act required that the Appellant be discharged from detention.

5. The First-tier Tribunal decided that:

   a. each of the statutory criteria to detention was satisfied; and

   b. had the Appellant been subject to a restriction order under section 41 of the 1983 Act, he would not have been entitled to be discharged from liability to be detained in hospital for medical treatment,

   (the **"FtT Decision"**).

Grounds of appeal

6. The Appellant's grounds of appeal against the FtT Decision are that the First-tier Tribunal erred in law either:

a. by deciding whether the criteria in section 72(1)(b) were met without reference to the evidence and submissions on the availability of an alternative regime for achieving his compliance with medication; or

b. by failing adequately to explain what it made of such evidence and submissions.

Factual and Procedural Background

7. On 19 November 1986 the Appellant was convicted of manslaughter by reason of diminished responsibility and sentenced to life imprisonment. The circumstances of the Index Offence are very troubling indeed.

8. While in prison, the Appellant was assessed to be suffering from mental disorder and was diagnosed with paranoid schizophrenia. On 23 July 2006 the Secretary of State issued a warrant under sections 47 and 49 of the 1983 Act (i.e. a transfer direction with a restriction direction) restricting the Appellant's discharge without limit of time.

9. The Appellant was transferred from prison to hospital. At the time of the hearing before the First-tier Tribunal, he was detained at Kneesworth House Hospital.

10. He made an application for his section to be reviewed and, on 25 February 2022, the First-tier Tribunal held a remote video hearing of his application.

The case put to the First-tier Tribunal

11. By his application to the First-tier Tribunal the Appellant sought:

a. a notification under section 74(1)(a) of the 1983 Act that he would, if subject to a restriction order, be entitled to a conditional discharge; and

b. a recommendation under section 74(1)(b) of the 1983 Act that if not discharged by the Secretary of State he should continue to be detained in hospital (rather than be remitted to prison).

12. It was accepted by Mr Pezzani that the Appellant suffers from mental disorder (namely a diagnosis of paranoid schizophrenia, as well probably having a personality disorder and traits of autism spectrum disorder). It was also accepted that he required medical treatment to manage the risks associated with his mental disorder.

13. While the Appellant's responsible clinician and all but one of the other witnesses for the detaining authority supported the Appellant's continued detention in hospital, expert evidence from an independent forensic consultant psychiatrist instructed by the Appellant (Dr Chin) and an independent social worker and approved mental health professional instructed by the Appellant (Mr Spencer-Humphrey), as well as the evidence of the Appellant's primary nurse at Kneesworth House, indicated that he could be managed effectively in the community with 24 hour support in the context of a conditional discharge, with any necessary deprivation of liberty being authorised under the 2005 Act.

14. The issue of the Appellant's capacity to make decisions in his best interests was raised in each of the reports before the First-tier Tribunal, and Mr Pezzani made a clear submission about capacity in his position statement:

> "7. There is therefore a wealth of evidence to suggest that ML lacks capacity to make decisions about many of his post-discharge needs. That in turn indicates a reasonable likelihood that an MCA authorisation of a DoL care plan would be available. And that means that consideration of whether ML is entitled to conditional discharge should include an evaluation of how a DoL care plan would affect the question of whether the criteria in s.71(1)(b) are satisfied.
>
> 8. Active symptoms of mental disorder, whether positive or negative, do not on their own mean that detention in hospital or treatment is either appropriate or necessary. Otherwise, every person with a mental disorder would be liable to detention for treatment. The question is whether the symptoms mean that treatment and management of the risks can *only* be achieved by detention in a hospital. If the answer to that question is "no" because treatment and risk management can also be achieved outside hospital, then detention for treatment is neither appropriate nor necessary.
>
> 9. The issue is therefore whether the treatment and risk management that can be provided outside hospital is likely to represent a viable alternative to what is provided in hospital, i.e. is an alternative means of achieving the same ends. Dr Chin and Mr Spencer-Humphrey say that it is. What they recommend is in practice closely analogous to the current regime: it is proposed that ML will continue to have 24-hour support; will continue to receive medication, and care, and supervision. It follows from that that with suitable aftercare ML will be no more likely to relapse and/or present an unmanageable risk to himself or the public *outside* hospital than he does *in* hospital" (see p. 242 of the appeal bundle).

15. The First-tier Tribunal heard evidence that, while the Appellant would choose not to take medication if given a free choice, he would take medication if he were required to do so by a "rule".

The permission stage

16. ML applied to the First-tier Tribunal for permission to appeal the FtT Decision. Permission was refused by a judge of the First-tier Tribunal on the basis that there was no arguable error of law, but ML then applied to the Upper Tribunal for permission to appeal and the matter came before me. I granted permission.

The oral hearing of the appeal

17. I directed a remote video hearing of the appeal. The hearing was attended by Mr Pezzani of counsel and Mrs Hall of TV Edwards on behalf of the Appellant, and by Mr Cisneros of counsel for the Second Respondent. The First Respondent did not attend and was not represented. I am grateful to both counsel for their helpful and clear submissions on this appeal.

The Law

18. The First-tier Tribunal's jurisdiction over the Appellant was governed by section 74 of the 1983 Act, which imports the criteria in section 73(1) and (2), which in turn import the criteria in section 72(1)(b)(i), (ii) and (iia) of the 1983 Act.

19. Section 72 of the 1983 Act sets out the circumstances in which a tribunal may or, as the case may be, must discharge a patient. It provides (so far as relevant for the purposes of this appeal):

> **"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 –
>
> …
>
> (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 or 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 …"
>
> …

20. Section 73 of the 1983 Act sets out the power of the tribunal to direct the discharge of restricted patients. It provides (so far as relevant for present purposes):

> **"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-
>
> (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.

21. Section 74 of the 1983 Act provides:

> **"74. Restricted patients subject to restriction directions**

(1) Where an application to the appropriate tribunal is made by a restricted patient who is subject to a limitation or a restriction direction, or where the case of such a patient is referred to the appropriate tribunal, the tribunal –

(a) shall notify the Secretary of State whether, in its opinion, the patient would, if subject to a restriction order, be entitled to be absolutely or conditionally discharged under section 73 above; and

(b) if the tribunal notifies him that the patient would be entitled to be conditionally discharged, may recommend that in the event of his not being discharged under this section he should continue to be detained in hospital.

…

(6) Subsections (3) to (8) of section 73 above shall have effect in relation to this section as they have effect in relation to that section, taking references to the relevant hospital order and the restriction order as references to the hospital direction and the limitation direction or, as the case may be, to the transfer direction and the restriction direction…"

Discussion

22. The Appellant's case focused on the First-tier Tribunal's decision that the criteria in section 72(1)(b)(ii) were satisfied, which it explained in para. 21 of its decision notice (italics added for emphasis):

"21. The Panel equally has no doubt at this time it is necessary for the Patient's health and safety and for the protection of other persons that he should continue to receive medical treatment in hospital. *The Panel is satisfied if the Patient were discharged from a hospital environment with its comprehensive support and supervision the Patient would very quickly cease to accept his medication. The Panel notes that the only environment where his medication regime can be enforced is in hospital.* The Panel also notes that while in prison the Patient refused his medication. The Panel is satisfied that without psychotropic medication the Patient's positive symptoms of degree will return. The Panel is satisfied that if the Patient were so discharged his mental and physical health would deteriorate as his non-compliance would involve his physical health medication as even at the moment he requires prompting for basic hygiene. The Panel is satisfied in these circumstances the safety of the Patient would be at risk as he is at present vulnerable and has suffered bullying and teasing from other patients. The Panel is satisfied that Patient remains a risk of causing harm to other persons in light of the Index Offence. The Panel has no doubt that the Index Offence has serious sexual implications, notwithstanding the absence of a sexual offence charge. The Panel is surprised that Dr Chin contends the opposite in light of the known details. The Panel notes that the Patient was observed in 2021-22 staring at females in the manner described by Dr Singh."

