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| Dorset Healthcare NHS Foundation Trust v MH [2009] UKUT 4 (AAC)<br><br>Duty on parties to try and agree before applying to tribunal.<br><br>The parties should try to reach agreement and the tribunal can use its case-management powers under Rule 5(3)(d).<br><br>Starting point is that full disclosure should be given. Burden on Responsible Authority to demonstrate that it is appropriate to withhold disclosure. | Rule 2 of The Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 (SI 2008/2699) *("the HESC Rules")* imposes an obligation on the parties to assist in the avoidance of unnecessary applications and unnecessary delay. That requires parties to cooperate and liaise with each other concerning procedural matters, with a view to agreeing a procedural course where they are able to do so, and before making any application to the tribunal. This is particularly to be expected where parties have legal representation. If a salaried judge has made an interlocutory decision prior to the hearing, it is open to a panel at a hearing to reconsider the matter.<br><br>In relation to disclosure, the starting point is that full disclosure of all relevant material should generally be given. However, Rule 14 of the HESC Rules enables the tribunal to make an order prohibiting the disclosure of documents where disclosure would be likely to cause serious harm to the patient or some other person and, having regard to the interests of justice, such an order would be proportionate.<br><br>Additionally, there are other reasons why (and procedures by which) disclosure of documents might be withheld. For example, the Responsible Authority may consider that it owes a duty of confidence to relevant third parties, and is unwilling to disclose documents to the patient (and occasionally even to the patient's solicitors) without a direction. Here, the parties should first do all they can to agree the approach to be adopted and avoid applying to the tribunal unless it is absolutely essential. The burden will generally be on the Responsible Authority to demonstrate that it is appropriate to withhold disclosure. |
| BB v South London & Maudsley NHS Trust & MoJ [2009] UKUT 157 (AAC)<br><br>Where expert evidence conflicts, tribunal must explain its approach. | The essential test for adequacy of reasons is the requirement that 'Reasons' should enable the parties and any appellate tribunal readily to understand and review the analysis that was essential to the decision. Although, in mental health cases, written reasons have to be produced with speed, the tribunal should nevertheless have provided some explanation as to *why* it had accepted the evidence of one expert and rejected that of another. The tribunal failed to analyse the key points made by the independent psychiatrist and failed to explain what answer had been given by the Responsible Clinician to those points, or why the RC's explanation was preferred. This was an error of law. |
| AA v Cheshire & Wirral Partnership NHS Foundation Trust [2011] AACR 37<br><br>S.3 application survives a change of status to CTO | An application to the tribunal made while the patient is detained under S.3 of the Mental Health Act 1983 ("the Act") does not lapse if the patient is made subject to a Community Treatment Order under S.17A of the Act before the application is heard. It will clearly be incumbent on any representative of the applicant to inform the tribunal as soon as possible whether or not the application is being withdrawn, and it is also clearly incumbent on all parties to inform the tribunal whether or not a postponement of any hearing that has already been fixed will be required in the light of the change of circumstances.<br><br>*Note: In KF v Birmingham and Solihull Mental Health Foundation Trust [2010] UKUT 185 (AAC); [2011] AACR 3 (see below) a three-judge panel of the Upper Tribunal has held that this decision was correctly decided on the question of* |

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| | *the construction of section 72(1) of the Mental Health Act 1983.* |
| RH v South London & Maudsley NHS Trust & SoSJ [2010] EWCA Civ 1273<br><br>Factors to consider on application by patient already on a Conditional Discharge seeking removal of Restriction Order etc. | In relation to a conditionally discharged restricted patient who has not been recalled, and who has made an application to the tribunal under S.75(3) of the Act, the High Court has previously held, in R(SC) v MHRT [2005] EWHC 17 (Admin),that material factors to consider will include such matters as the nature, gravity and circumstances of the patient's offence, the nature and gravity of his mental disorder, past, present and future, the risk and likelihood of the patient re-offending, the degree of harm to which the public may be exposed if he re-offends, the risk and likelihood of a recurrence or exacerbation of any mental disorder, and the risk and likelihood of his needing to be recalled in the future for further treatment in hospital. Regard should also be had to the gravity of other past offences. The tribunal will also need to consider the nature of any conditions previously imposed, the reasons why they were imposed and the extent to which it is desirable to continue, vary or add to them.<br><br>Whether a Restriction Order should remain in force depends on an assessment of risk, taking account of (among other things) the patient's prognosis as regards the nature and gravity of any mental disorder from which he *might suffer in the future*. Indeed, it is not necessary for the continuation of a Conditional Discharge that the patient currently be mentally disordered at all.<br><br>It is not unfair, nor in any way disproportionate, to require the patient to satisfy the tribunal that the Conditional Discharge should cease to have effect: i.e. that it is not appropriate for him to remain liable to be recalled. In this case, it was not surprising that a Restriction Order imposed on a patient who had been convicted of two deliberate killings should remain in force for so long as that person was suffering from a mental disorder and needing psychiatric and other support. Thus, in some cases, the Restriction Order would remain in force for life. The tribunal must have regard to the seriousness of any risk of harm to others. Hence the relevance of the index offence for the purposes of S.75(3), and the relevance of this Appellant's index offences for the purpose of the tribunal's assessment of risk.<br><br>Previous tribunal decisions relating to a particular patient are not binding, and any future tribunal considering the same patient's case in the future will look at the facts and circumstances as they exist at that time. However, earlier decisions are material considerations, and they are admissible on that basis. |
| MD v Nottinghamshire Health Care NHS Trust [2010] UKUT 59 (AAC)<br><br>It is sufficient if "medical treatment" is to prevent a | A tribunal must direct the discharge of a patient liable to be detained otherwise than under S.2 of the Act if they are *not* satisfied (amongst other things) that appropriate medical treatment is available for him.<br><br>S.145(4) provides that it is sufficient if the medical treatment is for the purpose of preventing a worsening of the symptoms or manifestations, and that envisages that the treatment may not actually *reduce* the risk posed by the patient. It is also sufficient if it will only alleviate some of the symptoms or manifestations, and |

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| worsening of symptoms. | there is no reduction in the risk posed by the patient. The question whether treatment is "available" or "appropriate" and the boundary between containment and treatment are matters of fact and judgment for the tribunal exercising its judgment as an expert body. |
| DL-H v Devon Partnership NHS Trust v SoSJ [2010] UKUT 102 (AAC)<br><br>The tribunal should ask a series of structured and sequential questions, and show in its reasons how it dealt with the key arguments and evidence. | It is not necessary to introduce the concept of proportionality into the application of S.72 of the Act. Introducing it could divert attention from the wording of the legislation and bring with it connotations that are not appropriate in the mental health context. The tribunal must discharge the patient from hospital unless detention for medical treatment is necessary for the patient's health or safety or for the protection of others. The legislation authorises detention by reference to the twin requirements of treatment and protection, moderated by the word 'necessary'. That is a demanding test and provides ample protection for the patient without the need for any additional consideration of proportionality.<br><br>In assessing the balancing exercise, the U.T. will treat the tribunal's judgment with the respect appropriate to one made by an expert decision-maker. The tribunal's duty is to ensure that the conditions for continued detention are satisfied. The tribunal must look behind assertions, generalisations and standard phrases.<br><br>By focusing on specific questions, the decision-maker(s) will ensure that an individualised assessment is made. What precisely is the treatment that can be provided? What discernible benefit may it have? Is that benefit related to the patient's mental disorder or to some unrelated problem? Is the patient truly resistant to engagement? Regard must also be had to the definition of "medical treatment" in S.145(1) and S.145(4). |
| RM v St Andrew's Healthcare [2010] UKUT 119 (AAC)<br><br>Non-disclosure. Fairness and justice generally require openness. Here, the tribunal's order involved the sacrifice of the patient's right to challenge his detention effectively. The effect of the non-disclosure in this case would completely exclude the claimant from knowing of the real process that was being followed, and allow him to participate only in | In previous proceedings the patient had been told that he had been covertly medicated. He then refused medication and became suspicious of food and drink. His epileptic control worsened, his psychotic illness was exacerbated, his mental state deteriorated, he refused to engage in rehabilitation and he became physically aggressive and uncooperative. The epileptic seizures could easily lead to a worsening of his psychosis and could lead to a worsening of his cognitive function. He sustained injuries and required restraint and seclusion. He was at increased risk of sudden, unexpected death. From July 2009, therefore, he was again medicated covertly through his food and drink. This improved his epileptic control and reduced his psychotic symptoms. In November 2009, the patient applied to the tribunal for discharge, and two addendum reports were prepared that revealed that the patient was again being covertly medicated. The hospital applied for an order prohibiting disclosure of this information to the patient, and the tribunal prohibited disclosure. The patient's representative challenged this decision, causing the U.T. to ask: "What if a patient's best interests medically clash with his best interests legally? Can they be reconciled? If not, which prevails?" The U.T. decided that Dorset Healthcare NHS Foundation Trust v MH [2009] UKUT 4 (AAC) gave little guidance because it concerned information that had been provided to the health authority in confidence. That did not apply here. Relying principally on the House of Lords decision in SoS Home Dept v AF (No 3) [2009] 3 WLR 74, the U.T. noted how highly an Article 6 (ECHR) fair hearing is rated |

