IN THE UPPER TRIBUNAL **Case No** HM/535/2010
ADMINISTRATIVE APPEALS CHAMBER

Before UPPER TRIBUNAL JUDGE WARD

Attendances:

For the Appellant: Mr Tim Baldwin of Counsel, instructed by Scott-Moncrieff, Harbour and Sinclair

No appearance by the First, Second or Third Respondents

Decision: The appeal is dismissed. The decision of the First-tier Tribunal sitting at Birmingham on 19 November 2009 did not involve the making of an error of law and is upheld.

Publication: Save for the front sheet (which identifies the appellant by name), this decision may be made public (rule 14(7) of the Tribunal Procedure (Upper Tribunal) Rules 2008/2698.)

REASONS FOR DECISION

1. The appellant had been admitted to hospital under the Criminal Procedure (Insanity) Act 1964, which had the same effect as if he were a restricted patient in respect of whom a hospital order had been made, under sections 37 and 41 of the Mental Health Act 1983. What was sought on his behalf before the First-tier Tribunal was a conditional discharge. It was common ground that he was suffering from mental disorder of a nature which made it appropriate for him to be liable to be detained in hospital for medical treatment. What was in dispute was whether it was necessary for the health or safety of the patient or for the protection of other persons that he should receive medical treatment in hospital. It was accepted on his behalf that if a discharge was ordered, it was appropriate for him to be liable to be recalled to hospital for further treatment. (See sections 72 and 73 of the 1983 Act, which need not be set out at length here.)

2. At the time of the First-tier Tribunal hearing, the appellant was the patient of the First Respondent. His appeal was not upheld but permission to appeal was given by the Principal Judge. Subsequently he was transferred to be the patient of the Third Respondent. The effect of such a transfer is addressed by Section 19(2) of the 1983 Act, in the form modified by Schedule 1, Part II so as to apply to restricted patients, in terms that:

> "Where a patient is transferred in pursuance of regulations under this section, the provisions of this Part of this Act (including this sub-section) shall apply to him as if the order or direction under Part III of this Act by virtue of which he was liable to be detained before being transferred were an order or direction for his admission or removal to the hospital to which he is transferred."

3. This deeming provision is consistent with the First-tier Tribunal's rules, which make the "responsible authority" (by, necessary implication, I think, "from time to time") a "party" before them (see rule 1(3)(a) of the First-tier Tribunal rules) and probably also a "respondent" also (by virtue of the above deeming provision.)

4. Rule 1(3) (a) of the Upper Tribunal Rules however, defines "respondent" (so far as relevant) as "any person other than the appellant who…was a party before that other tribunal", before then going on in (e) to make provision for respondents added or substituted under rule 9. The First Respondent was therefore at the outset of the appeal to the Upper Tribunal an appropriate Respondent (subject and without prejudice to any order under rule 9), even if the patient was by then transferred The Third Respondent was joined under rule 9, so as to be a respondent for the purposes of the appeal to the Upper Tribunal, just as she would have been the respondent in the FtT if the transfer had been effected while proceedings there were still pending.

5. In the event, nothing was heard from the First Respondent; the Second Respondent did not reply, but on enquiry by Upper Tribunal staff indicated he would not be playing a part in the proceedings; and the Third Respondent indicated that she would not take part provided that the only remedy sought, if the appeal were to be allowed, would be to remit the appeal for re-hearing before the First-tier Tribunal, which the appellant's representative agreed to be so. As (in the usual way) the First-tier Tribunal itself played no part in the appeal, there was nobody arguing before me that the tribunal's decision should be upheld. Nonetheless, in a public law jurisdiction, I would only set it aside if I considered that such a course was justified.

6. The principal challenge was to the adequacy of the tribunal's reasons. The appellant had a diagnosis of paranoid schizophrenia (F20.0). He had been admitted on 6 October 2003, the index offence being one of attempted murder. He had taken a variety of drugs in the past but in more recent times had taken only cannabis, in strong ("skunk") form. He uses cannabis as a meditative aid and as part of his Rastafarian practices. There were issues around the extent to which he was prepared to accept that cannabis might have an adverse impact on his mental health and whether, if conditionally discharged, he was prepared to give it up. He had benefited from being treated with Olanzapine, though difficulties had come to light in July 2009 when he admitted to having taken only half the prescribed dosage over a prolonged period (of at least 18 months) and disposed of the remainder. There were issues around whether, if conditionally discharged, he would take the medication which was, it was accepted, essential to maintaining his mental health. There had been issues with regard to the appellant's behaviour while in the care of the First Respondents, including but not limited to in relation to his willingness to submit to drug testing.