23. Mr Pezzani had placed at the centre of his case for the appropriateness of a conditional discharge that the Appellant lacked capacity to make decisions in relation to his care plan, including whether to take his prescribed medication, and that an authorisation under the 2005 Act, coupled with appropriate conditions of discharge,

provided an alternative legal framework for securing his compliance with medication. The statement that "the only environment where his medication regime can be enforced is in hospital" fails to grapple with this central plank of the Appellant's appeal.

24. Indeed, despite several witnesses having raised the issue of capacity to make decisions relevant to his care plan in their evidence, the FtT Decision makes a finding only on the Appellant's litigation capacity (see para. 23 of the FtT Decision at p. 259 of the appeal bundle). It says nothing about the Appellant's capacity to make decisions about his treatment, care or where he should live, and nothing about the legal implications of a lack of capacity in these domains.

25. While the First-tier Tribunal acknowledged Mr Pezzani's submission, it did not say what it made of it:

> "Mr Pezzani also contends that the Patient lacks capacity to make decisions about many of his post discharge needs and that a DoLs care plan would be available" (see para. 16 of the FtT Decision at p. 258 of the appeal bundle).

26. It appears from this short acknowledgement, and its "noting" in para. 21 that "the only environment where his medication regime can be enforced is in hospital" that, rather than rejecting Mr Pezzani's argument, the First-tier Tribunal simply ignored it.

27. The Second Respondent opposed the appeal. The position that Mr Cisneros took was a rather technical one: he pointed to section 72(1)(b)(ii) being made up of two parts, either of which is capable of satisfying that limb of the statutory criteria. The first relates to the necessity of the patient receiving medical treatment *for his own health and safety*, and the second relates to the necessity of his receiving it for *the protection of other persons*. Mr Cisneros submitted that the FtT Decision had upheld continued detention on both bases, while the Appellant's grounds of appeal challenged only the first basis, but not the second. Therefore, he argued, even if Mr Pezzani was correct that the First-tier Tribunal had erred, the outcome would not have been materially different because it would still have found the detention criteria to have been satisfied on the second basis.

28. It is adequately clear to me from the FtT Decision, when read as a whole, that the First-tier Tribunal's decision turned on its concern that the Appellant might not comply with his psychotropic medication, and that if he did not comply with it his positive symptoms of degree would be liable to return, and these symptoms would present risks that would not be manageable in the community. This concern applied just as much to the risks contemplated by the second limb of section 72(1)(b)(ii) as to the first: if the Appellant did not relapse this would contain the risk not only to his own health and safety but also risks that would otherwise necessitate detention for treatment in the interests of the protection of other persons.

29. If the Appellant's compliance could be secured and authorised under the 2005 Act, together with appropriate conditions of discharge, then the risk of relapse would be contained, and contained lawfully.

30. Mr Cisneros's submissions refer in shorthand to the first of the two parts of section 72(1)(b)(ii) as being about "whether ML's detention is necessary for his own health and safety", and the second being about whether "his detention is necessary

for the protection of other person" (see paras. 11, 27 and 28 of the Second Respondent's response to the grounds of appeal at pp. 267 and 271 of the appeal bundle). While I appreciate that this was just shorthand, it mischaracterises the criteria in a very important respect: these criteria are not simply about the necessity of detention. Rather, they are about the necessity of the patient receiving medical treatment. Indeed, each of the criteria in section 72(1)(b) hinges on medical treatment: (i) requires there to be mental disorder that makes liability to detention for medical treatment appropriate, (ii) is about the necessity of receiving that treatment, and (iia) is about the availability of the treatment that is necessary. The First-tier Tribunal said that it was:

> "satisfied that the Patient remains a risk of causing harm to other persons in light of the Index Offence. The Panel has no doubt that the Index Offence has serious sexual implications, notwithstanding the absence of a sexual offence charge…" (see para. 21 of the FtT Decision),

but the 1983 Act does not permit patients to be detained simply to protect them or other persons, no matter how grave the risks may be. The need for detention must relate to the therapeutic endeavour.

31. Therefore, the First-tier Tribunal's findings in relation to the risk that the patient might cause harm to others *must* flow from its decision that liability to detention in hospital was necessary to secure medication compliance: *if* discharged the Appellant would not take medication; and *if* he stopped his medication his positive symptoms would return; and *if* the symptoms returned there would be risks to himself *and* others). The grounds of appeal for which I granted permission to appeal do, therefore, extend to both limbs of section 72(1)(b)(ii), and if the First-tier Tribunal erred in finding that "the only environment where his medication regime can be enforced is in hospital" that error would be material in the sense that such error would undermine its conclusion with respect both to the risk to the Appellant's own health and safety and to the need to protect others.

32. Mr Cisneros agreed with the Appellant's case that, were he discharged from hospital, the 2005 Act could be used to authorise a medication regime to the extent that he lacks capacity to make decisions relevant to that, but he maintained that the First-tier Tribunal was correct to say that the only setting where he could *currently* receive medication was in hospital, because there was no DOLS authorisation in place, and no guarantee that one could be obtained.

33. For the reasons Judge Jacobs gave in *MC v Cygnet*, there being uncertainty about whether the machinery of the 2005 Act will be available to authorise a deprivation of liberty does not obviate the need for a tribunal to consider alternatives to detention when determining whether the statutory criteria in section 72(1)(b) of the 1983 Act are satisfied.

34. In *MC v Cygnet* Judge Jacobs undertook a helpful review of the authorities that consider the point of transition of a mentally incapacitous patient from the 1983 Act regime to the 2005 Act regime, concluding that nothing in the Supreme Court's decision in *M v Secretary of State for Justice* [2017] 1 WLR 4681 and [2019] AC 712 (**"*M v SSJ*"**) undermined what Lieven J had decided in *Birmingham City Council v SR and Lancashire County Council v JTA* [2019] EWCOP 28 (**"*SR and JTA*"**):

> "26. *SR and JTA* was a case under the 2005 Act and Lieven J sits as a judge of the Court of Protection. It was not her role to decide whether the 1983 Act had been applied correctly, but she was aware of how the issues she had to decide related to the 1983 Act. She had to decide how the 2005 Act could be operated in a way that co-ordinated with the decisions taken under the 1983 Act. She confirmed that it would be possible to give an authorisation in advance or while a conditional discharge was deferred. Her reasoning is clear, cogent and persuasive."

