Upper Tribunal Case No: HM/4061/2014

IN THE UPPER TRIBUNAL
(ADMINISTRATIVE APPEAL CHAMBER)
ON APPEAL FROM THE MENTAL HEALTH REVIEW TRIBUNAL FOR WALES

BETWEEN:-

PJ

Appellant

-and-

(1) A LOCAL HEALTH BOARD

(2) THE WELSH MINISTERS

(3) THE DEPARTMENT OF HEALTH

Respondents

Tribunal	**Mental Health Review Tribunal for Wales**
Decision date	**2 May 2014**

Before: Mr Justice Charles

Attendances

For the Appellant Peter Mant instructed by GHP Legal

For the First Respondent Simon Burrows instructed by NWSSP – L&RS

The Second and Third Respondents were not represented and did not appear

(SAVE FOR THE COVER SHEET THIS DECISION MAY BE MADE PUBLIC. THAT SHEET IS NOT FORMALLY PART OF THE DECISION AND IDENTIFIES THE PATIENT AND THE HEALTH BOARD BY NAME).

DECISION:

(1) The MHRT erred in law in their application of the majority decision of the Supreme Court in *Cheshire West and Cheshire Council v P* [2014] UKSC 19 (*Cheshire West*) and so in their approach to whether the implementation of the conditions of the Community Treatment Order did or did not, on an objective assessment, deprive PJ of his liberty.

(2) The MHRT erred in law in concluding in the alternative that if PJ was deprived of his liberty in breach of Article 5 that the CTO framework must take precedence over any human rights issues.

(3) The parties (including the second and third Respondents who took no active part in the appeal) have permission to appeal (if they wish to do so).

(4) As PJ is no longer subject to a CTO remission is inappropriate and pursuant to s. 12(2) of the Tribunals Courts and Enforcement Act 2007 I do not set aside the decision of the MHRT.

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REASONS

Introduction

1. This is an appeal against a decision of the Mental Health Review Tribunal for Wales (the MHRT) of 2 May 2014. By that decision (the MHRT Decision) the tribunal upheld PJ's community treatment order (CTO). PJ was discharged from his CTO on 25 November 2014 and so the outcome of his appeal will have no immediate impact on him. But as I recognised when giving permission to appeal this appeal raises points of general importance. That is why I joined the second and third Respondents but neither has taken an active part.

Fortunately, the Health Board has and so I have had the benefit of oral argument on the issues raised in this appeal.

The underlying problems and points of general public interest

2. There are overlaps between the issues on this appeal and those in three appeals that I have recently decided (*YA v Central and NW London NHS Trust & Others* [2015] UKUT 0037 (AAC) (the *YA* case) *KD v A Borough Council and the Dep of Health* [2015] UKUT 0251 (AAC) (the *KD* case) and *Secretary of State for Justice v KC and C Partnership Foundation Trust* [2015] UKUT 0376 (AAC) (the *KC* case).

3. The Health Board rely on three recent decisions of Upper Tribunal Judge Jacobs (*SH v Cornwall Partnership NHS Trust* [2012] UKUT 290 (AAC) (the *SH* case), *GA v Betsi Cadwaladr University LHB* [2013] UKUT 0280 (AAC) (in which permission to appeal was refused on the papers by Richards LJ in terms that support the reasoning and conclusion of Upper Tribunal Judge Jacobs) (the *GA* case) and *NL v Hampshire* [2014] UKUT 0475 (AAC) (the *NL* case). Correctly the Health Board did not argue that the decision of Richards LJ in refusing permission to appeal was binding on me (see *Practice Direction (Citation of Authorities) (Sup Ct)* [2001] 1 WLR 1001).

4. As appears from the *KC* case, I rejected the argument of the Secretary of State on the extent of the ratio of the decision in *RB v Secretary of State for Justice* [2010] UKUT 445 (AAC) and *B v Secretary of State for Justice* [2012] 1 WLR 2043 (the *RB* case) and reached obiter conclusions that disagreed with the conclusion of a three judge panel of the Upper Tribunal in the *RB* case on the ability of a patient to give a valid consent to an objectively assessed deprivation of liberty.

5. As I said in the *KC* case an underlying purpose of the MHA is to:

   i) promote a move of a patient from detention in hospital towards him or her living in the community, whilst

   ii) providing the necessary protection of the public and the patient that his or her history indicates is needed

   (see, for example, the citation and comments at paragraphs 48 and 49 of the *KC* case).

6. Such a preliminary and conditional move is likely to be in the best interests of many, if not all, patients.

7. The underlying problem is whether the conditions that are necessary to protect the public and the patient, and so conditions that are needed on a proper application of the tests set by the MHA to protect the patient or the public, can be lawfully put in place and implemented.

8. That problem has been created by, or has grown in significance as a result of, the decision of the Supreme Court in *Cheshire West and Cheshire Council v P* [2014] UKSC 19 (*Cheshire West*) because, on any view, that decision has had the results that:

   i) more people are deprived of their liberty than had been thought by many to be the case (see, for example, paragraphs 3.39 and 2.40 of the Law Commission's Consultation Paper titled "Mental Capacity and Deprivation of Liberty A Consultation Paper" (the LC Paper), and

   ii) many, if not most, patients who are conditionally discharged on conditions that are necessary to protect either or both themselves or the public will be objectively deprived of their liberty on the *Cheshire West* approach to that issue and so to Article 5.

9. Some of those patients will have capacity to make decisions relating to their care and treatment regime and to any deprivation of liberty that its implementation will create. Other patients will not have that capacity. So the Mental Capacity Act 2005 (the MCA) will only apply to some of the patients and, as the *KC* case shows, there are problems in connection with both:

   i) the extent of the powers of MHA decision makers to impose or make conditional discharge orders on conditions that, when implemented, will objectively create a deprivation of liberty, and

   ii) whether that objective deprivation of liberty can be rendered lawful by the consent of a patient with capacity or, when the patient lacks the relevant capacity, by an order of the Court of Protection under the MCA or by an authorisation under its DOLS.

10. As the LC Paper points out at paragraph 1.14 the Strasbourg law operates on the *Guzzardi* principle that the starting point in assessing whether there has been a deprivation of liberty is "the concrete situation" of the person and the consideration of "a whole range of criteria such as the type, duration, effects and manner of implementation of the [restrictive] measure in question" (see *Guzzardi v Italy* (1980) 3 EHRR at paragraph 92 and 93). In my view, that principle and approach is a powerful pointer:

    i) to the conclusion that it is the practical situation on the ground created by a care and treatment regime, and so the practical impact on the freedom of the relevant person to act as he or she wishes, that matter when assessing whether objectively patients are deprived of their liberty, and

    ii) against the conclusion that the lack of provisions relating to the direct enforcement of, and so the specific performance by the

patient and those delivering the regime of care, of restrictive conditions have weight.

11. A combination of the jurisdictional arguments advanced in the *KC* case could have founded what many would consider to be the counter intuitive result a breach of Convention rights thwarts the implementation of a conditional discharge (or a direction by a guardian as to where the person should live) that:

    i) is the best interests of the relevant patients, and

    ii) promotes the underlying purpose of the MHA referred to in paragraph 5 hereof

    because the implementation of the relevant conditions is or would be a breach of those Convention rights (in particular Article 5, but potentially also Article 6, 8 and 14) and so unlawful.