7. For the appellant, written evidence was available from Professor Sashidharan, a Consultant Psychiatrist (report dated 12 October 2009); Susan Hope-Borland, Consultant in Forensic and Clinical Psychology (report dated 16 March 2009) and Jonathan Watkins, Independent Social Work

Consultant (report dated 21 July 2009). The First Respondent submitted, among other material, three reports by the Responsible Clinician, Dr Reed (reports dated 16 March 2009, 15 September 2009 and 13 November 2009.) It follows that what was in the appellant's experts' reports was in all three cases written without the benefit of potentially significant information contained in Dr Reed's third report, in the case of Mr Watkins the information in Dr Reed's second report also and in the case of Ms Hope-Borland certainly the two latter and in all probability the first report as well. This mean, for instance, that the reports of Mr Watkins and Ms Hope-Borland had been written on the basis of an incomplete understanding of whether the appellant was compliant with medication, as Dr Reed's second report had contained substantial evidence that he had not been fully so over a prolonged period. Dr Reed's reports would also suggest that the appellant, in telling Mr Watkins that had been fully compliant since the first 6-8 months of his admission and very possibly also in saying that he last smoked cannabis some 18 months ago i.e. in around January 2008, was not telling the truth. A similar question-mark arises over what he said to Ms Hope-Borland concerning drug abuse. However, the experts additionally all gave oral evidence and could thus be been cross-examined on their conclusions in the light of material in Dr Reed's reports. However, I do not have a record of the oral evidence to the First-tier tribunal and am thus heavily dependent on what can be derived from the written material, of which there is a lot.

8. Professor Sashidharan (among other matters):

a. noted that the appellant had been receiving psychiatric treatment in hospital for six years and that the mainstay of his treatment during this period had been antipsychotic medication. He was under the impression that the appellant was accepting medication on a regular basis. He accepted that the patient's illness would quickly manifest itself if treatment were to be stopped.

b. considered that incidents where the appellant had been recorded as "paranoid" in fact had more normative explanations and that the problems associated with his management by the First Respondent and incidents of oppositional and disruptive behaviour were more likely to have been a product of the institutional dynamics and the appellant's personality rather than of any deterioration in his mental condition.

c. expressed confidence that the appellant would be compliant with medication, as although he was not entirely convinced of the need to take the medication at the prescribed dose and for any length of time, he has insight and realises it is necessary to do so to secure his discharge

d. considered that the appellant is unlikely to pose a risk to himself or others in the absence of a relapse

e. considered that he would refrain from cannabis use in the community if this formed part of the conditions attaching to discharge, again on the basis that his intelligence and insight meant that he would accept the need to compromise on his desire to continue using cannabis

f. noted a number of positive features, including his supportive family and more than adequate daily living skills.

g. indicated his view that the appellant's treatment and supervision could be undertaken safely and effectively in less restrictive circumstances and that it was not necessary for him to remain in hospital to receive ongoing treatment. Accordingly, he recommended a deferred conditional discharge, subject to conditions as to compliance with pharmacological treatment, compliance with supervision and aftercare arrangements, regular medical and social supervision and abstaining from illicit drug use.

9. Ms Hope-Borland (among other matters):

a. sounded notes of caution in her report, suggesting that the appellant may not have answered in a completely forthright manner and appeared somewhat reluctant to recognize faults or problems in himself, so that the interpretive hypotheses in her report should be reviewed with caution. She also indicated that "attention should be paid to the possibility of denial of problems with drinking or drug use, as [the appellant] described certain personality characteristics that are often associated with involvement with alcohol or drugs."

b. agreed with an earlier study that a predicted level of risk appeared to be low, as long as the patient was mentally well, although (given the seriousness of the index offence and other assaults when psychotic) the cost of any re-offending "could be high".