35. I agree.

36. Judge Jacobs reiterated the point that he had made in *DN v Northumberland, Tyne & Wear NHS Foundation Trust* [2011] UKUT 327 (AAC), [2012] AACR 19 (at para. 10), that the "least restriction" principle was inherent both in the conditions to continued detention under the 1983 Act and a patient's rights to liberty and respect for his private and family life under Articles 5 and 8 of the Convention. He went on to explain at para. 28 of *MC v Cygnet*:

> "28. Those factors combine to provide the imperative for the First-tier Tribunal to apply the 1983 Act in a way that allows a patient to be discharged if there are means by which the patient's case can appropriately be dealt with under other legislation. The 2005 Act is such legislation. If a patient's case is to be dealt with correctly under the 1983 Act and fairly and justly under the tribunal's rules of procedure, the tribunal is under a duty to find a way that allows both Acts to be applied in a co-ordinated manner."

37. Judge Jacobs explained that if an advance authorisation of a prospective deprivation of liberty had already been given then the tribunal may be able to proceed to a conditional discharge "without more ado", but if there was no advance authorisation there were still at least two possible methods of achieving a successful, lawful and safe transition from the 1983 Act to the 2005 Act regime:

> "*The different hats approach*
>
> 30. If appropriate, the same judge could sit in the Court of Protection and in the First-tier Tribunal to ensure that all decisions could be made that would allow the patient to be conditionally discharged on appropriate conditions and with the benefit of a deprivation of liberty authorisation. This was the suggestion of the Court of Appeal in *M*. The Supreme Court did not deal with this possibility, but nor did it come within the possibilities that the Court expressly said it would not deal with. It was simply silent on the point.
>
> 31. The First-tier Tribunal and Upper Tribunal have been flexible in the way that they exercise their jurisdictions. The two tribunals sat together with the same panel to hear an appeal to the First-tier Tribunal and judicial review proceedings in the Upper Tribunal in *Reed Employment plc v the Commissioners for Her Majesty's Revenue and Customs* [2010] UKFFT 596 (TC). And the same panel of the Upper Tribunal heard an appeal together with a judicial review transferred from the High Court in *Fish Legal and Emily Shirley v Information Commissioner, United Utilities plc, Yorkshire Water Services Ltd, Southern Water Services Ltd and the Secretary of State for the Environment, Food and Rural Affairs* [2015] UKUT 52 (AAC), [2015] AACR 53 at [12]-[13]. The Lands Chamber of the Upper Tribunal has also approved in

> principle the practice of the same judge sitting in the county court at the same time as presiding as a member of a panel of the Property Chamber of the First-tier Tribunal in *Avon Ground Rents Ltd v Child* [2018] UKUT 204 (LC) at [84]. All of these cases are consistent with the suggestion by the Court of Appeal in *M* that the same judge could sit at the same time in the First-tier Tribunal and the Court of Protection in order to exercise both jurisdictions concurrently or separately.
>
> *The ducks in a row approach*
>
> 32. If it is not possible or appropriate for some reason to follow the same hat [sic] approach, it would be a proper use of the tribunal's powers to adjourn, to make a provisional decision or to defer discharge in order to allow the necessary authorisation to be arranged. I discussed these possibilities in *DC v Nottinghamshire Healthcare Trust and the Secretary of State for Justice* [2012] UKUT 92 (AAC). The choice may come to little more than a matter of preference for the tribunal. It may, though, depend on how sure the tribunal is that the mental capacity decision will be put in place and how confident it is of the terms of any such decision (the terms of the care package, for example)."

38. I have considerable sympathy for the First-tier Tribunal having to grapple with what was a very complex matrix of considerations, but Mr Pezzani had made a clear case, supported by evidence, that conditional discharge with a full care package to 24-hour staffed specialist accommodation represented an alternative means of containing the risks that a failure by the Appellant to comply with his prescribed medication might eventuate. It was incumbent on the First-tier Tribunal to address that case and to explain how it came to conclude that the section 72(1)(b) criteria were nonetheless satisfied, and that continued detention represented the least restrictive option for the management of the concerns arising from the Appellant's mental disorder.

39. It appears that the First-tier Tribunal was under the misapprehension that there was no way for it to co-ordinate the 1983 Act proceedings with a 2005 Act authorisation, and it made its decision on the section 72(1)(b) criteria without reference to the possibility that an alternative framework for managing the Appellant was available. That amounted to a material error of law.

40. If I am wrong on that, and the First-tier Tribunal considered the possibility but dismissed it, that still leaves the issue as to the adequacy of its reasons (the second ground of appeal).

41. In *Simetra Global Assets Ltd & Anor v Ikon Finance Ltd & Ors* [2019] EWCA Civ 1413 at para. 46 Males LJ provided a compelling analysis of what amounts to "adequacy" in judicial reasons. He said:

> "46. Without attempting to be comprehensive or prescriptive, not least because it has been said many times that what is required will depend on the nature of the case and that no universal template is possible, I would make four points which appear from the authorities and which are particularly relevant in this case. First, succinctness is as desirable in a judgment as it is in counsel's submissions, but short judgments must be careful judgments. Second, it is not necessary to deal expressly with every point, but a judge must say enough to show that care has been taken and that the evidence as a

> whole has been properly considered. Which points need to be dealt with and which can be omitted itself requires an exercise of judgment. Third, the best way to demonstrate the exercise of the necessary care is to make use of "the building blocks of the reasoned judicial process" by identifying the issues which need to be decided, marshalling (however briefly and without needing to recite every point) the evidence which bears on those issues, and giving reasons why the principally relevant evidence is either accepted or rejected as unreliable. Fourth, and in particular, fairness requires that a judge should deal with apparently compelling evidence, where it exists, which is contrary to the conclusion which he proposes to reach and explain why he does not accept it.
>
> 47. I would not go so far as to say that a judgment that fails to follow these requirements will necessarily be inadequately reasoned, but if these requirements are not followed the reasoning of the judgment will need to be particularly cogent if it is to satisfy the demands of justice. Otherwise there will be a risk that an appellate court will conclude that the judge has "plainly failed to take the evidence into account."

42. Given the importance and centrality of Mr Pezzani's argument that there was a less restrictive alternative to hospital detention, I am satisfied that the FtT Decision's failure to deal expressly with it renders the reasons inadequate. This itself amounts to a material error of law.

43. For these reasons I am satisfied that the FtT Decision involved the making of an error of law which was material.

Disposal

44. Section 12(2) of the Tribunals, Courts and Enforcement Act 2007 gives me a discretion whether to set aside a decision which I have found to involve an error of law.

45. In all the circumstances, the interests of justice require that I exercise my discretion to set aside the decision in this case. Because further facts need to be found I remit the matter to be redetermined by the First-tier Tribunal.

Thomas Church
Judge of the Upper Tribunal

Authorised for issue on

20 September 2023

THE UPPER TRIBUNAL
(ADMINISTRATIVE APPEALS CHAMBER)

UPPER TRIBUNAL CASE NO: UA-2023-000013-HM
[2023] UKUT 64 (AAC)

PC v CORNWALL PARTNERSHIP NHS TRUST

Decided without a hearing

Representatives

Claimant	Conroys Solicitors
NHS Trust	Took no part

DECISION OF UPPER TRIBUNAL JUDGE JACOBS

This decision may be made public (rule 14(7) of the Tribunal Procedure (Upper Tribunal) Rules 2008 (SI No 2698)).