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| a pretence of a process. | when balanced with non-disclosure. The overriding objective in Rule 2 of the HESC Rules requires that the rules of procedure be applied so that cases are dealt with fairly and justly. This includes ensuring full participation, so far as practicable. Rule 14(2) requires the tribunal to have regard to the interests of justice. Fairness and justice generally require openness. Here, non disclosure would completely exclude the claimant from knowing of the real process that was being followed, leading to a pretence of a process. |
| R.(RB) v First-tier Tribunal (Review) [2010] UKUT 160 (AAC)<br><br>The power to review a decision under Rule 46 should be exercised by the First-tier Tribunal only where there is a clear error of law in the original decision. | The power to review a decision should be exercised by the tribunal only where the original decision was clearly wrong in law.<br><br>The tribunal directed a deferred Conditional Discharge of a restricted patient, the conditions including ones that the patient must reside in a named care home and must not leave its grounds except when supervised. The Upper Tribunal found that the conditions amounted to a deprivation of liberty.<br><br>*Note: Charles J has now held that a capacitous restricted patient can give valid consent to conditions being imposed upon him (by way of a Conditional Discharge) that amount to a deprivation of liberty. However, such conditions cannot be imposed without the patient's valid and informed agreement or, if the patient lacks capacity, a DoLS authorisation or Ct of Protection order.* |
| KF v Birmingham & Solihull Mental Health NHS Foundation Trust [2010] UKUT 185 (AAC)<br><br>There are a number of situations where the tribunal may refuse to consent to the withdrawal of an application.<br><br>Referrals survive a change of status. | This case involved three different patients. The first issue raised related to Rule 17 of the HESC Rules which provides that a Notice of Withdrawal of an application will not take effect unless the tribunal consents. The tribunal would be justified in refusing consent to a withdrawal where it is no more than such a tactical ploy. However, that should not be taken as meaning that a tribunal should only refuse its agreement in such a scenario. There is no automatic right to withdraw, and the case for accepting a withdrawal will depend very much on the particular circumstances of the case.<br><br>The tribunal should always have regard to the overriding objective when considering withdrawals but where the patient has since been discharged, there will be no public interest in continuing proceedings.<br><br>Now see: AMA v Gtr Manchester West MH NHS Foundation Trust & Otrs [2015] UKUT 0036 (AAC)<br><br>The U.T. held that any movement from S.2 to S.3 or from S.3 to a CTO does not affect the continuing validity of an extant and undetermined application or reference to the tribunal, which still falls to be determined in accordance with the patient's status at the time of the actual hearing. Referrals cannot be withdrawn and both applications and referrals survive a change in 'status'. |
| LC v DHIC (CHL) & SoSJ & CUK [2010] UKUT 319 (AAC) | In R v SoS Home Dept, ex parte IH (FC) [2003] UKHL 59 the House of Lords that if, after deferral and before directing discharge, there was a material change of circumstances, the tribunal could reconsider its decision to direct a Conditional Discharge afresh. A change in circumstances may be demonstrated by new |

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| A deferred Conditional Discharge is a provisional decision and, if the tribunal is not satisfied with the arrangements it has power to reconsider the case *ab initio*. | material placed before the tribunal. Such material may, for instance, show that the patient's condition had relapsed. It may show that the patient's condition has improved. It may demonstrate that it is not possible to put in place the arrangements necessary to enable the conditions to be satisfied.<br><br>The original decision should be treated as a provisional decision, and if problems arise with making arrangements to meet the conditions, the tribunal can further defer its decision, amend or vary the conditions, remove the conditions, or decide that the patient must remain in hospital for treatment. |
| CB v Suffolk CC [2011] AACR 22<br><br>Non-compliance with a witness summons issued under Rule 16(1)(a). The First-tier Tribunal can refer non-compliance to the Upper Tribunal, which can impose a sentence of imprisonment or a fine. | A witness summons issued by the tribunal under Rule 16(1)(a) of the HESC Rules is to be complied with, unless and until it has been set aside or varied by the tribunal under Rule 16(4), or set aside by the Upper Tribunal on an application for judicial review. Tribunals should always consider alternatives, including the power to order a person to give evidence in writing, or produce relevant documents. Personal attendance of a witness may well be justified for the following reasons:<br><br>(1) The sequential nature of issues to be determined by a tribunal may make it very difficult for written directions to be formulated on one point until evidence has been taken on the others;<br><br>(2) Rule 2(2)(c) provides that dealing with a case fairly and justly includes ensuring, so far as practicable, that the parties are able to participate fully in the proceedings. Thus there will be cases where either or both of the parties wish to have the opportunity to question the witness about his or her evidence. For example, one piece of the witness's evidence may generate further lines of enquiry, as those present come to grips with the possible implications of the evidence which has been given;<br><br>(3) Because of the nature of their work, many jurisdictions seek to bring cases on promptly, and Rule 2(2)(d) provides that dealing with a case fairly and justly includes avoiding delay, so far as compatible with proper consideration of the issues. There may come a point when the most effective way of doing this is to require the attendance of witnesses, rather than to risk delay requiring written evidence.<br><br>(4) There can be great benefits in having everyone with relevant evidence to give sitting around the table together. Tribunals have a wide discretion in case management and it is often a question of balancing competing interests. Consequently, it is not suggested that every last avenue must always be explored to avoid issuing a witness summons. Tribunals will, as always, need to be guided by the terms of the overriding objective in Rule 2.<br><br>The tribunal may refer to the U.T., and ask the U.T. to exercise its power under S.25 of the 2007 Act, in relation to any failure by a person to comply with a requirement imposed by the Tribunal: |