12. I did not reach that conclusion and the issues in this case relate to whether, and if they can how, the First-tier Tribunal (and so the MHRT) address breaches or potential breaches of Convention rights that have been or will be created by the implementation of conditions that are necessary to protect the public and the patient, and so conditions that are needed on a proper application of the tests set by the MHA for those purposes.

13. Based on the three decisions of Upper Tribunal Judge Jacobs the argument of the Health Board was to the effect that a First-tier Tribunal and so the MHRT:

    i) as a matter of jurisdiction should limit itself to its statutory role, under which it has no jurisdiction or powers to investigate, consider and reach decisions on whether there has been a breach of human rights, and so for, example, issues of consent for the purposes of Article 8 and Article 5, and alternatively and in any event when exercising their discretion

    ii) should ignore any breach of Convention rights and so permit such an unlawful state of affairs to continue because if the tribunal is not satisfied that the criteria set by the MHA for a discharge are met, and so it has concluded that the patient requires treatment and should be subject to recall, it should uphold the CTO because, in those circumstances, it would be perverse to discharge using its discretion.

14. If correct this would mean that the First-tier Tribunal (and so the MHRT) cannot as a matter of jurisdiction, or should not as a matter of discretion, address and seek to bring an end to any such unlawfulness.

15. I do not accept that argument and so, to the extent that it is supported by them, I do not accept the reasoning and conclusions in the three

decisions of Upper Tribunal Judge Jacobs on the limits of the matters that can be taken into account by a First-tier Tribunal (and so the MHRT) in applying the statutory tests set by the Mental Health Act 1983 (the MHA) or in exercising their discretion under s. 72(3) of the MHA.

16. The main reasons for this are that the reasoning and conclusions in those cases do not have regard to:

    i) the relevant provisions of the Human Rights Act 1998, and

    ii) the role and function of the First-tier Tribunal described for example by Baroness Hale in *R(H) v SSH* [2006] 1 AC 441 (see Headnote para (2) and paragraphs 25 and 26 and 30 to 33 of her speech) the First-tier Tribunal and thus the MHRT provide a tribunal in which patients are entitled to speedily challenge the lawfulness of their detention and obtain an order for release if it is not lawful.

17. I have not had time to read and give proper consideration to the LC Paper. A preliminary read indicates that it does not directly address the underlying points and problems relating to the MHA and Mental Capacity Act 2005 (the MCA) and its Deprivation of Liberty safeguards (DOLS) referred to above but that they will, or are likely to, be relevant to the solutions and approach set out in the preliminary views on which the Law Commission are consulting. The same can be said about:

    i) the *Re X* issues (see [2014] EWCOP 37 and [2015] EWCA Civ 599**),**

    ii) the points relating to inquests mentioned at paragraph 15.46 et seq of the LC Paper, and

    iii) possibly in the case of CTOs the impact of ss. 64A to 64G (see paragraph 118 hereof).

18. I invite the Law Commission and those commenting on the LC Paper to bear these points and problems in mind.

Permission to appeal

19. The impact of these points and problems (and the fact that I disagree with conclusions reached in earlier Upper Tribunal decisions on (i) the ability of a patient to consent to a deprivation of liberty, and (ii) the approach to the exercise of its statutory powers by the First-tier Tribunal (and the MHRT) have caused me to give permission to appeal to the parties (and the two Government Departments who have thus far taken no part in this case).

20. If those Departments (and, on their guidance or independently, relevant health trusts or providers of care and treatment regimes outside

hospital) disagree with my conclusions it seems to me that the sooner the relevant issues get to the Court of Appeal and then possibly the Supreme Court the better and that the constitution of a three judge panel of the Upper Tribunal to address conflicting Upper Tribunal decisions is unlikely to assist on a case by case basis or in respect of the consideration and implementation of changes in the underlying law and procedures.

PJ's history

21. PJ is in his forties and has a diagnosis, confirmed in a psychiatric report dated 25 April 2014, of mild learning disability associated with a significant impairment of behaviour requiring attention and treatment and autistic spectrum disorder. In 2008, he was assessed as having a full scale IQ of 66.

22. He has spent most of his adult life in hospital, with a forensic history dating back to 1986. In 1999, when he received an unrestricted hospital order for actual bodily harm and threats to kill, he was admitted to a medium secure unit at C hospital. He was discharged to a residential placement under a supervised discharge order. That placement gained hospital status in 2007 whereupon he remained there voluntarily until May 2009 when he was detained under s. 3 of the Mental Health Act 1983 (the MHA).

23. On 30 September 2011, he was made the subject of a CTO and discharged to a care home (the Care Home) which is a specialist facility for up to 10 men with moderate to borderline learning disability and histories of challenging or offending behaviour.

24. In the Form CP1 dated 27 September 2011, PJ's responsible clinician stated that PJ did not require treatment for his health, but rather for his safety and for the protection of others and the need for the CTO is explained as follows:

> Previously [PJ] has been non compliant with treatment without the framework of the Mental Health Act but has been compliant with care within CTO since move to [the Care Home]. Recent concerns about behavior and non-compliance suggest that there is continuing need for framework of CTO to support treatment and management plan and minimize risks to the public and [PJ] himself.

25. The CTO conditions were as follows:

    i) to reside at the Care Home with nursing and adherence to rules of residence there;

    ii) to abide by the joint section 117 care plan drawn up by multidisciplinary team;

    iii) to abide by the risk mitigation plans for community access with regards levels of staff supervision.

26. The regime at the Care Home included the following in respect of PJ:

    i) within the unit, his whereabouts were monitored at all times, with 15 minute observations, and all observations were rigorously implemented and documented;

    ii) there was a "time out" policy in operation;

    iii) he was escorted by staff on all community outings, including when he was attending college and meeting his girlfriend;

    iv) all unescorted leave had to be agreed by the responsible clinician and social supervisor;

    v) at the time of the tribunal hearing, the following weekly unescorted leave was agreed:

        a) 30 minutes per week to do his banking;

        b) 30 minutes per week for shopping;

        c) 30 minutes on two other occasions "as long as safe to do so";

        d) two to three nights with his mother every fortnight.

    vi) there was an absconding protocol which provided for restraint techniques to be used as a last resort;

    vii) his alcohol usage was limited to four units per week and he was breathalysed to ensure compliance, with provision that any alcohol reading after home leave or contact with his brother would result in suspension of home leave with immediate effect; and

    viii) there was provision for unescorted leave to be stopped if risk factors increased (which was activated for a period in June 2013 when he displayed unsettled behaviour).

27. The Risk Mitigation Plans are relevant. The plan dealing with sexually inappropriate behaviour identified a number of factors. The "history" section, suggests that PJ is the source of the facts and that he recognizes the risk he poses. This is supported under the heading "Service user perception of risk identified" where it is recorded that PJ "is fully aware of his risk and history, although it has been established historically that PJ lacks meaningful victim empathy which increases the risk".

28. The risk management strategies are devised to assist PJ and other sex offenders to address their risk factors. The emphasis is on support, which means working with PJ rather than simply imposing upon him.

29. The risk management plan directed to "Escorted community leave" proceeds along similar lines stating that PJ "is fully aware of his risk and history, and can identify when and where risk time and places occur when unsupervised in the community". The same is true of plans directed to absconding and alcohol management where it is sated that PJ "appears honest about reporting his history of excessive drinking".