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

Reference:	MH/2022/21504
Decision date:	3 November 2022
Hearing:	Remote

As the decision of the First-tier Tribunal involved the making of an error in point of law, it is SET ASIDE under section 12(2)(a) and (b)(i) of the Tribunals, Courts and Enforcement Act 2007 and the case is REMITTED to the tribunal for rehearing by a differently constituted panel.

REASONS FOR DECISION

The issues

1. I have set the decision of the First-tier Tribunal aside on the ground that it failed to make the necessary findings of fact to justify proceeding in the patient's absence. I explain why the rules on proceeding in the patient's absence are particularly important in the mental health jurisdiction. I also correct the misunderstanding in the First-tier Tribunal's decision to refuse permission to appeal.

2. The grounds of appeal also criticised the tribunal's conclusion on whether a medical examination was impractical, but I do not need to deal with that issue, as any error will be subsumed by the rehearing.

What happened

3. PC was subject to a Community Treatment Order. He was recalled on 19 August 2022 and his case was referred to the First-tier Tribunal on 22 August 2022. His case was listed for 7 October 2022, but the hearing was postponed as the social circumstances report had not been filed. It was relisted for 3 November 2022. The report was not provided until 2 November, the day before the hearing. PC's solicitor applied on that day for the hearing to be a postponed, but this was refused by a judge. The hearing took place on 3 November 2022, when the solicitor applied for the hearing to be adjourned. This was refused and the tribunal proceeded in PC's absence.

The power to proceed in the patient's absence

4. Rule 39 of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 (SI No 2699) provides for a hearing to proceed in the patient's absence:

> **39. Hearings in a party's absence**
>
> (1) Subject to paragraph (2), if a party fails to attend a hearing the Tribunal may proceed with the hearing if the Tribunal—
>
> (a) is satisfied that the party has been notified of the hearing or that reasonable steps have been taken to notify the party of the hearing; and
>
> (b) considers that it is in the interests of justice to proceed with the hearing.
>
> (2) The Tribunal may not proceed with a hearing that the patient has failed to attend unless the Tribunal is satisfied that—
>
> (a) the patient—
>
> (i) has decided not to attend the hearing; or
>
> (ii) is unable to attend the hearing for reasons of ill health; and
>
> (b) an examination under rule 34 (medical examination of the patient)-
>
> (i) has been carried out; or
>
> (ii) is impractical or unnecessary.

This rule is not limited to patients, but I refer only to a patient being absent as that is what happened in this case.

5. Rule 39 is in two parts. The first part in paragraph (1) is positive. It sets out conditions that allow a tribunal to proceed in the patient's absence. The second part in paragraph (2) is negative. It set out circumstances in which a tribunal must not proceed. The rule uses the same word – 'may' – in both paragraphs, but it has a different meaning in each. In paragraph (1), it authorises the tribunal to proceed without requiring it to do so. In paragraph (2) with the addition of 'not', it is a prohibition. To put it another way, paragraph (2) contains condition precedents that

must be satisfied before the power in paragraph (1) arises. I come back later to the importance of keeping the paragraphs separate.

6. Paragraph (2) contains two conditions. Both must be satisfied before the power to proceed arises. Paragraph (2)(a) deals with non-attendance. A tribunal may not proceed unless it is satisfied as a matter of fact that either the patient had decided not to attend or was unable to attend for reasons of ill health. If the tribunal is not so satisfied, it must not proceed, regardless of whether the conditions in paragraph (1) are satisfied. Paragraph (2)(b) deals with medical examinations.

In this case, the tribunal did not make findings to show that paragraph (2)(a)(i) or (ii) was satisfied

7. The tribunal dealt with the application to adjourn as a preliminary issue. That required it to decide whether it was entitled to proceed in the patient's absence. If it was not, it had no option but to adjourn. The tribunal set out the steps taken to notify the claimant and found that:

> We are satisfied that reasonable steps have been taken to notify him of the hearing by the detaining authority, CPN and his solicitor who have all told him by telephone or in writing.

That dealt with rule 39(1)(a). The tribunal then explained why 'it is in the interests of justice to proceed'. That dealt with rule 39(1)(b). I see no error of law in either of those conclusions. So far so good. But the tribunal did not make any finding on rule 39(2)(a)(i) or (ii). On the face of its reasoning, it looks as if it overlooked paragraph (2)(a). Perhaps it thought the answers were self-evident. If it did, they are not self-evident to me.

8. Starting with paragraph (2)(a)(i), the question was: had the patient decided not to attend? He did not notify his solicitor or the tribunal that he had decided not to attend. The issue was whether the tribunal could infer that he had decided not to do so. There was evidence that the patient 'is often very difficult to contact as his engagement is poor. A previous tribunal had been adjourned on three occasions as he did not attend. His contact with services is sporadic and occasional.' But that did not mean that the patient had decided not to attend. It may be that his absence was more to do with a manifestation of his condition rather than a conscious decision. That brings us to paragraph (2)(a)(ii) and the question: was he *unable* to attend for reasons of ill health, such as his mental condition? Again, the tribunal did not analyse that possibility, let alone make a finding.

9. So, the tribunal did not make a finding to show that either paragraph (2)(a)(i) or (ii) was satisfied and it was not self-evident from what it did say that one or other of them must be satisfied. In those circumstances, paragraph (2) was not satisfied, regardless of any finding that might be made under paragraph (2)(b). Proceeding in the patient's absence was an error of law.

The refusal of permission by the First-tier Tribunal judge

10. I now deal with the reasons given by the judge who refused permission to appeal. I am not attributing those reasons to the panel that decided the appeal. Nor am I saying that any defects in that judge's reasons permit me to set aside the

tribunal's decision. An appeal to the Upper Tribunal lies only against the decision of the First-tier Tribunal on the reference. The reasons given for refusing permission are not part of that decision. The Upper Tribunal does not review those reasons: *CIS/4772/2000* at [2]-[11]. Nor may they be used to show that a point of law arises from the decision: *Albion Water Ltd v Dŵr Cymru Cyf* [2009] 2 All ER 279 at [67].

11. The judge who refused permission set out the text of rule 39, but only as it was originally made in 2008, rather than the version with the new paragraph (2) that was substituted in 2014. I am sure that this mistake did not affect the judge's reasoning, but it is always good to start with the correct law.

12. The judge wrote that he was satisfied the tribunal's reasons

> address the legal criteria correctly. They record that [the patient] had been notified of the hearing by his legal representatives and his care coordinator and were entitled to find that the requirements of rule 39 had been met. There is no requirement for proof that he [the patient] was aware of the hearing date, simply that on the balance of probabilities that he has been notified of it, or that reasonable steps had been taken to do so.

13. That seems to me to confuse rule 39(1)(a) and 39(2)(a). The former is about notification or service. That does not require actual knowledge, as the reference to 'reasonable steps' shows. Actual knowledge may be irrelevant under paragraph (2)(a)(i). It is possible for a patient to say: 'I am not coming to the hearing, regardless of when and where it will take place.' But knowledge of the hearing may also be relevant as part of the factual foundation for an inference that the patient has decided not to attend, but it is not of itself a sufficient foundation for that finding or a substitute for that finding.