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| | (a) to attend at any place for the purpose of giving evidence;<br>(b) otherwise to make themselves available to give evidence;<br>(c) to give evidence as a witness;<br>(d) to produce a document; or<br>(e) to facilitate the inspection of a document or any other thing (including any premises).<br><br>The U.T. powers of enforcement include a power to impose a sentence of imprisonment or a financial penalty (in this case £500 with 7 days imprisonment in default). |
| DL v SLAM NHS Trust & SOS [2010] UKUT 455 (AAC)<br><br>Factors to consider on application by patient already on a Conditional Discharge seeking removal of Restriction Order etc.<br><br>Whilst the tribunal was under no obligation to accept the conclusions of the experts, it was under an obligation to explain why it rejected their opinions, or preferred one piece of evidence over another, | A restricted patient appealed against the First-tier Tribunal's decision to refuse his application for an absolute discharge, with the consequence that he remained subject to a conditional discharge. Following R(SC) v MHRT [2005] EWHC 17 (Admin) a tribunal considering S.75 should consider whether it is satisfied that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment. If the tribunal is not so satisfied, then it is difficult to see that it will be appropriate for it to make an order under S.75(3)(b). Relevant factors laid down in *R(SC)* include such matters as the nature, gravity and circumstances of the patient's offence, the nature and gravity of his mental disorder, past, present and future, the risk and likelihood of the patient re-offending, the degree of harm to which the public may be exposed if he re-offends, the risk and likelihood of a recurrence or exacerbation of any mental disorder, and the risk and likelihood of his needing to be recalled in the future for further treatment in hospital. The tribunal will also need to consider the nature of any conditions previously imposed, whether by the tribunal or by the Secretary of State, the reasons why they were imposed and the extent to which it is desirable to continue, vary or add to them. The tribunal in this case said that it took into account the relatively recent date of the index offence and the relatively short time since the appellant had been conditionally discharged. However, it is not the mere passing of time that is significant, but what happens during the time that has passed. This, therefore, was not so much a question of irrelevance, but of inadequate reasons.<br><br>The tribunal should provide an explanation as to why it has accepted the evidence of one expert and rejected that of another – see BB v South London & Maudsley NHS Trust & MoJ [2009] UKUT 157 (AAC).<br><br>Where there is a coherent, reasoned opinion expressed by a suitably qualified expert, the tribunal should state how and why it disagreed with that reasoning. Whilst the tribunal was not obliged to accept the conclusions of the experts, it was under an obligation to explain succinctly why it rejected their opinions. |

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| JLG v Llanarth Court & SOS [2011] UKUT 62 (AAC)<br><br>Essential ingredients of a written decision. | The essence of the legal requirement for a tribunal's decision is that:<br>• the tribunal asked itself the correct legal questions - and it is helpful if tribunals set out their reasons under the headings provided by those questions because it makes it easier to show that the tribunal has dealt with each of the questions and how;<br>• it made findings of fact that were rationally based in the evidence; and<br>• it answered the legal questions appropriately given its findings of fact.<br><br>Additionally, the tribunal must give the parties a fair hearing; and provide adequate reasons.<br>Tribunals are assumed to know the essentials of what their work involves. It is permissible for them to be selective in their references to evidence when drafting reasons. All that a tribunal has to do is express its conclusions and explain why and how it reached them. Proportionality is not a separate issue. Any issue of proportionality is amply covered by the terms of legislation and the allocation of the burden of proof – see DL-H v Devon Partnership NHS Trust v SoSJ [2010] UKUT 102 (AAC). |
| RB v Nottinghamshire Healthcare NHS Trust [2011] UKUT 73 (AAC)<br><br>Recommendations are only likely to be made where the RC or Responsible Authority has not considered the possibility or would be unlikely to do so. And in the event of non-compliance the panel has to decide what practical value reconvening would serve. It has no power to enforce the recommendation and is not reconvening for that purpose. | The exercise of powers to make a statutory recommendation must be tempered by the reality that a tribunal has no power to coerce. It would assist those responsible for the patient's care and detention to know the tribunal's reasoning and the reasons may also provide a basis for considering how to proceed if the recommendation is not complied with. However, i is undesirable to give a patient false hope.<br><br>The first question is whether to make a recommendation at all. The more obvious the recommendation, the more likely it is that the authority will consider it anyway. So recommendations are only likely to be made in those cases where the authority has not considered the possibility or would be unlikely to do so. If the tribunal does make a recommendation, it has to take account of the tenuous nature of its control. This makes it essential to consider very carefully the timescale and the directions that the tribunal might give in order to be fully informed by the time it has to decide whether to reconvene. It may be appropriate for the tribunal to direct that a position statement be provided shortly before a specified date so that it can decide if there is any practical purpose in reconvening. Finally, the tribunal has to decide whether to reconvene. In making that decision, it has to decide what practical value this would serve. It has no power to enforce the recommendation and is not reconvening for that purpose. It has to make a judgment on what it can practically achieve, if anything. |

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| AH v West London MH Trust [2011] UKUT 74 (AAC)<br><br>Factors to consider when dealing with a request for a public hearing. | Rule 38(1) of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 provides that hearings must be held in private unless the tribunal considers that it is in the interests of justice for the hearing to be held in public. Relevant facts to consider are:<br><br>1. It is a fundamental principle, both in common law and in Article 6 ECHR, that justice should be open and transparent. Any exception to the open justice principle must be clearly justified.<br>2. Generally, the protection of the interests and right to confidentiality of mental health patients will justify an exception to that principle;<br>3. In any application for a public hearing, the factors to be considered include:<br>(a) whether it is consistent with the subjective and informed wishes of the patient (assuming that he is competent to make an informed choice);<br>(b) whether it will have an adverse effect on his mental health in the short or long term, taking account of the views of those treating him and any other expert views;<br>(c) whether there are any other special factors for or against a public hearing;<br>(d) whether practical arrangements can be made for an open hearing without disproportionate burden on the hospital or relevant authority (paragraphs 29 and 44);<br>4. If the tests for establishing a right to a public hearing have been satisfied, the question then arises of how the right to a public hearing can practically and proportionately be achieved will depend on the facts of each individual case, including the facilities available in the hospital in question.<br><br>In this case the Upper Tribunal directed that the First-tier Tribunal hold a public hearing. |
| MP v Mersey Care NHS Trust [2011] UKUT 107 (AAC)<br><br>A panel can only recommend that the RC consider making a CTO if the S.3 criteria are established. | The panel discharged the patient from S.3 but also made a recommendation that the RC consider making a CTO. However, only if the panel is satisfied as to the conditions for liability for detention can it go on to consider a recommendation, and a recommendation to consider a CTO can only be a consideration in a case where the tribunal is not under a positive duty to discharge. If a tribunal discharges a patient, but defers the discharge to a future date, that decision brings to an end any CTO on the date that the patient is discharged. Where there is an inconsistency between a discharge and a recommendation, the discharge will nevertheless take effect if the panel states that it was not satisfied as to the conditions for detention. |

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| CM v DHNHSFT and SoSJ [2011] UKUT 129 (AAC)<br><br>"Nature" refers to the particular mental disorder from which the patient is suffering, its chronicity, its prognosis, and the patient's previous response to receiving treatment. "Degree" refers to the current manifestations of the patient's disorder. | The criteria require consideration of both the nature and degree of a patient's mental disorder. Nature refers to the particular mental disorder from which the patient is suffering, its chronicity, its prognosis, and the patient's previous response to receiving treatment for the disorder. Degree refers to the current manifestations of the patient's disorder. The words "nature" and "degree" in S.72(1)(b)(i) are to be read separately so that, for example, even if the degree of mental disorder does not make it appropriate for the patient to be liable to be detained for treatment, the nature of the disorder might make such detention appropriate, see R v MHRT ex parte Smith [1998] EWHC 832 (Admin)<br><br>If the nature of a patient's illness is such that it will relapse in the absence of medication, then whether the nature is such as to make it appropriate for him to be liable to be detained in hospital for medical treatment depends on the evidence that, if he were free in the community, the patient would not take the necessary medication and would consequently relapse in the near future. |
| TR v Ludlow St Healthcare Ltd & TR [2011] UKUT 152 (AAC)<br><br>Challenge to a case management decision. Generally, despite a challenge, it will be appropriate to proceed with the case. | All decisions of the First-tier Tribunal, including interlocutory decisions and case-management decisions can be appealed to the Upper Tribunal by the parties, except for those decisions excluded by S.11(5) of the Tribunals, Courts and Enforcement Act 2007. In the first instance, however, most case-management decisions should be questioned by going back to the First-tier Tribunal (see Dorset Healthcare NHS Foundation Trust v MH [2009] UKUT 4 (AAC)). Brief reasons are generally acceptable in relation to case management decisions. Judges are not expected to write judgments when making routine rulings on the future conduct of a proceedings.<br><br>If a party applies for permission to appeal against a case management decision it does not mean the substantive case cannot go ahead. Generally, it will be appropriate to continue with the proceedings. It is in the nature of many case management decisions that the Upper Tribunal will be unlikely to give permission to appeal. There is also the danger of a party using an application for permission in order to obtain the advantage that the case management decision has denied. That tactic should not succeed. |
| RN v Curo Care/OE [2011] UKUT 263 (AAC)<br><br>Tribunals are entitled to preview the case before the hearing begins. This may lead the panel to reach provisional conclusions. But it is not permissible is to reach firm conclusions or prevent | The tribunal indicated at the outset that it was not prepared to entertain argument about a recommendation that the RC consider making a CTO. This was an error of law. Tribunals are entitled to preview the case before the hearing begins and that may lead the panel to come to provisional conclusions. But it is not permissible is to reach firm conclusions and prevent the parties from arguing to the contrary. Moreover, the tribunal did not explain why it had not made a recommendation, which it should have done.<br><br>For a recommendation under S.72(3A) the tribunal does not have to decide that a patient satisfies the conditions for a CTO at the time of the hearing. A recommendation can be used to trigger consideration of the steps that could be taken to move the patient towards eventual release on a CTO. Reasons may show that the patient was not ready for release at the time of the hearing, but a recommendation is not limited to |