30. These and other reports before the MHRT indicate that PJ was involved in his care planning and regulation. No question is raised in them as to PJ's capacity to consent to his care plan or specifically to the conditions in the CTO.

31. PJ's responsible clinician stated that the conditions of his care plan were non-mandatory and reports indicate that this is what PJ was told.

32. There was evidence before the MHRT that PJ had expressed (a) a wish to have greater freedom to see his family and his girlfriend without restrictions and that these wishes had not been complied with, and (b) the view that he was generally happy with and at the Care Home. A psychiatric report dated 25 April 2014 records that PJ had expressed his understanding of the CTO in the following terms: *"in my language it means if you **** up its goodbye everything".*

The MHRT Decision

33. Before the MHRT PJ sought discharge of the CTO. The skeleton argument filed on his behalf noted that he had expressed to staff at the Care Home and to his care team that he would like more unaccompanied time in the community but this had been opposed; the arrangements for care under the CTO amounted to an unlawful deprivation of liberty in breach of Article 5; and, on this basis, the MHRT should exercise its discretionary power to discharge.

34. The MHRT refused this application holding that PJ was not deprived of his liberty in the following terms:

> 4.9 The Tribunal has carefully considered the legal argument made in this case and the evidence given to the Tribunal. Each case must be considered on its merits, particularly so with regard to the issue of "Deprivation of Liberty". It appears to us that the current Case Law and Guidance, which it is noted has "yet to be fully tested", essentially considers whether the person concerned is "subject to continuous supervision and control" and "whether they are free to leave". From the evidence received, relating to these specific matters, it is clear to us that the Applicant has significant time where he is not supervised and there is a flexible and progressive plan in place, to encourage and enable more time to be spent "unsupervised". Therefore, we find that this is not "deprivation" of liberty but rather a "restriction" of liberty, which is necessary and proportionate, based on the evidence, and considering the likelihood of the Applicant suffering harm and the seriousness of that harm. Since this element is not satisfied (in our view) the Tribunal does not need to deal with the "freedom to leave" issues.

35. The MHRT upheld the CTO, concluding as follows:

> 4.11 The Tribunal accepts that there is a “need” because the Applicant’s historic nature of illness, and current “uncertainties”, based on the risks that have been evident and the need for treatment through on-going therapy, structure and support. The CTO is a framework, which can also enable monitoring, review and recommendations and the Tribunal believes that this must take precedence over any human rights issue”. (emphasis added).

The two main issues on the appeal

36. These are whether the MHRT erred in law in concluding that:

    i) PJ was not deprived of his liberty, and

    ii) if he was, that the CTO framework must take precedence over any human rights issues.

37. These issues raise questions on the approach to be taken by the MHRT and the First-tier Tribunal in respect of:

    i) the consideration of issues raising an alleged breach of fundamental human rights and so, for example, a deprivation of liberty under Article 5, and

    ii) the exercise of its powers when such an alleged breach is raised.

38. In addition to my recent decisions in the *YA, KD* and *KC* cases the three recent decisions of Upper Tribunal Judge Jacobs in then *SH, GA and NL* cases are relevant to these issues.

Article 5

39. Article 5 of the European Convention on Human Rights provides that:

> (1) Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
>
> (e) the lawful detention… of persons of unsound mind…;
>
> (4) Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

40. In *Cheshire*, *West* Baroness Hale starts her judgment by stating that what that case was about is the criteria for judging whether the living arrangements made for a mentally incapacitated person amount to a deprivation of liberty. All of the Justices address this by reference to Article 5 and the Strasbourg and other cases relating to it (e.g. Baroness Hale from paragraph 19 onwards).

41. At paragraph 37, Baroness Hale sets out the well established and accepted proposition that the essential character of a deprivation of liberty has three components namely:

    i) the objective component of confinement in a particular restricted place for a not negligible length of time;

    ii) the subjective component of lack of valid consent; and

    iii) the attribution of responsibility to the state.

42. The point that valid consent to the confinement in question has the result that there is not a deprivation of liberty for the purposes of Article 5 (and so the objective deprivation of liberty is lawful) is also made by the quotation in paragraph 22 of Baroness Hale's judgment from *Stanev v Bulgaria* (2012) 55 EHRR 696 which is in the following terms:

> 117. Furthermore, in relation to the placement of mentally disordered persons in an institution, the Court has held that the notion of deprivation of liberty does not only comprise *the objective element* of a person's confinement in a particular restricted space for a not negligible length of time. A person can only be considered to have been deprived of his liberty if, as *an additional subjective element*, he has not validly consented to the confinement in question. (Emphasis supplied)

43. So it is important to remember that for the purposes of Article 5, and so its breach, a deprivation of liberty has these two components.

44. *The objective element.* Regularly, the term deprivation of liberty is used, or effectively used, to describe only the objective element or component because, for example, the relevant person lacks the capacity to supply the subjective element or the context so requires. The decision in, and so the guidance given by, *Cheshire West* was directed to the objective element of a deprivation of liberty.

45. The MHRT Decision was also directed to the objective element.

46. *The subjective element.* This raises issues of and relating to:

    i) capacity,

    ii) whether consent has been given, and

    iii) whether it can be given.

47. I address issues of capacity in the *YA* case in the context of the capacity to instruct a representative and to conduct proceedings. The general comments on the issue of decision specific assessment of capacity apply to the assessment of the capacity of persons to make decisions about where, and the conditions in and on which, they should live and thus to their care and treatment regime.

48. They show that the fact that a person is objecting does not mean that they have capacity to consent to their care regime or a part of it. Also an objection does not of itself indicate whether a person with capacity is or is not consenting to the care regime. So PJ's graphic description of the effect of the conditions of a CTO and their breach together with his objections to aspects of it do not indicate whether or not he has consented to it (or his capacity to do so).

49. In the *KC* case I have addressed on an obiter basis whether a patient with capacity can give a valid consent to an objectively assessed deprivation of liberty created by the implementation of conditions that the MHA decision makers have concluded are necessary and appropriate to protect the public. As appears therefrom, the combination of the decision and reasoning of the Supreme Court in *Cheshire West* and those of the Court of Appeal in the *RB* case has created practical and legal problems in respect of this issue.

50. They are an aspect of the problems and points of general public interest referred to at the beginning of this decision (see paragraphs 2 to 18 hereof).

The incorporation of Article 5 into English and Welsh law

51. The requirements of Article 5 are incorporated into English and Welsh law by the Human Rights Act 1998 (the HRA), which imposes obligations on the MHRT and other MHA decision makers.

52. The most relevant sections are:

> 3 Interpretation of legislation.
>
> 3(1) So far as it is possible to do so, primary legislation and subordinate legislation must be read and given effect in a way which is compatible with the Convention rights.
>
> (2) -----------
>
> 6 Acts of public authorities.
>
> (1) It is unlawful for a public authority to act in a way which is incompatible with a Convention right.
>
> (2) Subsection (1) does not apply to an act if—
>
> (a) as the result of one or more provisions of primary legislation, the authority could not have acted differently; or
>
> (b) in the case of one or more provisions of, or made under, primary legislation which cannot be read or given effect in a way which is compatible with the Convention rights, the authority was acting so as to give effect to or enforce those provisions.
>
> (3) In this section "public authority" includes—
>
> (a) a court or tribunal, and
>
> (b) any person certain of whose functions are functions of a public nature,

but does not include either House of Parliament or a person exercising functions in connection with proceedings in Parliament.