The importance of a hearing in mental health cases

14. The general principle in all chambers of both the First-tier Tribunal and the Upper Tribunal is that a party has a right to a hearing and is entitled to attend that hearing. The rules (rule 1(3) in the rules for the Health, Education and Social Care Chamber) provide that this 'means an oral hearing'. They also confer power on a tribunal to proceed without a hearing and to proceed with a hearing in the absence of a party. For mental health cases, those powers are more restricted. So rule 35(1) provides the default rule that the tribunal must hold a hearing in a mental health case; rule 35(3) then allows a patient to opt out of a hearing of their reference. Rule 39 contains additional restrictions in paragraph (2). The reason for the restrictions in rules 35(3) and 29(2) is to be found in the special importance of safeguards when a patient's liability to be detained is in issue. A tribunal must always operate within its rules of procedure and that is particularly important when liberty is at stake. This is why I have dealt not only with the tribunal's reasoning but also with the reasoning in the refusal of permission.

Authorised for issue
on 02 March 2023

Edward Jacobs
Upper Tribunal Judge

SF v Avon and Wiltshire Mental Health Partnership NHS Trust and RB
[2023] UKUT 205 (AAC)

IN THE UPPER TRIBUNAL **Appeal No.** UA-2022-000062-HM
ADMINISTRATIVE APPEALS CHAMBER

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

Between:

SF (as Nearest Relative of RB)

Appellant

- v –

Avon & Wiltshire Mental Health Partnership NHS Trust

Respondent

RB

Interested Party

Before: Upper Tribunal Judge Church

Following a remote video hearing held on 20 April 2023

Representation:

Appellant:	Mr Roger Pezzani of counsel, instructed by Ms Angela Wall of Butler & Co, Solicitors
Respondent:	Not represented
Interested Party:	Not represented

DECISION

This decision may be made public (rule 14(7) of the Tribunal Procedure (Upper Tribunal) Rules 2008 (SI No 2698)).

The decision of the Upper Tribunal is to allow the appeal.

The decision of the First-tier Tribunal made on 18 November 2021 with case reference number MN/2021/14771 involved the making of an error on a point of law.

Since the patient has long since been discharged from detention and no purpose would be served by setting the decision aside, I do not exercise my discretion section 12(2)(a) of the Tribunals, Courts and Enforcement Act 2007 to set aside the decision.

REASONS FOR DECISION

What this appeal is about

1. This appeal is about RB, a woman with a primary diagnosis of autism spectrum disorder and a secondary diagnosis of complex post-traumatic stress disorder. RB was at the relevant time detained in hospital for treatment under section 3 of the Mental Health Act 1983 (the **"MHA"**).

2. An application was made to the First-tier Tribunal to review her section and it was the tribunal's job to hear evidence and argument and to decide whether the criteria set out in section 72(1)(b) MHA were satisfied. If they were not, it had to discharge her section.

3. The circumstances of this case are very distressing. By all accounts, RB was very unwell and unhappy. The witnesses from the clinical team accepted that RB needed psychosocial support, but this was not available in her current setting on an acute psychiatric ward at Fountain Way. They accepted that being on such a ward was "not beneficial" to RB's mental health. However, the witnesses from the clinical team didn't support RB's discharge because they held justifiable worries that, were her section to be discharged, RB might harm (or even kill) herself, or harm others.

4. In legal terms, the appeal is about the meaning of the requirement in section 72(1)(b)(iia) MHA that 'appropriate medical treatment' be available to a patient if she is to be liable to detention in hospital. I must decide whether the treatment that the First-tier Tribunal who heard the application found to be available to RB at Fountain Way was capable of satisfying that requirement, given its findings about the treatment that RB required.

5. It also raises an issue about whether the First-tier Tribunal should have adjourned the hearing for further information.

6. Although RB is no longer detained in hospital, her discharge has not rendered this appeal academic. That is because if what was found to be available to RB at Fountain Way was capable of satisfying section 72(1)(b)(iia) MHA on 18 November 2021, it follows that (provided that the other criteria to detention are met at the relevant time) the availability of the same treatment would be capable of justifying her detention in the future. That has clear implications for RB's future liability to detention.

7. The issue also has significance for others, especially those who are not neurotypical, who find themselves in a similar position.

Factual and Procedural Background

8. At the date of the application to which this appeal relates, RB was detained under section 3 MHA at Fountain Way, a hospital operated by the Respondent, on a mixed adult acute psychiatric ward.

9. These proceedings were brought by RB's mother, who is her 'nearest relative' for the purposes of section 26 MHA. I made RB an Interested Party in these proceedings because the proceedings are about her, about her treatment, and about her liability to be detained, so I considered it to be in the interests of justice for her to be given the opportunity to make her views known. RB chose to play no active role in the proceedings, as she was perfectly entitled to do, but it was important that she was given the opportunity to do so if she wanted to.

10. SF gave notice to the hospital managers of the Respondent of her intention to order RB's discharge from detention using her powers as nearest relative under section 23 MHA. RB's responsible clinician then issued a 'barring report' opining that RB would, if discharged, be likely to act in a manner dangerous to other persons or to herself. This had the effect of preventing SF from exercising her power of discharge for the next six months (see section 25 MHA).

11. SF made an application to the First-tier Tribunal under section 66(1)(g) MHA. The application was heard on 18 November 2021. At the hearing SF's case was that RB should be discharged from her liability to detention because appropriate medical treatment was not available to her at Fountain Way, and so the statutory criteria to detention were not met.

12. SF made a secondary application for an adjournment to obtain information about the aftercare that would be available to RB on discharge, discharge planning being inchoate.

13. RB did not attend the hearing and, while she had instructed a solicitor, she instructed the solicitor not to attend the hearing. She made a written statement to the First-tier Tribunal but in it she expressed no view on the application.

14. The Respondent resisted the application, RB's Responsible Clinician expressing particular concern about a recent "significant and severe escalation in the incidents of deliberate self-harm" (by RB) which had occurred on the ward.

15. The First-tier Tribunal refused both of SF's applications and upheld RB's section (the **"FtT Decision").**

The permission stage

16. SF applied to the First-tier Tribunal for permission to appeal the FtT Decision. Permission was refused by a judge of the First-tier Tribunal on 4 January 2022, but SF then applied to the Upper Tribunal for permission to appeal and the matter came before me.

17. Mr Pezzani produced detailed written grounds of appeal arguing that the panel which heard the Appellant's application on 18 November 2021 erred in law in two material respects:

a. It was wrong to find that appropriate medical treatment was available to the patient RB, and should instead have found that the requirement in Section 72(1)(b)(iia) MHA was not satisfied and the conditions to continued detention were not met; and

b. It was wrong to refuse the application for an adjournment to obtain information on the aftercare that would be available to RB should she be discharged.

18. In my decision granting permission I said:

> "6. The availability of appropriate medical treatment is rarely a matter of contention, but given the quite unusual circumstances in this case, which concerns a patient with a primary diagnosis of autism spectrum disorder, and a secondary diagnosis of C-PTSD, there is a real issue as to whether what is available to her in hospital has the necessary therapeutic purpose. Indeed, there was evidence before the Tribunal that continued detention in hospital could be significantly counter-therapeutic.
>
> 7. I am persuaded that it is arguable with a realistic (as opposed to fanciful) prospect of success that the Tribunal erred in law in the ways which Mr Pezzani contends that they have, and a grant of permission to appeal to the Upper Tribunal is warranted."