c. In a key paragraph, wrote:
"In my opinion [the appellant] has good insight into his mental health difficulties. He appears to have awareness that "chemically" illicit substances i.e. LSD, ecstasy, cocaine and amphetamines are not good for him. However he does present in believing that his mental state is not affected by the use of cannabis. [He] has indicated the evidence for why he believes that his mental state is not affected by cannabis [particulars are then given]. [He] therefore attributes his psychotic episode to a build up of stress in his life, including the stress of the sudden death of his younger sister. [He] does not accept that cannabis is implicated in his mental health difficulties. I am therefore of the opinion that [he] would benefit from some psycho educative work in relation to the role that cannabis can play in the development of psychosis. [The appellant] in my opinion presents as an intelligent man and I consider that he needs to be able to access documentation which has indicated the link between cannabis abuse, paranoia and psychosis. In my opinion such work could be carried out in a specialised hostel type environment where he can be supported within the community, his mental health can be monitored and he can also undertake psycho educative work in relation to the role of cannabis and mental health. I do not consider that [the appellant] needs a medium secure environment in order to undertake this work. I understand too that [the appellant] has successfully undertaken two relapse prevention courses. He further also considers that medication has been beneficial to him and would

be compliant in relation to this. Therefore my opinion is that he could carry out further work in a less restrictive environment than that of medium security."

10.Mr Watkins (among other matters):

a. recorded that the appellant had told him that he would smoke cannabis when he has the opportunity when he leaves hospital and anticipated smoking cannabis at the end of the day to relax. He considered he could smoke cannabis without harmful effects and indeed had had many treatment sessions with one of the hospital doctors while under the influence of cannabis without it being evident to the doctor concerned.

b. considered it was reasonable to conclude that cannabis consumption was likely to have a detrimental effect on the appellant's mental health and recommended that a risk management plan for when he leaves hospital must include substance misuse education work and support

c. noted that the appellant still harboured suspicions about certain events in his life which Mr Watkins considered should be addressed by psychiatrists

d. carried out a risk assessment. In relation to the risk of injury to a child (the circumstances of the index offence), Mr Watkins considered the likelihood and seriousness of consequences by saying that "It is possible that this could recur on the basis of previous behaviour, however, if [the appellant] has robust monitoring, deterioration in his mental state would be picked up. This would be highly serious." In relation to the measures which need to be in place to manage the risk of harm occurring, Mr Watkins drew attention to the need for "adherence to medication for the foreseeable future and engagement with a clinical team, whether in hospital or in the community. [The appellant] must abstain from abusing illicit drugs. [He] must be monitored by professionals who are experienced in recognising and responding to deterioration in mental state and in working with clients with a forensic history. [He] will have a social and psychiatric supervisor; initially he should reside in a residential care home."

e. noted that the appellant's personality might mean that he found it difficult to co-operate with a social and psychiatric supervisor in the community, though in Mr Watkins's view this should not act as a bar to his being discharged

f. indicated the view that the appellant "now poses a level of risk that could be managed in the community. [He] should be supported [through] a gradual transition from hospital to community using the time of a deferred conditional discharge.

g. set out particulars of a recommended aftercare package to address the appellant's needs and the issues raised by the risk assessment. This included:

- a psychiatric and social supervisor from a specialised forensic team,

- residence in a registered residential care home where the staff members have experience of working with people recovering from a mental illness, a history of substance misuse and who have a forensic history. Also members of staff who have experience in recognising and responding to changes in mental health and behaviour and in making judgements about risk
- provision for the appellant to attend a substance misuse programme in the community
- provision for the appellant to take up a training course at a college.

Mr Watkins went on to identify an organisation providing residential care of the type he was recommending and provided information sheets about two of their homes.

11. Evidence for the appellant therefore supported the view that it was necessary to secure both his compliance with medication and that he should refrain from cannabis. To that extent, there was no significant divergence with the views of the responsible clinician. The difference was about the steps needed to secure these aims.

12.While in particular Mr Watkins and Ms Hope-Borland did not have the advantage of the material contained in all Dr Reed's reports, their recommendations were made with some degree of realism: see in particular [9a] and [10 a and c] above.

13. In the reasons for its decision, the tribunal indicated that it found the evidence of the responsible clinician compelling, in the terms below. Questions of the weight to be given to evidence were exclusively a matter for it.