(4)

(5)

(6) "An act" includes a failure to act but does not include a failure to—

(a) introduce in, or lay before, Parliament a proposal for legislation; or

(b) make any primary legislation or remedial order

7 Proceedings.

(1) A person who claims that a public authority has acted (or proposes to act) in a way which is made unlawful by section 6(1) may—

(a) bring proceedings against the authority under this Act in the appropriate court or tribunal, or

(b) rely on the Convention right or rights concerned in any legal proceedings,

but only if he is (or would be) a victim of the unlawful act.

(2) In subsection (1)(a) "appropriate court or tribunal" means such court or tribunal as may be determined in accordance with rules; and proceedings against an authority include a counterclaim or similar proceeding.

53. So, s. 3 requires that, so far as it is possible to do so, primary legislation and subordinate legislation must be read and given effect to in a way which is compatible with the Convention rights. And, importantly in respect of the approach to be taken by the MHRT and the First-tier Tribunal:

i) s. 6 provides that it is unlawful for a public authority, which includes the MHRT (and the First-tier Tribunal), to act in a way that is incompatible with the Convention rights, unless having applied s. 3 primary legislation requires them so to act or they are giving effect to or enforcing primary legislation, and

ii) in this context, an act includes a failure to act, and

iii) s. 7 provides that a person who claims that a public authority has acted (or proposes to act) in a way that is incompatible with their Convention rights (and so here the MHRT and a First-tier Tribunal) may rely on the Convention rights concerned in any legal proceedings, which would include proceedings on an application before the MHRT or a First-tier Tribunal.

54. These provisions are relevant and important to the determination of whether the CTO framework must take precedence over any human rights issues.

55. Further these provisions, and perhaps in particular whether a failure to act is incompatible with Convention right, must be considered and

applied by reference to the positive obligation imposed by Article 5(1) on public authorities to take reasonable steps to prevent a deprivation of liberty of which they have or ought to have knowledge (see for example *Storck v Germany* (2006) 43 EHHR 6 (at paragraphs 101 to 103 and 149).

The role and function of the First-tier Tribunal and so of the MHRT

56. A useful description is given in *R(H) v SSH* [2006] 1 AC 441. At paragraphs 25 and 26 and 30 to 33 of her speech Baroness Hale says:

> 25. That is why our system tries hard to give patients and their relatives easy access to the tribunal which is itself designed to meet their needs. The managers of the hospital have a statutory duty, under section 132 of the Act, to take such steps as are practicable to ensure that the patient understands the effect of the provisions under which she is detained and the rights of applying to a mental health review tribunal which are available to her. This has to be done as soon as practicable after the patient is detained. Unless the patient wishes otherwise, this information is also to be given to the patient's nearest relative. Under the Code of Practice (published March 1999 pursuant to section 118 of the Act by the Department of Health and Welsh Office), section 14, information should be given to the patient "in a suitable manner and at a suitable time" by a person who "has received sufficient training and guidance". Patients and nearest relatives have to be told how to apply to a tribunal, how to contact a suitably qualified solicitor, that free legal aid may be available, and how to contact any other organisation which may be able to help them make an application. In other words, the hospital managers have to do the best they can to make the patient's rights practical and effective.
>
> 26. Mental health review tribunals were also designed with that object in mind. Before they were created, in the Mental Health Act 1959, compulsory detentions were authorised by a judicial officer, who was widely regarded as a 'rubber stamp' of little practical value in challenging the decision to detain. Tribunals are composed of a legally qualified presider, a medical member with expertise in the diagnosis and treatment of mental disorder, and a third member with other suitable experience, for example in the social services. Although the procedures have become more formal since the advent of legal assistance for patients, they are designed to be user-friendly and to enable the patient and her relative to communicate directly with the tribunal. A reference to the tribunal must be considered in the same way as if there had been an application by the patient: see r 29. Hence although the initiative is taken by someone else, the patient's rights are the same. Although an application has to be made in writing, it can be signed by any person authorised by the patient to do so on her behalf: see r 3(1). This could be any relative, a social worker, an advocate, or a nurse, provided of course that the patient has sufficient capacity to authorise that person to act for her. The common law presumes that every person has capacity until the contrary is shown and the threshold for capacity is not a demanding one. These principles have recently been confirmed by Parliament in the Mental Capacity Act 2005.
>
> 30. The preferable means is what happened in this case: that the Secretary of State uses her power under section 67(1) to refer the case to a tribunal. This is preferable because mental health review tribunals are much better suited to determining the merits of a patient's detention and doing so in a way which is convenient to the patient, readily accessible, and

> comparatively speedy. As already seen, a reference is treated as if the patient had made an application, so that the patient has the same rights within it as she would if she herself had initiated the proceedings. It can, of course, be objected that this solution depends upon the Secretary of State being willing to exercise her discretion to refer. But the Secretary of State is under a duty to act compatibly with the patient's Convention rights and would be well advised to make such a reference as soon as the position is drawn to her attention. In this case this happened at the request of the patient's own lawyers. Should the Secretary of State decline to exercise this power, judicial review would be swiftly available to oblige her to do so. It would also be possible for the hospital managers or the local social services authority to notify the Secretary of State whenever an application is made under section 29 so that she can consider the position. These applications are not common: they no longer feature in the annual published *Judicial Statistics*, but when they did feature they tended just to make double figures every year. So the burden on the authorities, the Secretary of State and the tribunals would not be high.
>
> 31. Judicial review and/or habeas corpus would, of course, also be available to challenge the lawfulness of the patient's detention. Any person with sufficient standing could invoke them. Before the Human Rights Act 1998, the European Court of Human Rights held that these were not a sufficiently rigorous review of the merits, as opposed to the formal legality, of the patient's detention to comply with article 5(4): see *X v United Kingdom* (1981) 4 EHRR 188. It may well be that, as the Administrative Court must now itself act compatibly with the patient's rights, it would be obliged to conduct a sufficient review of the merits to satisfy itself that the requirements of article 5(1)(e) were indeed made out. But it is not well equipped to do so. First, it is not used to hearing oral evidence and cross examination. It will therefore take some persuading that this is necessary: cf *R (Wilkinson) v Broadmoor Special Hospital Authority* [2002] 1 WLR 419 and *R (N) v M* [2003] 1 WLR 562. Second, it is not readily accessible to the patient, who is the one person whose participation in the proceedings must be assured. It sits in London, whereas tribunals sit in the hospital. How would the patient's transport to London be arranged? Third, it is not itself an expert tribunal and will therefore need more argument and evidence than a mental health review tribunal will need to decide exactly the same case. All of this takes time, thus increasing the risk that the determination will not be as speedy as article 5(4) requires.
>
> 32. Hence, while judicial review and/or habeas corpus may be one way of securing compliance with the patient's article 5(4) rights, this would be much more satisfactorily achieved either by a speedy determination of the county court proceedings or by a Secretary of State's reference under section 67. Either way, however, the means exist of operating section 29(4) in a way which is compatible with the patient's rights. It follows that the section itself cannot be incompatible, although the action or inaction of the authorities under it may be so.