The oral hearing of the appeal

19. I directed a remote video hearing of the appeal. While the Respondent and the Interested Party were each notified of the hearing, only SF attended and was represented. I was satisfied that the parties had been given due notice of the hearing and had chosen not to attend or be represented, and that it was in the interests of justice to proceed.

20. Mr Pezzani made oral submissions which developed the points made in his statement of facts and grounds document and the written speaking note he had submitted in advance of the hearing. I am grateful to him for the clear and succinct way in which he put his arguments.

The Law

21. Section 72 MHA sets out the powers and duties of the tribunal when considering an application. It provides (so far as is relevant to patients detained other than under section 2 MHA):

> **"Powers of tribunals**
>
> **72.-** (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 –
>
> …
>
> (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 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 or 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; or

(iii) in the case of an application by virtue of paragraph (g) of section 66(1) above, that the patient, if released, would be likely to act in a manner dangerous to other persons or to himself."

22. Somewhat unusually, section 145(1) MHA provides an inclusive, rather than an exhaustive, definition of the term "medical treatment":

> "medical treatment" includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care".

23. This inclusive definition is to be construed in a purposive way in accordance with section 145(4) MHA, which provides:

> "Any reference in this Act to medical treatment, in relation to mental disorder, shall be construed as a reference to medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms, manifestations".

Discussion - Ground 1

What the First-tier Tribunal said about the availability of treatment

24. The First-tier Tribunal explained its decision making in relation to the availability of appropriate medical treatment in paragraphs [13]-[16] of its statement of reasons:

> "13. Appropriate medical treatment: The RC told us that the primary disorder should be treated with psychosocial support which could not be provided on this ward. She did however explain that "offshoots of the disorder" which included anxiety, depression, rigid thinking and more recently [RB's] behaviour in the "aftermath of the Court of Protection issues" were the subject of appropriate treatment.
>
> 14. [RB] had refused to engage with the RC since her appointment in August. The team had been able to offer some therapeutic treatment to [RB] in the form of OT and art therapy provided by a therapist. [RB] had engaged to a limited extent with one OT but refused to engage otherwise. The nurse described how [RB] was unsuccessfully prompted to take care of her personal hygiene by nursing staff daily. The nurse regularly volunteered to take [RB] on escorted ground leave, but [RB] consistently refused to engage. Some mobility aids had been provided for [RB], but these had to be risk assessed in view of her propensity to deliberate self-harm. Nonetheless, [RB] had declined to use them. [RB's] dietary intake was a matter of concern throughout the duration of this admission. To monitor her general health a food and diet chart was in place and her blood sugar levels were tested twice daily as well as her blood pressure and pulse. The treating team were guided by experts as regards the treatment of [RB's] rheumatoid arthritis. The RC told us that the stopping of this treatment was a manifestation of her primary disorder. As explained above treatment had been stopped, nonetheless, the RC remained in contact with the rheumatoid arthritis consultant. Because of the significant risks she currently presents. [RB] is currently nursed on constant 1:1 observations to reduce the risk of deliberate self-harm/death.

15. All the witnesses wanted to move [RB] on from the acute ward, but she refused to engage with this process. [RB] made it clear that she would not sign any tenancy agreement. This was a matter of great concern for the nearest relative, the community team, and the treating team. The involvement of Imagineer and a potential placement through Studio 3 was outlined in the reports, the funding for this work had been rescinded by the CCG. Nonetheless, [RB's] case remained the subject of weekly MDT's. Mrs O'Neill told us that she was working in liaison with the community social worker. It had been decided that a specialist assessor would become involved to assess [RB's] capacity surrounding accommodation. An independent assessor was deemed necessary as [RB] declined to engage with most of the professionals already involved in her care pathway and there were concerns that any decision regarding capacity should be made independently of the team.

16. All the professional witnesses who gave evidence agreed that an acute psychiatric ward was not beneficial to [RB's] mental health. This, however, was not the test we are required to apply. We fully accepted that the treatment provided to [RB] was not tailored to her diagnosis, and the essential psychosocial work was not available on this acute ward. We did, however, conclude that medical treatment for the purpose of preventing a worsening of the symptoms or manifestations of her disorder, is available, appropriate and necessary. In reaching this decision we reminded ourselves of the guidance provided in *DL-H v Partnerships in Care & SoSJ* [2014] AACR 16 and *DL-H v Devon Partnership NHS Trust v SoSJ* [sic] [2010] UKUT 102 (AAC). We decided that [RB's] refusal to engage with most of the professionals and the limited therapies available on this ward did not negate the availability nor appropriateness of that treatment. The treatment available today was OT and art therapy. Intensive 1:1 observation sought to protect [RB] against significant acts of deliberate self-harm which might otherwise prove fatal. [RB's] physical health was closely monitored because she restricted her diet. As recently as the last week she has been referred to the general ward following concerns regarding her deteriorating physical health. When appropriate, sedative medication had been administered with [sic] in the last week or so to protect [RB's] own safety but also protect nursing staff from her outbursts. Discharge planning was ongoing, it was not at all well advanced. This was due in part at least to [RB's] lack of engagement. We concluded that discharge planning was part of the treatment. The team wanted to explore the options to move [RB] on to a setting, possibly under a legal framework, where she might present fewer risks and receive a more tailored treatment in a less restrictive setting. The benefit of the inpatient treatment was to keep [RB] physically well, safe and protect those seeking to care for her. Whilst these treatments would not serve to treat the overarching autism long-term, they played an important role in her immediate treatment plan. In relation to Ms Wall's closing submissions, we decided that the current treatment did offer a therapeutic benefit to [RB] in the short term. The outcome was that [RB] had been prevented from harming herself (perhaps even fatally) and others around her were kept safe. The negative impact of this treatment was that it removed autonomy. [RB] sought to control decisions regarding her diet, well-being and treatment. Ms Wall

> submitted that the adverse effects of the inpatient setting greatly outweighed its benefits. The professional witnesses did not agree with this view. Mr Prochazka told us that the detention and the treatment provided on the ward superseded the alternative which was a 'risk of death'. We accepted the evidence of the professionals as articulated by Mr Prochazka. We decided that the benefits of inpatient treatment outweighed the adverse effects."

25. The first thing to say about the criteria in section 72(1)(b)(1)-(iii) is that if any of them is not satisfied the tribunal must discharge the patient from liability to detention. While in the majority of cases the availability of appropriate medical treatment in hospital is uncontroversial, and the requirement for it receives little attention, it is nonetheless a crucial element of the protections provided by the MHA. Indeed, section 3 MHA (the section to which RB was subject at the relevant time) is headed "Admission for treatment", and all but one of the limbs of the criteria in section 72(1) relates to the treatment of the patient's mental disorder (whether its appropriateness (in sub-paragraph (i)), its necessity (in sub-paragraph (ii)), or its availability (in sub-paragraph (iia))).

26. The First-tier Tribunal made a clear finding (based on its acceptance of the evidence of RB's clinical team) that "the treatment provided to [RB] was not tailored to her diagnosis, and the essential psychosocial work was not available on this acute ward" (see paragraph [16] of the decision with reasons).