> "The evidence from Dr Reed, the RC from whom we have heard, in support of detention pursuant to the statutory criteria has been consistent, persuasive and wholly compelling. We have considered her evidence with care. In our view, it has not been successfully contradicted although she was closely cross-examined and was at a forensic disadvantage because she had not seen the other reports in the case, and in particular had not seen the report of Professor Shashidharan, until the morning of the hearing. Despite any self-perceived disadvantage, Dr Reed gave her evidence in a convincing manner. She made concessions where appropriate, remained resolute in her opinion that detention was appropriate and necessary, and was internally consistent in her oral evidence, consistent with her submitted reports, and consistent with the medical records. She drew attention to [the appellant's] repeated lack of full compliance with medication, his abuse [of] controlled drugs (cannabis), his manipulation of drug testing procedures, the likelihood of significant drug abuse if discharged into the community, the repeated concerns about his behaviour on the ward, his only partial engagement with the treatment team, and his risk of relapse in the community as a result of non-compliance and/or drug abuse. With relapse, the risk of harm to himself and others would be

significant. Dr Reed emphasised that should he suffer a relapse of his psychosis [the] patient was likely to develop delusions similar to those he experienced at the time of his index offence, namely to kill a member of the family. We accept her evidence as being accurate and we are able to rely upon it."

14. The tribunal then turned to the recommendation of Professor Shashidharan for deferred conditional discharge, which was also the recommendation "with varying degrees of enthusiasm" of Ms Hope-Borland and Mr Watkins. The tribunal dealt with this by saying:

> "We cannot regard the recommendation for a conditional discharge as appropriate given the agreed mental disorder from which [the appellant] suffers; the risk of non-compliance and relapse in the community; the abuse of cannabis in the community and the adverse effect of such abuse on potential relapse and the risk of harm; the continuing incidents of concern on the ward documented by the nursing staff; the safeguarding adult procedures in three separate cases still to be investigated; and the lack of full engagement with the treating team. We believe that if discharged into the community, even with conditions, [the appellant] would quickly return to cannabis abuse. He has admitted as much in conversation with members of the treating team and to Mr Watkins...Moreover given his reluctance to self[-medicate] a significant question mark has to be raised about his likely compliance in the community. With a non-compliance of his anti-psychotic medication and a return to cannabis abuse, the risk of harm to himself and others is likely to eventuate.
>
> We remind ourselves that index offence was very serious. Mr Watkins agreed that a robust approach was demanded of risk assessment.
>
> The parties agree that [the appellant] suffers from a mental disorder. It is appropriate that he is detained in hospital; for treatment. We doubt that in the community he would be fully compliant with his medication or that he would engage fully with the clinical team. Moreover, we fear that the abuse of cannabis would lead to a serious deterioration in his mental state. In these circumstances, when taken together, we believe that he will present as a real candidate for relapse if discharged into the community. A substantial risk of harm to his own health and safety and to the safety of others may very well then occur. We have no doubt that medical treatment in hospital is necessary to maintain his own health and safety and for the protection of others..."

15. In essence the real dispute is not one of fact, but about expert opinion as to the management of risk. The tribunal considered that the risk of non-compliance and relapse in the community was too great. They considered if the appellant was released into the community, he would quickly return to cannabis abuse. Why? Because he had said as much. Professor Sashidharan's view was based on the ability of the appellant to keep off

cannabis (as all the experts agreed were necessary). The tribunal did not accept that premise.

16. The tribunal found a reluctance to self-medicate. They concluded that this raised a "significant question mark" over compliance. Non-compliance meant that the risk of harm is "likely to eventuate". If harm materialised it would be serious. Professor Sashidharan's report was based on a premise that the appellant had been compliant and in the interests of securing his discharge would be compliant in future. The tribunal evidently did not agree with either part of that premise.

17. Recommendations had been put forward by the appellant's experts for treatment in the community. The tribunal was persuaded by the appellant's stated position with regard to cannabis use. By necessary implication the psycho educative work and the substance misuse programme proposed by Ms Hope-Borland and Mr Watkins respectively were considered insufficient to counter it.

18. Successful treatment in the community along the lines proposed by Mr Watkins would be heavily dependent on the relationship between the appellant and the clinical team. The tribunal found he would not engage fully with them.