57. So, as mentioned earlier, the First-tier Tribunal and thus the MHRT provide a tribunal in which patients are entitled to speedily challenge the lawfulness of their detention and obtain an order for release if it is not lawful. For example as to this in *AMA v Greater Manchester West Mental Health NHS Foundation Trust and Others* [2015] UKUT 0036 (AAC) I said in the different context of an application to withdrawal of an application:

The role of the FtT

38. The FtT is a tribunal that has the function of reviewing detentions under the MHA. It therefore plays an important role in fulfilling the substantive and procedural requirements of Article 5(4) ECHR, and the underlying purposes of the MHA and the procedural fairness required by the common law. As appears from *YA*:

i) The main purpose of Article 5 is to provide that no one should be deprived of their liberty in an arbitrary manner.

ii) The reviewing body, and so the FtT, must consider whether the reasons that initially justified detention continue and review the substantive and procedural conditions that are essential for the deprivation of liberty to be lawful.

iii) Article 5(4) applies to those reviews and is directed to ensuring that there is a fair procedure for reviewing the lawfulness of a detention.

iv) To my mind the most important principles to take into account in the decision making process of the FtT are: (a) the underlying purpose and importance of the review and so the need to fairly and thoroughly assess the reasons for the detention, (b) the vulnerability of the person who is its subject and what is at stake for that person (i.e. a continuation of a detention for an identified purpose), (c) the need for flexibility and appropriate speed, (d) whether, without representation (but with all other available assistance and the prospect of further reviews), the patient will practically and effectively be able to conduct their case, and if not whether nonetheless (e) the tribunal is likely to be properly and sufficiently informed of the competing factors relating to the case before it and so able to carry out an effective review. (As to this the tribunal should when deciding the case review this prediction).

v) The presumption of capacity and the requirement for it to be assessed by reference to the relevant decision, issue or activity must be remembered but care needs to be taken not to embark on unnecessary assessments and to maintain flexibility to achieve the underlying purpose, namely a practical and effective review of a deprivation of liberty in an appropriate timescale.

58. In my view, it would therefore be surprising if those tribunals either (a) could not as a matter of jurisdiction take into account a breach of Convention rights, or (b) in the exercise of their discretion should leave to other courts, and so effectively ignore, a breach of Convention rights.

The most relevant provisions of the MHA relating to a CTO

59. Section 17A of the MHA sets the criteria for a CTO. It provides:

(1) The responsible clinician may by order in writing discharge a detained patient from hospital subject to his being liable to recall in accordance with section 17E below.

(2) A detained patient is a patient who is liable to be detained in a hospital in pursuance of an application for admission for treatment.

(3) An order under subsection (1) above is referred to in this Act as a "community treatment order".

(4) The responsible clinician may not make a community treatment order unless–
(a) in his opinion, the relevant criteria are met; and
(b) an approved mental health professional states in writing–
(i) that he agrees with that opinion; and
(ii) that it is appropriate to make the order–

(5) The relevant criteria are–
(a) the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;
(b) it is necessary for his health or safety or for the protection of other persons that he should receive such treatment;
(c) subject to his being liable to be recalled as mentioned in paragraph (d) below, such treatment can be provided without his continuing to be detained in a hospital;
(d) it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) below to recall the patient to hospital; and
(e) appropriate medical treatment is available for him.

(6) In determining whether the criterion in subsection (5)(d) above is met, the responsible clinician shall, in particular, consider, having regard to the patient's history of mental disorder and any other relevant factors, what risk there would be of a deterioration of the patient's condition if he were not detained in a hospital (as a result, for example, of his refusing or neglecting to receive the medical treatment he requires for his mental disorder).

60. The conditions which may be specified in a CTO are governed by section 17B which provides:

(1) A community treatment order shall specify conditions to which the patient is to be subject while the order remains in force.

(2) But, subject to subsection (3) below, the order may specify conditions only if the responsible clinician, with the agreement of the approved mental health professional mentioned in section 17A(4)(b) above, thinks them necessary or appropriate for one or more of the following purposes–

(a) ensuring that the patient receives medical treatment;

(b) preventing risk of harm to the patient's health or safety;

(c) protecting other persons.

(3) The order shall specify–

(a) a condition that the patient make himself available for examination under section 20A below; and

(b) a condition that, if it is proposed to give a certificate under Part 4A of this Act [that falls within section 64C(4) below] in his case, he make himself available for examination so as to enable the certificate to be given.

(4) The responsible clinician may from time to time by order in writing vary the conditions specified in a community treatment order.

(5) He may also suspend any conditions specified in a community treatment order.

(6) If a community patient fails to comply with a condition specified in the community treatment order by virtue of subsection (2) above, that fact may be taken into account for the purposes of exercising the power of recall under section 17E(1) below.

(7) But nothing in this section restricts the exercise of that power to cases where there is such a failure.

61. Section 17D of the MHA provides:

(1) The application for admission for treatment in respect of a patient shall not cease to have effect by virtue of his becoming a community patient.

(2) But while he remains a community patient–

(a) the authority of the managers to detain him under section 6(2) above in pursuance of that application shall be suspended; and

(b) reference (however expressed) in this or any other Act, or in any subordinate legislation (within the meaning of the Interpretation Act 1978), to patients liable to be detained, or detained, under this Act shall not include him.

(3) And section 20 below shall not apply to him while he remains a community patient.

(4) Accordingly, authority for his detention shall not expire during any period in which that authority is suspended by virtue of subsection (2)(a) above.

62. The responsible clinician's powers of recall are governed by section 17E, which provides:

(1) The responsible clinician may recall a community patient to hospital if in his opinion–

(a) the patient requires medical treatment in hospital for his mental disorder; and

(b) there would be a risk of harm to the health or safety of the patient or to other persons if the patient were not recalled to hospital for that purpose.

(2) The responsible clinician may also recall a community patient to hospital if the patient fails to comply with a condition specified under section 17B(3) above.

(3) The hospital to which a patient is recalled need not be the responsible hospital.

(4) Nothing in this section prevents a patient from being recalled to a hospital even though he is already in the hospital at the time when the power of recall is exercised; references to recalling him shall be construed accordingly.

(5) The power of recall under subsections (1) and (2) above shall be exercisable by notice in writing to the patient.

(6) A notice under this section recalling a patient to hospital shall be sufficient authority for the managers of that hospital to detain the patient there in accordance with the provisions of this Act.

63. The power of the MHRT and the First-tier Tribunal to discharge a CTO is set out in s. 72 of the MHA which provides that:

(1) Where application is made to the appropriate tribunal by or in respect of a patient who is liable to be detained under this Act or is a community patient , the tribunal may in any case direct that the patient be discharged, and—

(b) the tribunal shall direct the discharge of a patient liable to be detained otherwise than under section 2 above if it is not satisfied—

(i) that he is then suffering from mental disorder or from mental disorder of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or

(ii) that it is necessary for the health of safety of the patient or for the protection of other persons that he should receive such treatment; or

(iia) that appropriate medical treatment is available for him; or

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

(c) the tribunal shall direct the discharge of a community patient if it is not satisfied–

(i) that he is then suffering from mental disorder or mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment; or

(ii) that it is necessary for his health or safety or for the protection of other persons that he should receive such treatment; or

(iii) that it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) above to recall the patient to hospital; or

(iv) that appropriate medical treatment is available for him; or

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

1A) In determining whether the criterion in subsection (1)(c)(iii) above is met, the tribunal shall, in particular, consider, having regard to the patient's history of mental disorder and any other relevant factors, what risk there would be of a deterioration of the patient's condition if he were to continue not to be detained in a hospital (as a result, for example, of his refusing or neglecting to receive the medical treatment he requires for his mental disorder).