27. This is a striking finding indeed. What amounts to 'appropriate medical treatment' for mental disorder must differ from patient to patient, according to their individual circumstances and needs.

28. When deciding whether 'appropriate medical treatment' was available, the First-tier Tribunal had to do so in the context of what it knew about RB's mental disorder, and its symptoms and manifestations. If all that was required by section 72(1)(iia) was for the tribunal to be satisfied that generic medical treatment, not tailored to the particular patient, was available, it would provide no meaningful protection, and the word 'appropriate' would add nothing.

29. The First-tier Tribunal found that the following interventions were available to RB:

a. OT;
b. art therapy;
c. intensive 1:1 observation
d. close monitoring of RB's physical health;
e. administration of sedative medication; and
f. discharge planning

30. The First-tier Tribunal correctly took the purposive approach to the assessment of the treatment on offer that section 145(4) MHA required of it. It made clear findings of fact about what the intent of the treatment was:

> "Intensive 1:1 observation sought to protect [RB] against significant acts of deliberate self-harm which might otherwise prove fatal. [RB's] physical health was closely monitored because she restricted her diet. As recently as the last

> week she has been referred to the general ward following concerns regarding her deteriorating physical health. When appropriate, sedative medication had been administered with [sic] in the last week or so to protect [RB's] own safety but also protect nursing staff from her outbursts" (paragraph [16] of the decision with reasons).

31. Each of the First-tier Tribunal's findings as to the purpose of the interventions provided relates solely to concerns for RB's physical health or for her physical safety and the physical safety of those attempting to care for her. The First-tier Tribunal acknowledged this in paragraph [16] of its decision with reasons:

> "The benefit of the inpatient treatment was to keep [RB] physically well, safe and protect those seeking to care for her. Whilst these treatments would not serve to treat the overarching autism long-term, they played an important role in her immediate treatment plan … The outcome was that [RB] had been prevented from harming herself (perhaps even fatally) and others around her were kept safe".

32. The First-tier Tribunal didn't need to be satisfied that the treatment available would "serve to treat the overarching autism long-term", but it did need to be satisfied that the treatment available at least had the purpose to "alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations" (section 145(4) MHA).

33. The First-tier Tribunal found that RB's self-harming and violent behaviour were symptoms or manifestations of her mental disorder (see paragraph [11] of its decision with reasons). It was entitled to do so, but was it entitled to find that the interventions available on the ward (described above) satisfied limb (iia) of the criteria in section 72(1) MHA?

34. In *PM v Midlands Partnership NHS Foundation Trust* [2020] UKUT 69 (AAC); [2020] AACR 23, at paragraph 8.3, I considered whether monitoring of a patient could, of itself, amount to 'medical treatment':

> "Monitoring would not, in and of itself, necessarily qualify as "medical treatment" for the purposes of section 145(1) MHA (as construed in accordance with section 145(4) MHA). For example, if monitoring were by way of observation of a patient via a CCTV feed, that monitoring (as opposed to any intervention made in response to what was observed) could not be said to be done with therapeutic intent. Such monitoring would fall into the category identified by Stanley Burnton J. in *R. (on the application of O'Reilly) v Blenheim Healthcare Ltd* [2005] EWHC 241 (Admin) at [14] as "acts carried out for the purpose of treatment, or with a view to deciding on treatment", rather than treatment itself."

35. While the monitoring detailed in the treatment plan does not, of itself, amount to 'medical treatment', it is adequately clear that the monitoring was carried out with a view to staff intervening should they see something of concern, i.e. signs of RB engaging in self-harming behaviour (including restricting her diet) or violence towards people or property, and it is clear that staff have intervened when they have seen such signs. The question then arises whether the interventions available on the ward are made for the purpose of preventing a worsening of the self-harming and violent behaviours which the First-tier Tribunal found to be symptoms or manifestations of

RB's autism spectrum disorder, or whether their purpose was merely to contain the risk of harm resulting from those behaviours?

36. Restraint, whether physical, mechanical or chemical, can form a legitimate part of a patient's treatment plan, but that doesn't necessarily mean that it amounts to "medical treatment" in the MHA sense. To do so it must have the purpose of (at a minimum) preventing a worsening of relevant symptom or manifestation (in this case RB's urge to harm herself or others). In the case of a neurodiverse patient such as RB such an outcome does not seem likely. Indeed, such an intervention is likely to exacerbate a neurodiverse patient's frustration and need for control and to increase their anxiety.

37. While the definition of 'medical treatment' in the MHA hinges on the purpose for which it is administered rather than its effect, as I commented in *SLL v (1) Priory Health Care and (2) Secretary of State for Justice (Mental Health)* [2019] UKUT 323 (AAC) at [47]:

> "it is difficult to see how a form of medical treatment which is not believed to have any realistic prospect of achieving any therapeutic benefit to a patient whatsoever could properly be considered "appropriate" for him even if it fell within the MHA definition of 'medical treatment'.

38. If the requirement for appropriate medical treatment could be satisfied simply by confining someone with mental disorder in a way that prevents them from engaging in risky behaviour arising from a symptom or manifestation of their mental disorder, this would mean that all manner of interventions would amount to treatment in and of themselves, such as confinement in a soft room, sedation, and mechanical restraint, and nothing else would be required.

39. If such 'treatment' satisfied section 72(1)(iia) then there is no reason why it shouldn't continue to do so for as long as the symptoms or manifestations persist. If such 'treatment' stands no real prospect of achieving any therapeutic purpose beyond preventing physical harm, then this could result in indefinite detention (subject to periodic review under sections 66, 68(2) and 68(6) MHA)).

40. Context is important when engaging in statutory interpretation. As Toulson LJ put it in *An Informer v A Chief Constable* [2012] EWCA Civ 197; [2013] QB 579, para 67:

> "Construction of a phrase in a statute does not simply involve transposing a dictionary definition of each word. The phrase has to be construed according to its context and the underlying purpose of the provision."

41. I must therefore construe the phrase 'appropriate medical treatment' in the wider context of the MHA as a whole and according to the underlying statutory purpose behind making the availability of appropriate medical treatment a criterion for lawful detention for treatment. Taking that approach, I am sure that parliament cannot have intended that the kind of stasis I have described in paragraph [38]-[39] above should be permitted. If it was intended that detention for the sole purpose of ensuring physical safety were to be permitted then there was no need for section 72(1) MHA to make any reference to medical treatment at all. Rather, it could have said that the tribunal shall direct the discharge of a patient liable to be detained otherwise than under section 2 if it is not satisfied:

a. 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, and

b. that it is necessary for the health or safety of the patient or for the protection of other persons that he should be detained, and

c. (in the case of an application by virtue of paragraph (g) of section 66(1) MHA, that the patient, if released, would be likely to act in a manner dangerous to other persons or to himself.

42. The fact that section 3 is headed "Admission for treatment", and the fact that the purpose of treatment runs through all but the last of the criteria in section 72(1), indicates that to interpret the provisions as permitting detention where the only treatment available is provided for the purpose of maintaining physical safety, without treating the mental disorder itself, would be to frustrate parliament's statutory purpose.

43. That leaves us with OT, art therapy and discharge planning, which the First-tier Tribunal found to form part of the treatment available at Fountain Way.