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| argument to the contrary. | the present. The power can also be used as a trigger for action in the future.<br>*Note –The non-RPP decision template number 8 allows a judge to direct that the panel will not reconvene.* |
| KL v Somerset Partnership NHS Foundation Trust [2011] UKUT 233 (AAC)<br><br>There must be an element of hospital treatment in the patient's on-going care plan to justify liability to detention under s.2 or s.3 MHA. | There must be an element of hospital treatment in the patient's on-going care plan for liability to be detained under S.2 or S.3 to be justified. However, a patient may have S.117 leave and hospital treatment includes treatment provided at clinics, dispensaries and outpatient departments maintained in connection with hospitals; and can include reviews.<br><br>If the tribunal considers that a S.3 order should continue but also thinks that a CTO might be appropriate and makes a recommendation that a CTO be considered, it may subsequently reconvene if the recommendation is not followed, and may reconsider the matter afresh if the RC does not give a persuasive reason for not following it. The panel should not, however, just repeat the recommendation. |
| MB v BEH MH NHST & SoSJ [2011] UKUT 328 (AAC)<br><br>Granting permission withdraw an application is a decision that can be appealed. | Permission at a hearing to withdraw an application is a decision that can be appealed to the Upper Tribunal, and is not a decision excluded from the right to appeal.<br><br>Where the application to withdraw follows a strong indication from the judge that the appeal cannot succeed, the Upper Tribunal will look at the question of whether the panel had formed a preconceived concluded opinion before it had heard all the relevant evidence and submissions. |
| DN v Northumberland Tyne & Wear NHS Foundation Trust [2011] UKUT 327 (AAC)<br><br>In relation to detained patients, he Mental Health Act 1983 is generally intended to have primacy over the Mental Capacity Act 2005. | The Upper Tribunal agreed with the judgement of Charles J., sitting in the Court of Protection, in the case of: GJ v The Foundation Trust, The PCT, & SoS Health [2009] EWHC 2972 (Fam) that, where it applies in relation to detention, the Mental Health Act 1983 (MHA) "has primacy" over the Mental Capacity Act 2005 (MCA). This means that the MHA is to have primacy when it applies, and clinicians and others cannot pick and choose between the two statutory regimes as they think fit unless the MCA regime has clear advantages over the MHA regime. This is in line with the underlying purpose of the amendments to the MCA –which was to fill a gap namely the "*Bournewood Gap*". This shows that the purpose was not to provide alternative or duplicate regimes but to leave the existing regime under the MHA 1983 in place with primacy, and to fill the gap left by it in relation to compliant patients who lack capacity to object. |
| SoSJ v RB & Lancashire Care [2011] EWCA Civ 1608 | If the tribunal is not satisfied as to the S.73(1)(a) criteria but considers that it is, nevertheless, appropriate for the patient to remain liable to be recalled to hospital for further treatment, it must direct a Conditional Discharge. At least in relation to a patient with capacity who has not given informed and valid consent, any |

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| At least in relation to a patient with capacity who has not given informed and valid consent (or an incapcitous patient where there is no DoLS authorisation or welfare order) a Conditional Discharge must not have the inevitable consequence that the patient will be deprived of their liberty. | conditions imposed under S.73(4)(b) must, in practice, fall short of an inevitable deprivation of liberty.<br><br>The Ct of Appeal did not in terms consider what happens if a patient with capacity decides that it is in his or her best interests to consent to a Conditional Discharge involving conditions amounting to a deprivation of liberty (e.g. if this permits the first steps to be taken to move out of hospital into the community).<br><br>However, in MM, Charles J in the Upper Tribunal has held that such a patient can consent to conditions leading to a deprivation of liberty out of hospital, just as a DoLS authorisation or welfare order can give *de facto* consent in relation to a patient lacking capacity to agree to such an arrangement for themselves. Thie decision in MM is currently subject to a possible appeal to the Ct of Appeal. |
| DP v Hywel DDA Health Board [2011] UKUT 381 (AAC)<br><br>An application cannot be made to the tribunal except in such cases and at such times as are expressly provided by the Act. | An application cannot be made to the tribunal except in such cases and at such times as are expressly provided by the Act (see S.77(1)). There is no discretion to accept jurisdiction outside the parameters set by the Act. In this case, a person purported to be the patient's nearest relative, but he was not ordinarily resident in the United Kingdom, as required by S.26(5)(a) of the Act.<br>*Note: this case illustrates the importance of carefully checking jurisdiction - especially in relation to which situation is said to generate the right to an application, whether the application has been made within the relevant period, and also in relation to all referrals.* |
| DC v Nottinghamshire Healthcare NHS Trust & SoSJ [2012] UKUT 92 (AAC)<br><br>A tribunal should not adjourn if it is able to give a decision. When deferring a conditional discharge, the proposed conditions for must be identified and formulated. | A tribunal should not adjourn if it is able to give a decision but, when making a provisional decision deferring a direction for a conditional discharge, the conditions for discharge must be identified and formulated because the purpose of the deferral is to allow time for the necessary arrangements to be made. If the conditions cannot be formulated, there is no basis upon which make a provisional decision.<br><br>The power to adjourn cannot be exercised to override the provisions of the substantive legislation, so a tribunal cannot adjourn if it is obliged to direct a discharge under S.73 of the 1983 Act. In a restricted (RPP) case the tribunal must direct a conditional discharge under if the tribunal is satisfied that the patient should not be detained but should be subject to recall. Conditions can be imposed. The question in this case was: had the tribunal reached the stage where it had to make a decision and defer it? |
| CNWL NHS Foundation Trust and H-JH [2012] UKUT 210 (AAC)<br><br>A discharge may be directed on a future date, by which time medication may be reduced. | In the hope that the RC would reduce the level of the patient's medication, the tribunal directed discharge of a CTO on a date 3 months in the future under S.72(3. This was permissible. A tribunal is not entitled to use the power to discharge on a future date in order to test whether a patient is ready for discharge - but it had not done so. A firm decision had been made and a fixed date for discharge specified. If the patient's condition deteriorated during the period after the hearing but before the fixed date for the discharge, ordinary CTO powers could be exercised by the RC. Medication could be changed and the patient could be recalled. After discharge, if the grounds were made out, a patient could be re-detained under S.3. |
| SH v Cornwall Partnership | The issue in this case was whether treatment given without the patient's consent was "appropriate". The |