19. Put in the terms of *English v Emery Reinbold & Strick Limited* [2002] 1 WLR 2409, I would consider that the tribunal evidently concluded that the evidence of Dr Reed accorded more satisfactorily with facts found by the tribunal. The evidence on behalf of the appellant as to the management of risk was to a significant degree based on false premises of fact with regard to (notably) cannabis use and compliance with medication. When the tribunal accepted Dr Reed's evidence on those points, the ground was in substantial measure cut away from under the appellant's experts' reports. I think it is for this reason also that the admittedly robust style of the tribunal's reasons is nonetheless sufficient to address the test in *Flannery v Halifax Estate Agencies Ltd* [2000] 1 WLR 377, that "[Where] the dispute involves something in the nature of an intellectual exchange, with reasons and analysis advanced on either side, the judge must enter into the issues canvassed before him and explain why he prefers one case over the other", for when significant parts of the factual substratum are not accepted, the evidence is weakened.

20. I am conscious that there are significant matters at stake here: "the liberty of detained patients on the one hand, and their safety as well as that of other members of the public on the other hand. Both the detained persons and members of the public are entitled to adequate reasons" (per Dyson LJ in *R(H) v Ashworth Health Authority* [2002] EWCA Civ 923; [2002] MHLR 314.) However, this does not mean that the reasons have to be convoluted when a direct style would do. Reading the reasons as a whole, as one must, if one asked the question what were the principal reasons why the appellant could not be treated in the community with a conditional discharge, one would answer with the points at [15] to [18] above. They also provide the answer to why continued detention is proportionate.

21. In these relatively early days of the Upper Tribunal's jurisdiction in respect of appeals in mental health cases, I test my conclusions against those of the three-judge panel which sat in *BB v South London & Maudsley NHS Trust* [2009] UKUT 157 (AAC)[1], not so much for any proposition of law which it contains which, so far as relevant, is contained in other decisions in any event, but to seek a broadly consistent approach. Although there are a number of similarities, it is evident that in that case, in which there was a conflict between the evidence from the responsible clinician and the patient's expert, the criticism made was that the tribunal had rapidly leapt to a preference for the responsible clinician's evidence based on the role of the responsible clinician rather than on the substance of his or her evidence. In the present case the tribunal did engage with the substance of the responsible clinician's evidence, and discussed it in its reasons and it was this that provided an answer to the evidence of the other experts, for the reasons given above.

22. The makes reference to a number of factors (including the "safeguarding adult procedures in three separate cases still to be investigated"), while leaving it only to be inferred what relative weight was attached to them. Although it is not the principal point made on the appellant's behalf, complaint is made that it was unfair to rely on the safeguarding procedures when no evidence as to them had been given other than the mere fact that a need for them was considered to exist, to which Dr Reed had referred in reports. In a jurisdiction concerned with the management of risk, I cannot see that it is necessarily inappropriate to have regard to the existence of a need for investigations under safeguarding procedures yet to be carried out. The weight to be given to that need is a matter for the tribunal. Clearly it must be taken to have carried some weight, otherwise the tribunal's decision would not have mentioned it. But reading the decision as a whole, the tribunal's primary concern was with the issues around compliance, drug abuse and the seriousness of risk and I am unable to discern that the tribunal erred materially in its approach to the yet to be investigated matters.

23. The tribunal's decision fails to comply with the Senior President of Tribunal's Practice Statement "Form of Decisions and Neutral Citation – First-tier Tribunal and Upper Tribunal on or after 3 November 2008." This requires decisions (including for this purposes statements of reasons) to use paragraph numbering. Failure to do so is poor practice and may make the Upper Tribunal's task harder, but is not of itself an error of law.

24. I am only concerned with whether the reasons are adequate to reach the minimum standard required by law. The decision is robust in its approach. There were other approaches which the tribunal might have adopted which might have avoided the need for this appeal. But when it comes down to the fundamental question of whether the decision "enables the parties and any appellate tribunal readily to analyse the reasoning that was essential to the

[1] The reference in that decision to *R(H) v Mental Health Review Tribunal for North and East London Region* [2001] is a slip for a reference to the *Ashworth* decision and has now been corrected under the slip rule.

tribunal's decision" (cf. *English*, [21] and *BB* [6]) I conclude, for the reasons above, that it does meet the test.

CG Ward
Judge of the Upper Tribunal
30 July 2010