(2)

> (3) A tribunal may under subsection (1) above direct the discharge of a patient on a future date specified in the direction; and where a tribunal does not direct the discharge of a patient under that subsection the tribunal may—
>
> (a) with a view to facilitating his discharge on a future date, recommend that he be granted leave of absence or transferred to another hospital or into guardianship; and
>
> (b) further consider his case in the event of any such recommendation not being complied with.
>
> (3A) Subsection (1) above does not require a tribunal to direct the discharge of a patient just because it thinks it might be appropriate for the patient to be discharged (subject to the possibility of recall) under a community treatment order; and a tribunal—
>
> (a) may recommend that the responsible clinician consider whether to make a community treatment order; and
>
> (b) may (but need not) further consider the patient's case if the responsible clinician does not make an order.
>
> (4) Where application is made to the appropriate tribunal by or in respect of a patient who is subject to guardianship under this Act, the tribunal may in any case direct that the patient be discharged, and shall so direct if it is satisfied—
>
> (a) that he is not then suffering from mental disorder; or
>
> (b) that it is not necessary in the interests of the welfare of the patient, or for the protection of other persons, that the patient should remain under such guardianship.

64. So unlike the position in respect of a restricted patient the First-tier Tribunal and the MHRT has no power to impose conditions itself and can either discharge the CTO or keep it in place on the conditions set by the responsible medical officer with the agreement of the approved mental health professional. Also the power to defer a direction for a conditional discharge of a restricted patient conferred by s. 73(7) of the MHA does not apply to a CTO.

65. Another difference, which is potentially relevant to the issue whether a patient with capacity can give a valid consent to conditions that when implemented create on an objective assessment a deprivation of liberty, is that the section authorising the patient's detention in hospital, in this case s. 3 of the MHA, remains in place during the currency of the CTO, but it is suspended. In contrast a restricted patient always remains liable to be detained until his absolute discharge (see s. 42(2) MHA). That liability was a factor in the decision of the Upper Tribunal in the *RB* case that RB could not give a valid consent to the conditions that created a deprivation of liberty.

The first main issue on this appeal.

Did the MHRT err in law in concluding that PJ was not deprived of his liberty?

66. In my view the answer is "yes" it did err in law in its application of the then recently decided case of *Cheshire West.*

67. At paragraph 49 of her judgment in *Cheshire West,* in answering whether there was an "acid test" (see paragraph 48 of her judgment) Baroness Hale stated:

> The answer, as it seems to me, lies in those features which have consistently been regarded as "key" in the jurisprudence which started with *HL v United Kingdom* 40 EHRR 761: that the person concerned "was under continuous supervision and control and was not free to leave" (para 91). I would not go so far as Mr Gordon, who argues that the supervision and control is relevant only insofar as it demonstrates that the person is not free to leave. A person might be under constant supervision and control but still be free to leave should he express the desire so to do. Conversely, it is possible to imagine situations in which a person is not free to leave but is not under such continuous supervision and control as to lead to the conclusion that he was deprived of his liberty. Indeed, that could be the explanation for the doubts expressed in *Haidn v Germany*.

68. This is the test identified by the MHRT. It is expressed by Baroness Hale as a composite test with two parts. She envisages that a person who is not free to leave may not be not under such (my emphasis) continuous supervision and control as to found a conclusion that he or she is deprived of his or her liberty. But, she does not divide up the two parts in the way that the MHRT did by considering the degree of supervision and control in isolation and then not going on:

    i) to consider it with, or

    ii) to consider at all

    whether PJ was free to leave (or effectively alter the conditions that limited his freedom action).

69. Neither of the other majority judgments provide support for the approach taken by the MHRT.

70. Also, in taking this approach to the key issue as identified by Baroness Hale, the MHRT overlooked that the fact that a person may have unescorted leave in the community does not mean that he is not deprived of his liberty if the leave is regulated and controlled, and he is not free to leave in the sense of removing himself permanently in order to live where and with whom he chooses.

71. As to this, in *Stanev v Bulgaria* (2012) 55 EHRR 22, the ECtHR stated at paragraph 116 that:

> In the context of deprivation of liberty on mental health grounds, the court has held that a person could be regarded as having been "detained" even during a period when he was in an open hospital ward with regular unescorted

> access to the unsecured hospital grounds and the possibility of unescorted leave outside the hospital.

72. This is a reference to *Ashingdane v United Kingdom* (1985) 7 EHRR 528 at paragraph 42. There the court was concerned with the question of whether Article 5 could protect a patient from being detained in a secure hospital such as Broadmoor when he did not need to be there. The court accepted that a compulsory patient is deprived of his liberty in the hospital where he is detained (and so not free to leave), irrespective of the openness or otherwise of the conditions there. The relevant regime was described as follows:

> There is no surrounding wall and neither the main entrance nor the reception area is locked... With effect from December 1980, he was allowed freedom, unescorted, in the hospital grounds for two hours a day. In the summer of 1981, he was moved to an open ward. Since then, regular, unescorted leave to visit his family has become a feature of his life at Oakwood. As at November 1984, he was going home every weekend from Thursday till Sunday and was free to leave the hospital as he pleased on Monday to Wednesday, provided only that he returned to his ward at night.

73. Accordingly, the MHRT erred in law in its approach to:

    i) the assessment of the degree of supervision and control required, and

    ii) by divorcing that consideration from the freedom of PJ to leave (or to effectively refuse to abide by the relevant conditions).

74. Further, the MHRT overlooked, and so failed to take into account, the guidance given in *Cheshire West* that the reason or purpose of the relevant conditions was not relevant to the assessment of whether the objective element of a deprivation of liberty was satisfied.

75. *An alternative approach advanced by the Health Board.* An alternative argument advanced on behalf of the Health Board was that, on a proper analysis of the provisions of the MHA, PJ was “free to leave” because the conditions were unenforceable and so any error of approach in law by the MHRT was immaterial. This argument was that PJ was “free to leave” because the only sanction for breach of the relevant conditions was that such a breach would be taken into account in exercising the power of recall to hospital. Counsel contrasted the position under guardianship where there is a statutory power to return the patient to the placement (see s. 18(3) of the MHA).

76. A similar argument to that advanced on behalf PJ in respect of a CTO could have been advanced on behalf of RB who was a restricted patient because again breach of a condition would only be a factor in exercising the power of recall (see the *KC* case at paragraphs 51 to 54). But it was not so argued before me in the *KC* case or at any stage in the *RB* case.

77. From the starting point of the Strasbourg cases encapsulated in the *Guzzardi* principle (see paragraph 10 hereof) in my view, a distinction based on the statutory power to return someone subject to guardianship to his or her placement is not warranted. Such an approach would be too technical. As would one based on a distinction between the suspension of the original detention (as with a CTO) and the continuation of it (as with the conditional discharge of a restricted patient).

78. So, in my view, the "free to leave" issue based on the lack of a provision for direct enforcement of relevant conditions in the MHA and the practical effect of the power of recall needs to be considered on the alternative bases, that an objectively assessed deprivation of liberty (a) is or can be made lawful, and (b) is not and cannot be made lawful.