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| NHS Trust [2012] UKUT 290 (AAC)<br><br>Tribunals should not get involved in issues about consent. The treatment of patients under the Act is subject to judicial oversight *by the courts.* Even if given without consent, treatment can be available and appropriate. | patient was on a CTO and when the patient attended for his depot injection, he said that he did not consent to it. It was argued that, as a consequence, the treatment was not appropriate.<br><br>As a statutory tribunal constituted under the Tribunals, Courts and Enforcement Act 2007, the tribunal only has the powers conferred on it. It can order the discharge of a CTO patient, but no more. It does not have power to direct any steps in respect of the patient's treatment, and it should not get involved in issues about consent. Judicial oversight by the tribunal is limited to whether the statutory criteria are met. The precise nature of the treatment under the Act is for the RC and subject to judicial oversight *by the courts.* Even if administered without consent, treatment can be both available and appropriate. Medication can be administered without consent and co-operation if need be and if the law permits. Even counselling and psychological therapies can be available and appropriate, even where a patient refuses to engage. |
| AM v West London MH NHS Trust & SoSJ [2012] UKUT 382 (AAC)<br><br>Where the patient had not reached the point where there was a real likelihood of discharge, the tribunal did not need to have specific information about aftercare. | Contrary to the Practice Direction, the social circumstances report presented to the tribunal did not say, even in outline, what community support would be made available if the patient were to be discharged. An adjournment was sought for a S.117 meeting to be held, but the tribunal refused to adjourn as the S.117(2) duty is only owed to a person who ceases to be detained and leaves hospital. On appeal, Judge Jacobs said: *"I do not accept that it is essential for the tribunal to have specific information about aftercare in every case".* The tribunal asked questions and concluded that the patient was not yet at the stage where there was a real likelihood of discharge, so the question of what aftercare was available did not arise.<br><br>*Note: Application to appeal to the Court of Appeal was refused. Although caution was needed, it was open to a tribunal to conclude in the circumstances of a particular case that information or better information about aftercare was incapable of affecting the decision, and that an adjournment to secure its provision could achieve nothing beyond additional expense and delay, and would therefore be inappropriate.* |
| JP v SLAM [2012] 486 (AAC)<br><br>Reference to "the unanimous opinion of the professional witnesses", without more, is an inadequate explanation for accepting disputed evidence. | The tribunal had relied on 'the unanimous opinion of the professional witnesses'; without identifying the opinions and how they were justified. It did not discuss the details of any of this evidence, but instead made broad generalisations about the reports. This was problematic since one report, for example, appeared simply to have been a recitation of information from other sources. Another problem is that all of the opinions *might* have agreed because they were based on the same source. So the evidence needed to be analysed in greater depth and the tribunal's decision had not provided a sufficient basis for the patient to understand why the evidence had been accepted |
| AC v Partnerships in Care Ltd v SoSJ [2012] UKUT 450 (AAC)<br><br>The tribunal should only take account of its own powers. | In the case of a restricted patient transferred from prison who is subject to a limitation direction or a restriction direction, the tribunal must notify the Secretary of State whether the patient would, if subject to a S.41 restriction order, be entitled to be absolutely or conditionally discharged. The tribunal has no power to impose conditions as to release from prison, which is the exclusive preserve of the Parole Board. In considering whether a patient would, if subject to a restriction order, be entitled to a conditional discharge, the tribunal should only take account of the conditions it could itself properly impose under S.73(4). |

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| SoSJ v MP & Nottinghamshire Healthcare NHS Trust [2013] UKUT 025 (AAC)<br><br>There is power to order a conditional discharge even if the patient does not now have a mental disorder - although a drug induced psychosis is a mental disorder under the Act. A tribunal must explain its decision, including a decision not to impose conditions other than the power of recall. | The Upper Tribunal made a number of distinct observations in this case:<br>• The First-tier Tribunal has no jurisdiction to decide whether the patient was properly detained in the first place. The issue for the tribunal is whether the patient should now be discharged.<br>• "Mental disorder" means any disorder or disability of the mind, although, by virtue of S.1(3) dependence on alcohol or drugs is not considered to be a disorder or disability of the mind. Thus, the mere fact that a person is dependent on alcohol or drugs is not of itself sufficient to justify detention under the Act. However, this limitation does not cover the consequences that flow from that dependence. A drug-induced psychosis is a mental disorder within the meaning of the Act.<br>• There is power to direct a conditional discharge even if the patient does not have a mental disorder.<br>• A conditional discharge is so named because the patient is liable to recall. It is permissible to direct a conditional discharge without imposing any further conditions, as envisaged by S.73(4)(b).<br>• A tribunal is under a duty to explain its decision, including a decision not to impose further conditions. In some cases, the circumstances alone may be sufficient to show why the tribunal did not impose conditions. But, as with other decisions, cogent reasons should generally be given. |
| EC v Birmingham and Solihull Mental Health NHS Trust [2013] AACR 1<br><br>In RPP cases, the tribunal has no *legal* power to make a non-statutory recommendation. If panels are routinely spending a great deal of time doing so, that practice is to be deprecated. | Since Parliament has not provided the tribunal to make recommendations in restricted (RPP) cases, there can be no expectation that the making of a non-statutory recommendation will be considered by the tribunal in all cases, or in any particular case. The contrast between the S.72(3) power to make certain recommendations with a view to discharge on a future date in non-restricted cases, is noteworthy. The absence of such a power in S.73 is stark and obviously deliberate. The tribunal has no *legal* power to make an extra-statutory recommendation and can never be compelled to consider doing so. If panels are routinely spending a great deal of time considering issues not necessary for the exercise of their statutory functions for no better reason than that a party has asked them to do so, that practice is to be deprecated.<br><br>An appeal to the Court of Appeal was dismissed – although the Court accepted that if the tribunal is ever faced with the argument (supported by evidence) that leave or transfer is *a necessary or desirable part of the restricted patient's* ***treatment***, then that is something which they must consider in that context. |
| GB v SW London & St. George's MH NHS Trust [2013] UKUT 058 (AAC)<br><br>This case illustrates the danger of judicial office holders making any comments during the hearing. | When questioning the RC about the nature and degree of the patient's Schizoaffective Disorder, the tribunal medical member had said: *"I have no issues with the nature - it is chronic, relapsing … (etc)."* The appeal to the Upper Tribunal was on the basis that this comment represented a concluded view, or at the very least gave rise to a reasonable apprehension that the Medical Member had formed a concluded view, as to the criterion of "nature". The Upper Tribunal found that, on the facts, it was not likely that a fair minded and informed observer would think that the Medical Member had reached a fixed and concluded view on the nature of the Appellant's mental health condition.<br>*Note: Although the tribunal's final decision was upheld, the case illustrates the danger of judicial office holders making any comments during the hearing, and especially when asking questions. An open mind is essential.* |