44. OT and art therapy are interventions that are capable of amounting to 'medical treatment' for the purposes of the MHA, but does the First-tier Tribunal make sufficient findings about RB's needs and the intent of the OT and art therapy to permit it to conclude that these interventions amount to 'appropriate medical treatment' for what it describes as 'offshoots' of RB's mental disorder (anxiety, depression, rigid thinking and challenging behaviour)?

45. Unfortunately, it does not say very much about these matters at all. There is an account in paragraph [14] of the decision with reasons of the attempts made to engage with RB but little in the way of explanation of how these interventions fit into RB's treatment plan.

46. It is insufficiently clear to me from the First-tier Tribunal's reasons what, other than the containment of the physical risks that I have addressed above, it found that the OT and art therapy were intended to achieve and how that related to RB's needs in the context of her mental disorder, its symptoms and its manifestations. This must be viewed in the context of the First-tier Tribunal's stark finding that:

> "the treatment provided to [RB] was not tailored to her diagnosis, and the essential psychosocial work was not available on this acute ward" (paragraph 16 of the decision with reasons).

47. The remaining item in the First-tier Tribunal's list of available treatment is discharge planning. The First-tier Tribunal says:

> "Discharge planning was ongoing, it was not at all well advanced. This was due in part at least to [RB's] lack of engagement. We concluded that discharge planning was part of the treatment. The team wanted to explore the options to move [RB] on to a setting, possibly under a legal framework, where she might present fewer risks and receive more tailored treatment in a less restricted setting" (paragraph 16 of the decision with reasons).

48. The context for this is that RB had, by the date of the hearing before the First-tier Tribunal, been detained in hospital for nearly 18 months on a ward which the witnesses

for the detaining authority accepted was "not beneficial to [RB's] mental health" (paragraph [16] of the decision with reasons). While the First-tier Tribunal reached the conclusion that discharge planning was "part of the treatment" it is by no means clear what was actually being done by way of preparing for RB's discharge. If discharge planning had reached stasis then it is difficult to see how it can be said to have been "available".

49. In any event, the First-tier Tribunal does not appear to have placed significant reliance on the availability of OT, art therapy or discharge planning, as its explanation of the purpose and outcome of RB's treatment is limited to maintaining her physical health and safety and the safety of those around her:

> "The benefit of the inpatient treatment was to keep [RB] physically well, safe and protect those seeking to care for her … The outcome was that [RB] had been prevented from harming herself (perhaps even fatally) and others around her were kept safe" (see paragraph 16 of the decision with reasons).

50. 'Appropriate medical treatment' can only mean treatment that is appropriate to the relevant patient's particular needs. While it is accepted that to satisfy the requirement in section 72(1)(b)(iia) the treatment available need not be the best or the most comprehensive treatment that could be provided, but it cannot be the case that treatment that is wholly inadequate for a patient's needs can satisfy that test.

51. This case is unusual in that the First-tier Tribunal reached a clear finding of what treatment RB required (psychosocial support) and an equally clear finding that such treatment was not available at the hospital in which she was detained. Importantly, the First-tier Tribunal characterised that treatment as 'essential'. 'Essential' does not mean 'ideal', or 'desirable' or 'the most appropriate'. It means that nothing else will do. If treatment that was 'essential' was not available, it must follow that the treatment that was available was not, by itself, 'appropriate'.

52. My interpretation of the proper meaning of 'appropriate medical treatment' in MHA is consistent with the approach that the Grand Chamber of the European Court of Human Rights took in *Rooman v Belgium* [2019] ECHR 105 (***"Rooman"***) when it considered the requirements of Article 5(1)(e) of the European Convention on Human Rights in the context of the detention of mental health patients. The court emphasised that the deprivation of liberty contemplated by Article 5.1(e) has a "dual function":

> "on the one hand, the social function of protection, and on the other a therapeutic function that is related to the individual interest of the person of unsound mind in receiving an appropriate and individualised form or therapy or course of treatment" (see paragraph [210] of *Rooman*)

53. The court said that "real therapeutic measures" were required:

> "Mere access to health professionals, consultations and the provision of medication cannot suffice for a treatment to be considered appropriate and thus satisfactory under Article 5 …"
>
> Rather, what was required was:

> "… an individualised programme … taking into account the specific details of the detainee's mental health with a view to preparing him or her for possible future reintegration into society (see paragraph [209] of *Rooman*).

54. This leads me to the conclusion that the First-tier Tribunal erred in law in deciding that 'appropriate medical treatment' was available to RB at Fountain Way because its decision was based on two misunderstandings:

a. that interventions which had the purpose merely of containing risk of physical harm, were capable of amounting to 'medical treatment'; and

b. that medical treatment may be 'appropriate' even where it is "not tailored to [the patient's] diagnosis", and where treatment that is "essential" is not available.

Ground 2

55. The second ground of appeal relates to the First-tier Tribunal's refusal of the Nearest Relative's application for an adjournment. The Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 (the **"FtT Procedure Rules"**) give tribunals very broad case management powers, including the power to adjourn. Generally, the Upper Tribunal is very reluctant to interfere with the case management decisions of the First-tier Tribunal.

56. The First-tier Tribunal found itself in an invidious position. It had heard evidence from each of the witnesses for the detaining authority to the effect that the ward was not a suitable environment for RB and they couldn't give her the treatment she needed, but if she were discharged the consequences for her were likely to be dire, and possibly fatal. Given its obvious discomfort about the unsatisfactory nature of the situation, it is perhaps surprising that it didn't take the opportunity to agree to the adjournment application to explore whether the risks to RB's safety could be managed more appropriately in the community with appropriate aftercare. Had it not reached the firm findings that it did (about what was 'essential' treatment and what was available in hospital) such a decision would have been open to it. Indeed, it would have been entitled to adjourn of its own motion to seek such information.

57. In the absence of such findings, it would also have been open to the First-tier Tribunal to make a recommendation (including for transfer to another hospital) to RB's responsible clinician with a view to facilitating discharge on a future date, and to consider RB's case again should the recommendation not be complied with.

58. However, the First-tier Tribunal did make those findings and, having made them, it should have concluded that 'appropriate medical treatment' was not available where she was detained. Having reached this conclusion, it would have had no option but to order discharge as section 72(1)(b) MHA requires.

59. Since any analysis of the First-tier Tribunal's decision-making on the adjournment application would require me either to assume that it didn't make the findings that it made, or that it was entitled to come to conclusions based on those findings that I have said it shouldn't have come to, it don't think that it would be very helpful for me to rule on whether it erred in law in how it dealt with the application. It is enough that I have found that it erred in the way described in Ground 1.

Disposal

60. For the reasons explained above I am satisfied that the First-tier Tribunal erred in law in a way which was material.

61. Section 12(2) of the Tribunals, Courts and Enforcement Act 2007 gives me a discretion whether to set aside a decision which I have found to involve an error of law.

62. Given that RB has already been discharged from detention, I do not consider it to be appropriate to exercise my discretion to set aside the FtT Decision. As Mr Pezzani conceded, in the circumstances the interests of justice require only that I identify and explain the error.

Thomas Church
Judge of the Upper Tribunal

Authorised for issue on

16 August 2023