79. When a patient lacks capacity an objectively assessed deprivation of liberty can be made lawful by an order of the Court of Protection under the MCA or an authorisation under its DOLS. In the *KC* case (see paragraphs 124 to 139) I concluded (obiter) that an objectively assessed deprivation of liberty of a patient with capacity can be made lawful by that patient giving consent to it (see paragraphs 124 to 139). However, a different view on the ability of a restricted patient with capacity to give a valid consent was reached by the Upper Tribunal in the *RB* case and was not an issue or was assumed to the case by the court of appeal in that case. That different view is reflected in the argument set out at paragraph 14 of the *GA* case.

80. Mr Mant, on behalf of PJ, advanced that different view before me and Mr Burrows advanced an argument in line with my obiter conclusion in the *KC* case. They both did so on the basis that PJ had the relevant capacity to consent. I shall return to this argument.

81. *A lawful deprivation of liberty.* If and so long as the implementation on the ground of the relevant restrictions would be lawful it seems to me tolerably clear that the relevant person is not "free to leave" even though the reality of enforcement is the exercise of the power of recall (or a resetting of conditions).

82. *An unlawful deprivation of liberty.* If and so log as implementation on the ground would not be lawful (and so (a) pending an order of the Court of Protection, or a DOLS authorisation, or a valid consent, or (b) as soon as such a valid consent is withdrawn by a person with capacity or authorisation under the MCA ends) and so it is only the risks and potential consequences of the exercise of the power of recall that provide pragmatic enforcement of the relevant conditions the position is less clear. But, in my view, the pragmatic force of those risks and consequences is that for the purposes of Article 5 it cannot be said that the relevant person is "free to leave". However, I acknowledge that a different view can be founded on the approach taken by Holman J in

R(SH) v MHRT [2007] EWHC 884 (Admin), [2007] MHLR 234 (see the *KC* case at paragraph 135).

The first issue: conclusion and its consequences

83. The MHRT erred in law in their application of the majority decision of the Supreme Court in *Cheshire West.*

84. As PJ has been discharged from his CTO there is no point in remitting his case to the MHRT.

85. I decline to answer whether PJ was deprived of his liberty. On a remission I would have given guidance on the application of *Cheshire West.* Alternatively, if the issue was a live one, I might have decided whether PJ was deprived of his liberty and indeed his appeal. I acknowledge, as did Mr Burrows on behalf of the Health Board, that it is difficult to see how a further analysis of the facts would found the conclusion, applying *Cheshire West*, that assessed objectively PJ was not deprived of his liberty.

86. However, on that assumption, I do not accept the premise of the arguments before me, namely that PJ had the relevant capacity to consent to the care regime and was objecting to it. In my view, applying the *YA* case the premise that he had that capacity is far from being clear and would need investigation. Also, in my view, on the existing evidence and findings of the MHRT it is not clear whether, if it is found that PJ had the relevant capacity, he had not consented to the deprivation of liberty (as Mr Mant argued), or had consented to it (as Mr Burrows argued). The evidence indicates that these issues were not addressed by reference to either (a) PJ's understanding of or his ability to weigh the competing factors, or (b) any decision he made after they had been discussed with him. So those issues would have to have been remitted.

87. The answer to these issues found different analyses of whether a breach of Article 5 would arise on the implementation of the conditions necessary to protect the public and PJ.

88. If the case was remitted, my conclusion on the second issue on this appeal, would have founded the giving of guidance to the MHRT on how to approach the question whether there would or would not be a breach of Article 5. As remission was not suggested I did not hear argument on what that guidance should be.

89. In those circumstances, and although a general function of the Upper Tribunal is to give guidance, I have concluded that it would not be appropriate for me to seek to utilise this case to seek to convert my obiter conclusions in the *KC* case relating to the ability of a patient with capacity to give a valid consent for the purposes of Article 5 to something more under the guise of general guidance, or the guidance I would have given if I had remitted this case.

90. There is little doubt that this issue will arise in a case in which it will be part of the ratio.

The second main issue on this appeal.

Did the MHRT err in law in concluding that the CTO framework must take precedence over any human rights issues?

91. As appears above the MHRT expressed this conclusion by stating that the CTO framework "took precedence over any human rights issues".

92. This assumes the existence or possible existence of a breach of human rights and so here a deprivation, or possible deprivation, of PJ's liberty in breach of Article 5. So it is a conclusion that a MHRT and a First-tier Tribunal can and indeed should:

i) ignore possible breaches of Convention rights, or

ii) permit, or effectively permit by doing nothing directed to it, an unlawful state of affairs (i.e. a breach of Convention rights) to continue.

93. I agree with the submission made on behalf of PJ that both conclusions are an error of law.

Generally the statutory jurisdiction to take into account breaches of Convention rights

94. It seems to me that the only basis on which these conclusions of the MHRT could be justified is that the MHRT (and the First-tier Tribunal) are bound by the MHA to act in this way and so, as a matter of jurisdiction, they do not have the power when either:

i) construing and applying the tests set for them by the MHA, or

ii) exercising a discretion given to them by the MHA

to take into account, or to take any steps to address or prevent a breach of a Convention right and so a breach of Article 5 or Article 8.

95. In my view the language and underlying purposes of the MHA do not support that construction of the MHA and thus that result.

96. Rather that language and the following, namely:

i) the role and function of the MHRT (and so the First-tier Tribunal) (see paragraphs 56 to 58 hereof), and so the points made by Baroness Hale on their role and the problems relating to and thus the adequacy of an available challenge in other courts,

ii) ss. 3, 6 and 7 of the HRA (the relevant terms and effects of which are set out at paragraphs 59 to 65 hereof),

iii) the positive obligations under Article 5 (see paragraph 55 hereof),

iv) the point that Parliament is most unlikely to have intended that any of the tests set by the MHA should or could be construed and applied in a way that created an unlawful result, and

v) the point that Parliament is also most unlikely to have intended that a tribunal set up to determine challenges to and to review decisions made under the MHA could or should not address any such unlawful result and if it found one had been created do nothing about it

found the conclusion that the MHRT (and so the First-tier Tribunal) in applying their statutory jurisdiction can and should take into account whether the decision that is the subject of the proceedings before them creates an unlawful result.

97. It follows that in my view a First-tier Tribunal (and so the MHRT) cannot ignore and so effectively sanction a continuation of, or a possible continuation of, a deprivation of liberty in breach of Article 5 created by the implementation of the conditions of a CTO and so an unlawful, or possibly unlawful, state of affairs.

98. If these conclusions are wrong issues of incompatibility would arise.

The arguments against that conclusion.

99. The Health Board argued that the MHRT misdirected itself in considering whether PJ was being and would continue to be deprived of his liberty in breach of Article 5 but that that misdirection did not result in a final decision that was wrong in law.

100. As I have already mentioned, its submission was to effect that a MHRT and a First-tier Tribunal:

i) as a matter of jurisdiction should limit itself to its statutory role, under which it has no jurisdiction or powers to investigate, consider and reach decisions on whether there has been a breach of human rights, and so for, example, issues of consent for the purposes of Article 5 and Article 8, and

ii) should ignore any breach of Convention rights and so permit such an unlawful state of affairs to continue because if the tribunal is not satisfied that the criteria set by the MHA for a discharge are met, and so it has concluded that the patient requires treatment and should be subject to recall, it should uphold the CTO because, in those circumstances, it would be perverse to discharge using its discretion.