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| MS v North East London Foundation Trust [2013] UKUT 092 (AAC)<br><br>Panels should take care not to drift into the wrong language in expressing their reasons.<br><br>A failure to give reasons for not making a recommendation is an error of law, but the decision need not be set aside. Rather, upon review, the salaried judge should ask the panel to add the necessary brief explanation. | In a S.3 case, the tribunal had incorrectly applied part of the S.2 criteria. This was a serious error because the difference in wording between S.72(1)(a) and S.72(1)(b) is deliberate and reflects the different purposes of the sections. The conditions for detention under S.2 are less demanding than for S.3, since the need for treatment is not clear. This lower threshold reduces the protection for the patient, but that is balanced by the fact that, unlike S.3, a limited period of detention under S.2 requires proof of the need for an assessment (whether it is stand-alone assessment or assessment followed by medical treatment).<br>*Note: If the Responsible Authority failed to prove that detention for assessment (or assessment followed by medical treatment) was warranted, the patient should be discharged from S.2.*<br><br>Applying the wrong criteria is careless - and casts doubt on the tribunal's reasoning as a whole.<br><br>In all cases, the tribunal's written reasons should succinctly:<br>• state what facts the tribunal found;<br>• explain how and why the tribunal made them;<br>• show how the tribunal applied the law to those facts.<br><br>In addition, the panel in this case had been asked to make a statutory recommendation, but it did not do so and it did not explain why not. However, the First-tier Tribunal can review the decision, and then amend its reasons under S.9(4)(b) of the Tribunals, Courts and Enforcement Act 2007 by adding an explanation. |
| MM v Nottinghamshire Healthcare NHS Trust [2013] UKUT 0107 (AAC)<br><br>No adverse inference should be drawn when an independent psychiatrist is instructed but not relied on. | A tribunal should not draw any adverse inference from the fact that an independent psychiatrist visited the patient and had been instructed to prepare an independent report even though, at the hearing, the patient's representative did not produce and did not rely on that report.<br><br>So long as a tribunal is clear that no adverse inference will be drawn, there is nothing objectionable in a panel knowing that an independent expert was instructed (or visited the patient). All judicial office holders should be able to put this out of their minds. |
| MD v Mersey Care NHS Trust [2013] UKUT 127 (AAC)<br><br>Risk can be highly relevant to the question whether medical treatment is available and appropriate. Lack of engagement does not mean | In a S.3 or S.37 case, risk is clearly relevant to the question whether mental disorder of a nature or degree which makes it appropriate for the patient to be liable to be detained in a hospital for treatment; whether it is necessary for the health of safety of the patient or for the protection of other persons that he should receive such treatment, and whether appropriate medical treatment is available for a patient.<br><br>Lack of engagement does not mean that the disorder not susceptible to treatment, or that available treatment is somehow not appropriate The Upper Tribunal agreed that both the high likelihood of harm occurring, and the grave consequences of such harm if it occurred, especially when considered together, |

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| treatment is not appropriate. | can be relevant to all aspects of the case. |
| GA v Betsi Caowaladr University LHB [2013] 0280 (AAC)<br><br>Although the patient only accepted treatment because he feared recall, he did still have a choice, and he exercised that choice. Should the patient refuse his depot injection, this was his right, although consequences would probably follow. | This appeal raised the issue of the powers of a tribunal when the patient professes to withhold consent to treatment – this time whilst subject to a community treatment order. The First-tier Tribunal found that, even though the patient only accepted treatment because he feared recall to hospital, he nevertheless did have a choice, and he exercised that choice at the time of administration of the depot injection. Should the patient refuse that injection, this was his right, although consequences may follow. This was not undue or unfair pressure but the reality of the situation. The Upper Tribunal did not find any error of law .<br><br>It was also argued that the tribunal should have exercised its discretionary power to discharge under the tribunal's general S.72(1) power. However, the discretionary power is one to be used in exceptional circumstances only. It is hard to imagine many circumstances where the applicable statutory criteria are all satisfied but it would still be right to discharge.<br>*Note: Jones gives an example of a tribunal using its power to allow a patient to join his parents in the USA, where he could receive treatment.* |
| SoSJ etc v SB [2013] UKUT 0320 (AAC)<br><br>Conditions on a Conditional Discharge must not amount to detention or to an unlawful deprivation of liberty such the "discharge" can hardly be characterised as such. | In the case of a patient transferred from prison the tribunal said that, if the patient had been detained under Section 37/41, it would have granted a conditional discharge with conditions, including:<br>• to reside at such supported accommodation as directed by the RC;<br>• to comply with all directions of the RC in regards to his mental well-being;<br>• not to leave the premises during the first 13 weeks of residence unless under the direction of the staff and thereafter only under the guidance of such staff.<br>• to communicate to the RC or the social supervisor the fact of any relationship formed by him with any person, whether intimate or not, and to keep the RC informed of the progress and/or termination of any such relationship.<br><br>There was an enormous amount of power placed in the hands of the RC without any requirement that his directions be reasonable or even lawful. The condition about not leaving the premises could be read as permanently preventing the patient from leaving his residence without the permission of the staff or under whatever conditions the staff or the RC saw fit to impose, whether reasonable or lawful or not. The requirement to communicate "any relationship" appeared to be oppressively unclear and capable of arbitrary application by the relevant staff. |

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| AM v SLAM NHS Trust & SoS Health [2013] UKUT 365 (AAC)<br><br>The MCA can sit alongside, or be used instead of a CTO or Guardianship. | In the case of patients who lack capacity to agree to, or object to, detention or treatment, but who are compliant, questions may arise as to whether or not 'deprivation of liberty safeguards' (DoLS) under the Mental Capacity Act 2005 (MCA) are definitely available and, if so, whether they offer a more appropriate means of providing a person with medical treatment than them being subject to the Mental Health Act 1983 (MHA). The MHA has primacy in relation to detained patients, but the MCA can sit alongside, or be used instead of, Guardianship or a CTO - where preferable. However the Code of Practice makes it clear that DoLS are **not** inherently less restrictive than a person remaining subject to the MHA, with its safeguards. |
| DL-H v Partnerships in Care & SoSJ [2014] AACR 16<br><br>A refusal to engage with therapy is not decisive to the issue of appropriate treatment. | Once again, the issue in this case was a patient with a personality disorder refusing to engage with therapy. However, this refusal was not decisive to the question of available and appropriate treatment. The patient may well continue to satisfy the statutory criteria, despite refusing to engage. Questions in addition to those listed in DL-H v Devon Partnership NHS Trust v SoSJ [2010] UKUT 102 (AAC) (above) are: What is the purpose of the proposed treatment? Is it actually available? Will it produce a significantly better outcome than the present position? Does it have any adverse effects that outweigh its benefits? |
| Equilibrium Health Care v AK [2013] UKUT 0543 (AAC)<br><br>The test for whether or not there was a real possibility of bias was "whether the fair-minded and informed observer, having considered the facts, would conclude that there was a real possibility that the tribunal was biased". | In early 2011, in a previous case involving an entirely different patient, the tribunal Medical Member (supported by the panel judge) had reported the RC in that case to the General Medical Council. However, in the event, the GMC took no disciplinary action against RC. In September 2013 the same Medical Member was listed to sit on a tribunal involving the same RC, but an entirely different patient. The RC objected to giving evidence and argued that the Medical Member was (or would appear to be) biased. The Upper Tribunal held that the test for the real possibility of bias was 'whether the fair-minded and informed observer, having considered the facts, would conclude that there was a real possibility that the tribunal was biased' - see Porter v Magill [2002] 2 AC 357. All doctors know that their performance is open to scrutiny.<br><br>*Note: In order to ensure consistency, direct complaint by a judicial office holder is now strongly discouraged and, instead, all complaints should be referred to Salaried Judge Postgate, or Chief Medical Member Dr Rutherford. This will prevent retaliatory allegations of bias arising in a personal context, and will ensure a consistent threshold.* |
| HK v Llanarth Court Hospital [2014] UKUT 0410 (AAC)<br><br>Adequate reasons are especially important for detained patients - such detention being a serious interference with their right to liberty under Article 5 ECHR. The Upper Tribunal gives general guidance on giving | 1. Reasons themselves must be clear and unambiguous.<br>2. Merely narrating what each witness told the tribunal is, without more, liable to render a set of reasons erroneous in law. What is required is to explain:<br>(i) what facts the tribunal found as a result of that evidence, and<br>(ii) what conclusions on those facts the tribunal reached.<br>3. The tribunal's written reasons should address how the tribunal dealt with any disputes as to either the law or the evidence. If this is not done, the unsuccessful party might believe that the tribunal has ignored important issues and may render a set of reasons inadequate.<br>4. It is not necessary for the tribunal's reasons to mention all of the evidence in a case. It is entitled to be selective in its references to evidence in its reasons though it should identify and resolve disputes.<br>5. It would be helpful if tribunals were to set out or summarise their reasons by reference to each of the |

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| written reasons.<br><br>*Note – as the 'Wizard of Oz song goes – the most important part of the decision is not the narration of facts, but the '**Because, Because, Because'** part.* | relevant criteria for detention. One way to show that the tribunal has dealt with each of the legal criteria is to use headings within the statement of reasons. The tribunal has made template decisions which set out the grounds. These should then be individually addressed in the 'Reasons' part of the decision and summarised at the end, addressing each one of the relevant criteria in turn.<br><br>In this case there was no hint in the reasons that there were any disputes about the evidence or the criteria for detention, and the reasons did not explain what findings of fact the tribunal made from the evidence. The panel then failed to explain the conclusions to be drawn from any facts found. It was thus difficult to discern precisely what the tribunal found in relation to the statutory criteria. |
| NL v Hampshire County Council [2014] UKUT 0475 (AAC)<br><br>The tribunal's discretionary power to discharge is one to be used only in exceptional circumstances, and only if such a decision is consistent with the panel's findings. | Mr L was made subject to the guardianship of his local authority and to a detailed care plan, the effect of which was to deprive the patient of his liberty. The tribunal refused to discharge the guardianship order because the statutory criteria for guardianship were established. In relation to the tribunal's discretionary power, the tribunal said: "If we were to discharge in this case, we would be acting inconsistently with the logic of our reasoning that the support and protection afforded by the guardianship is necessary.<br><br>The Upper Tribunal supported the tribunal's reasoning. The cause of the deprivation of liberty arose as a consequence of the care plan (and not the guardianship order) – over which the tribune al had no statutory remit. There was no basis to discharge the patient under the tribunal's discretionary powers. If a capacitous patient did not agree with the plan, or there was no DoLS authorisation or welfare order in the case of an incapacitous patient, the panel should clearly flag up the difficulty, so that steps could be taken to rectify. |
| Northampton Healthcare NHS Foundation Trust v ML and Others [2014] EWCOP 2<br><br>The Mental Health Act (rather than the DoLS) is, and is likely to remain, the "the magnetic north" when contemplating the detention or deprivation of liberty of those who fall within the scope of the Act.<br><br>If the evidence indicates that what is contemplated is treatment rather than an | Hayden J considered a case concerning a patient who lacked capacity to consent to deprivation of liberty, and was within the scope of the Mental Health Act 1983. The possibility of using Deprivation of Liberty Safeguards (DoLS) rather than detention under the MHA was considered. The judge said, however, that: having considered the case law and the statutory provisions, it was clear that "the magnetic north" when contemplating the deprivation of liberty of those who fall within the scope of the Mental Health Act 1983 is and is likely to remain the Mental Health Act.<br><br>The judge added that the rationale of the legislation drives one to the MHA where the Act is being considered by those who could make a S2 or S3 application.<br><br>The Court also considered the fact that, despite the fact that the patient was well known to mental health services, the hospital had requested an admission initially under section 2. However, the judge said:<br>"To my mind the evidence that I have heard plainly indicates that what is contemplated is an extensive course of treatment rather than an assessment ... Accordingly an application pursuant to section 3 seems both apposite and honest." |

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| assessment ... an application pursuant to section 3 is the most apposite and honest. | *Note: There is now guidance in the Code of Practice 2015 as to the appropriate use of S.2 and S.3, which challenges the views in the relevant footnote in 'Jones' (as does the approach of Hayden J in this case).* |
| YA v Central and NW London NHS Trust and Others [2015] UKUT 0037 (AAC)<br><br>Test for the tribunal to appoint a legal representative under Rule 11(7)(b). | For the tribunal to appoint a legal representative under Rule 11(7)(b), three things have to be established:<br>1) the patient must not have appointed a representative for themselves (whether legal or otherwise);<br>2) the patient must lack the capacity to decide whether or not to appoint a representative; and<br>3) the tribunal must believe that it is in the patient's best interests for the patient to be represented.<br><br>*Note: Representation may not be in a reluctant patient's best interests if having representation forced upon them could have seriously damaging consequences, such as to cause real distress, or undermine their right to autonomy.* |
| AMA v Gtr Manchester West MH NHS Foundation Trust & Otrs [2015] UKUT 0036 (AAC)<br><br>The tribunal's discretion to refuse to give consent to the withdrawal of an application provides a safeguard for the patient. Consent to withdrawal should not be given unless the tribunal is satisfied that a review of the patient's detention in hospital by an independent tribunal is, on the information and evidence known, unnecessary.<br><br>If in doubt, the tribunal should refuse consent and carry on with the hearing. | The patient's mother had been appointed as a 'welfare deputy' by the Court of Protection, but her power to make welfare decisions did not extend to deciding how to conduct tribunal proceedings. The patient's mother purported to withdraw the application to the tribunal, whilst the patient's solicitor wanted to carry on. The panel found that the patient's mother did have the right to withdraw the application and consented to the application being withdrawn. The Upper Tribunal looked at the Court of Protection authorisation, and found that the authorisation did not allow the mother to withdraw the application.<br><br>The Upper Tribunal further stated that the First-tier Tribunal's discretion to refuse to give consent was intended to (and does) provide a safeguard for the patient - as it means that such consent should not be given unless the tribunal is satisfied that a review of the patient's detention in hospital by an independent tribunal is, on the information and evidence known, unnecessary.<br><br>The tribunal must always ask for, and consider, who made the application to withdraw, how was it made, and what are the reasons for it (and thus the continuation of detention or a MHA order). The periodic review of a patient's detention is an important safeguard and is necessary for Article 5 ECHR purposes. It should not be abandoned lightly, especially if the hearing may achieve some good for the patient. The tribunal must make its own mind up on whether it should agree or, instead, proceed – and it should give reasons for its decision. If in doubt, the tribunal should refuse consent and carry on with the hearing.<br><br>*Note: The **2015 Code of Practice** provides that:*<br><br>*12.24 A request to withdraw an application may be made by the applicant in accordance with the Tribunal rules.* |

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| | *The Tribunal is not bound to agree, especially if the withdrawal is merely tactical or is sought within 48 hours of the hearing. The applicant may not withdraw a (mandatory) reference made by a hospital manager or the SoS.* |
| NM v Kent C.C. [2015] UKUT 0125 (AAC)<br><br>There is no rule that DoLS always trumps Guardianship. In this case, the power under Guardianship to require the patient to live at a particular place, and to ensure his return should he abscond, meant that Guardianship was necessary. | Deciding whether it is necessary that the patient should remain under guardianship may require a comparison of Guardianship with DoLs, having regard to the facts of the case. It is possible that DoLS may provide sufficiently for the person's welfare and the protection of others so that Guardianship is not necessary for the purposes of section 72(4)(b). But there is no rule that a DoLS always trumps Guardianship, any more than there is a rule that Guardianship inevitably trumps a DoLS.<br><br>In this case, the power of the Guardian to require the patient to live at a particular place, and to ensure his return should he leave without permission, meant that Guardianship was necessary.<br><br>The Mental Capacity Act deals with the person's best interests, whereas the Mental Health Act deals with protection of the patient and the public. |
| KD v A Borough Council, Dept of Health & Otrs [2015] UKUT 0251 (AAC)<br><br>When comparing DoLS with Guardianship (remembering that, for patients not detained in hospital, the two regimes can co-exist alongside each other) relevant factors include whether DoLS is actually available and the merits of and disadvantages of the rival regimes. | When it was argued that an alternative to Guardianship was available in the form of DoLS (for a patient who lacked capacity to agree to a care plan that gave rise to a deprivation of liberty as defined in P v Cheshire West & Chester Council [2014] UKSC 19) relevant matters to consider include:<br><br>(1) Is the proposed alternative actually available in practice? If not when will it be?<br>(2) What are the advantages and disadvantages of the rival alternatives?<br>(3) Have the parties provided sufficient evidence and argument on the above issues?<br>(4) What issues should the FTT decide?<br>(5) Should the FTT adjourn or discharge the guardianship?<br><br>For patients not detained in hospital, the MHA and MCA regimes can co-exist alongside each other, and a deprivation of liberty arising during Guardianship can, if necessary, be authorised under DoLS.<br>In this case, there was a continued need to have statutory authority to return KD to his placement (which was something that could not be achieved if the Guardianship was discharged). |

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| SoS Justice v KC & C Partnership NHS Foundation Trust [2015] UKUT 0376 (AAC)<br><br>Where a patient did not have capacity to consent to conditions in a Conditional Discharge amounting to a deprivation of liberty, they could be authorised under DoLS or a welfare order.<br><br>The panel could grant a Deferred Conditional Discharge for the purpose of allowing the accommodation provider to obtain the DoLS authorisation. | Where a patient did not have capacity to give consent, the protective conditions in a Conditional Discharge amounting to a deprivation of liberty could be authorised under DoLS (if the patient was placed in a hospital or care home) or, otherwise by a Ct of Protection welfare order. The said conditions would thereby be rendered lawful, and so not a breach of Article 5. The panel could grant a Deferred Conditional Discharge for the purpose of allowing the accommodation provider to obtain authorisation and, if the authorisation was not obtained for a patient lacking capacity to consent, the panel could reconsider.<br><br>It was further held that if a Conditional Discharge comprised conditions constituting a deprivation of liberty, there was still a "discharge" – i.e. from detention under the MHA to deprivation of liberty in different circumstances. So in the present case, the "discharge" was from KC's detention in a hospital pursuant to ss. 37 / 41 of the MHA, to deprivation of liberty created by the conditions imposed. That deprivation of liberty may be lawful or unlawful depending upon the circumstances.<br><br>Charles J also held (obiter) that a patient with capacity could consent to conditions amounting to a deprivation of liberty. However a patient with capacity could also refuse to consent, in which case such conditions cannot be imposed and, if that happens, it may not be possible to grant a Conditional Discharge.<br><br>*(Note – (see below) Charles J has since made the same decision in relation to the giving or refusing of consent by a capacitous patient (ratio) in MM v WL Clinic & SoS Justice [2015] UKUT 0644 (AAC)* |
| SL v Ludlow Street Healthcare [2015] UKUT 0398 (AAC)<br><br>'Medical treatment' includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care - the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations. | The patient was liable to be detained under section 3, but was living away from hospital on S.17 leave. The MHRT (Wales) declined to discharge the S.3, although the patient argued that almost all of the treatment that he received was being delivered in the community. The U.T noted that the issue for the tribunal was whether it was appropriate for the patient to remain *liable to be detained* in hospital for medical treatment. It was not whether it was appropriate for the patient to remain *detained*.<br><br>The hospital continued to include the patient's case in its review meetings and the definition of 'medical treatment' includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation (under medical supervision) and care - the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations.. That means that the patient's S.17 leave and the rehabilitation provided to him in his accommodation, both of which operated under medical supervision via the hospital, were themselves part of his treatment plan. It therefore remained appropriate for the patient to be liable to be detained in a hospital for medical treatment. |

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| PJ v A Local Health Board & Otrs [2015] UKUT 0480 (AAC)<br><br>If the panel learns of CTO conditions amounting to a deprivation of liberty to which the patient does not consent, it cannot ignore or disregard the breach of Article 5 ECHR. The DCP suggests highlighting the difficulty, but then proceeding to apply the statutory criteria. | A CTO condition required the patient to live in a care home where he was under continuous supervision and control, and was not free to leave. The condition therefore led to a deprivation of liberty, to which the patient (who had capacity) had not given consent. The U.T. held that the tribunal should not have ignored or disregarded the breach of Article 5 ECHR, even though the tribunal did not impose the CTO conditions and had no legal jurisdiction over them.<br><br>*Note: the question then arises as to what a tribunal should do if it is not to effectively sanction an unlawful deprivation of liberty. It is respectfully submitted that the tribunal should specifically and clearly highlight the apparent deprivation of liberty in its decision so that those responsible can take urgent steps to change the condition(s), obtain MCA authorisation, or recall the patient to hospital. The panel should then move on to consider the applicable statutory criteria. If satisfied as to the need for a CTO in principle, it should not discharge the CTO under discretionary powers as this could place the patient and public at serious risk.* |
| MM v WL Clinic & SoS Justice [2015] UKUT 0644 (AAC)<br><br>A restricted patient with the capacity can give a valid and effective consent to conditions on a Conditional Discharge that, when implemented create an inevitable deprivation of liberty. Such consent legitimises the conditions. | For the purposes of Article 5, a restricted patient with the capacity to do so can give a valid and effective consent to conditions on a Conditional Discharge that, when implemented, will (on an objective assessment), create an inevitable deprivation of liberty. Such consent means that the deprivation of liberty is not unlawful. This U.T. decision is intended to help restricted patients who need continuous supervision and control to nevertheless start their rehabilitation journey and step down from hospital. It should also stop bed-block and release beds for those patients who need to be detained in hospital.<br><br>If the patient lacks capacity, a DoLS authorisation or welfare order can provide *de facto* consent.<br><br>If a patient with capacity to consent refuses to give consent, such conditions cannot be imposed - and so then it may not be possible to grant a Conditional Discharge to the patient. |
| AM v Partnerships in Trust Ltd & SoS Justice [2015] UKUT 0659 (AAC)<br><br>Where disputed allegations underpin the case against the patient, the tribunal must make findings of fact before dealing with the statutory criteria. | If the panel's conclusions on whether or not it is satisfied that one or more of the statutory criteria are made out depend on whether or not certain factual allegations are probably true, then it must make findings of fact (on the balance of probabilities) before it can determine its decision regarding the statutory criteria. However, the range of facts which may properly be taken into account is infinite. In the present case relevant facts might involve not only whether certain allegations are proved to the civil standard, but also aspects of the patient's sexual or other history, his behaviour towards others, things that he said, and his attitudes. There may, in addition, be other relevant facts. But where disputed allegations form the bedrock of the case presented by the Responsible Authority, it was incumbent upon the tribunal to scrutinise the evidence, and to address the features of the evidence which both support, and undermine, the allegations. |

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| WH v Llanarth Court Hospital (Partnerships in Care) [2015] UKUT 0695 (AAC)<br><br>The tribunal is not obliged to accept the evidence of any witness, however important that witness might be. Instead the tribunal is required to evaluate the evidence and reach its own conclusions.<br><br>*See note opposite regarding the availability of medical treatment in hospital.* | The tribunal is not obliged to accept the evidence of any witness, however important that witness might be. Instead the tribunal is required to evaluate the evidence on its merits, and reach its own conclusions.<br><br>*Note, the U.T. also said that a tribunal only has jurisdiction to determine the appropriate treatment test with regard to the treatment that a patient is receiving at the detaining hospital. The DCP is uncomfortable with the bluntness of this view. Obviously, at one extreme, the 'available appropriate medical treatment' test is not satisfied by medical treatment theoretically available elsewhere but which the patient has no realistic chance of receiving within a reasonable time. On the other hand, a patient may be temporarily in the wrong hospital, or a new diagnosis or new treatment need may have emerged, or the patient may be ready and waiting for transfer in order to receive medical treatment (for example, by way of rehabilitation) that is not available in the current hospital. Serious consideration may have already been given to transfer and arrangements may be in the pipeline. Alternatively, the tribunal may be able to help to move the case on. But if this U.T. decision were correct, panels would have to discharge patients who may present a danger to themselves or to others. Moreover, the relevant statutory criteria do not state that the treatment must be available in the detaining hospital.*<br><br>*It is respectfully submitted that, where this situation arises, panels should point out that the treatment that is now most appropriate for the patient **is** available in a hospital, but not in the currently detaining hospital. In non-restricted cases, this may lead to a statutory recommendation, with a view to discharge on a future date, that the patient be transferred in order to receive (more) appropriate treatment in a named hospital where the evidence shows that it is available, and to which the patient could be transferred without delay. The tribunal could consider reconvening if the transfer does not take place within a reasonable time. In a restricted case, the panel could make a non-statutory recommendation for consideration by the SoS.* |