101. The argument before me did not address whether the MHRT and the First-tier Tribunal could itself impose conditions that when implemented would create a breach of Convention rights as could be the case with a restricted patient (see the *KC* case). In my view, that would be an impossible argument and the extent of the argument advanced by the Health Board is that, as a matter of jurisdiction and/or discretion, the MHRT and the First-tier Tribunal should close its eyes and ears to, and so "wash its hands" of, any argument that a CTO imposed conditions that when implemented create a breach of Article 5.

102. The Health Board submitted (and I agree) that on the face of the statutory provisions a tribunal has no reason to consider the issue of deprivation of liberty and it then relied on (a) the three decisions of Upper Tribunal Jacobs in the *SH* case, the *GA* case and the *NL* case, and (b) the refusal of permission to appeal in the *GA* case (in the terms set out at paragraph 10 of the *NL* case) to support its argument. Counsel described the approach taken in those cases by Upper Tribunal Judge Jacobs as a minimalist one.

103. Characteristically, the reasoning of Upper Tribunal Judge Jacobs in those cases is succinct and persuasive. My disagreement with it and his conclusions is based primarily on what is omitted from that reasoning.

104. I acknowledge, as pointed out by Richards LJ, that at first sight the conclusion of Upper Tribunal Judge Jacobs on the limited jurisdiction and role of the tribunal seems sensible and pragmatic. But, on reflection, I consider that the flaw in that view is demonstrated by the solution suggested by Richards LJ, namely recall under the CTO rather than discharge under s. 72 of the MHA. This is because this solution:

   i) recognises that the unlawful situation should not continue, but

   ii) fails to recognise that a tribunal with the role and function described in paragraphs 56 to 58 hereof has effectively "washed its hands" of an unlawful state of affairs continuing, apart from making a recommendation that may or may not be acted upon.

   The existence of this flaw does not depend on or envisage that the MHA decision makers will not act responsibly; rather it recognises the duty of all public authorities (and so tribunals) to address and take into account breaches of Convention rights.

105. Further, as I have already mentioned, in comparison to the position in the MHRT and the First-tier Tribunal, there are considerable practical hurdles placed in the way of a patient in challenging the views of the earlier MHA decision makers in the courts. The front line and effective process of challenge is in those tribunals.

106. Also, an approach based on a limited jurisdictional role of the tribunal does not avoid significant difficulties on the ground for any of (a) the

patient, (b) the providers of his or her care regime and (c) responsible medical officers and other MHA decision makers (and their NHS bodies) because they have to address the relevant Convention rights. It only excludes the tribunals from addressing them.

The construction and application of s. 72(1)(c) – the test or criteria to be applied by the tribunal in determining whether to discharge or uphold a CTO

107. The tests set by s. 72 of the MHA that govern the decision making of the tribunal mirror the powers of the earlier MHA decision makers who have made the decisions that are the subject of the proceedings before the tribunal.

108. Take a detention under s. 3 or guardianship. In such cases, the patient can argue that as a less restrictive available option is practically available he or she should be discharged from detention in hospital under s. 3 MHA or guardianship. The Health Board's argument would lead to or support the result that when considering respectively:

    i) whether it is not necessary for the patient to be in hospital for the appropriate treatment because it will be available under the proposed less restrictive option (see s. 72(1)(b)), or

    ii) whether the guardianship is not necessary (see s. 72(4)).

    the tribunal could not take into account whether the implementation of the less restrictive option would be lawful.

109. In my view, having regard to the role of the tribunal that would be a remarkable result and is not the case. Rather, as appears for example from (a) my approach in the *KD* case which concerned guardianship and the approach of Upper Tribunal Judge Jacobs in *NM v Kent County Council* [2015] UKUT 125 (AAC) – see paragraph 10 of the *KD* case), and (b) my approach in the *KC* case and in *AM v South London and Maudsley NHS Foundation [2013] UKUT 0365* (AAC) to the consideration of what is necessary to satisfy the MHA tests, the tribunal can and indeed should consider the lawfulness of the proposed alternative and less restrictive option. The issue of its lawfulness is an aspect of whether the alternative option is in practice available.

110. In the case of a CTO, s . 17A(5) of the MHA (the criteria for making a CTO) and s. 72(1)(c) of the MHA (the criteria for discharging or upholding a CTO) mirror each other.

111. I agree with the submission made on behalf of PJ that the terms "appropriate" and "available" medical treatment in ss. 17A(5)(e) and 72(1)(c)(iv) of the MHA should be read as referring to lawful treatment that is lawfully available. I add that in my view all references in s. 72(1)(c) to medical treatment is to treatment that is lawfully provided and delivered and Parliament cannot have intended the tests set by s. 17(A)(5) and s. 72(1)(c) of the MHA to refer to treatment that was

unlawful or which was being or would be given in an unlawful way or in unlawful circumstances.

112. This conclusion is reinforced by the terms of s. 17A(5)(c) which, unlike ss. 17A(5)(a) and (b), is not directly mirrored in s. 72(1)(c) (see (c) (i) and (ii)). Section 17A(5)(c) refers to "such treatment" being provided (and so the treatment referred to in ss. 17(5) (a) and (b) and s. 72(1)(c) (i) and (ii) being provided), subject to the power of recall, without the patient continuing to be detained in hospital. In my view, that must be a reference to treatment that is being lawfully provided. Also, as it is the treatment that will be being given outside hospital (subject to the power of recall) it is the treatment referred to in s. 72(1)(c)(iv) of the MHA.

113. I add that as all references to medical treatment in all of the subsections of s. 17A(5) and s. 72(1)(c) must be within the wide definition of treatment in ss. 145(1) and (4) of the MHA, it seems to me that, although s. 17B(2)(b) or (c) might be relied on to impose the conditions, there is no room for an argument that the aspects of care, support and treatment that are needed to protect the patient or the public and which, when implemented, will create an objectively assessed deprivation of liberty can be excluded when the provision, delivery and availability of suitable medical treatment is being considered. But if that is wrong, as appears below, the lawfulness of the implementation of those conditions would have to be considered by the tribunal in connection with the exercise of their discretion under s. 72(1) of the MHA to adjourn the hearing.

The argument against that conclusion.

114. This is founded on the decision in the *SH* case. There Upper Tribunal Judge Jacobs said:

> 10. I have decided that the First-tier Tribunal does not have jurisdiction to deal with issues of consent to treatment. This is why.
>
> 11. The Mental Health Act only applies in defined and restricted circumstances. It is controlled by three locks: mental disorder, protection, and treatment. All three locks must be secured before a person can be subject to the Act. If any of the locks is unfastened, the person is no longer subject to the Act. The tribunal is one of the key holders for those locks. If it opens any one of the locks, the patient must be discharged. This prevents the Act being used for pure containment.
>
> 12. Mr H was detained for treatment under section 3. The locks were represented by section 3(2)(a), (c) and (d). He was made the subject of a community treatment order under section 17A. The locks were then represented by section 17A(5)(a), (b) and (e). Those paragraphs mirror section 3(2)(a), (c) and (d). The tribunal's powers on his application were set out in section 72. The locks were then represented by section 72(1)(c)(i), (ii) and (iv). Those subparagraphs mirror both section 3(2)(a), (b) and (c) and section 17A(5)(a), (b) and (e). And, as a statutory tribunal constituted under section 3(1) of the Tribunals, Courts and Enforcement Act 2007, the First-tier Tribunal has only the powers conferred on it. The same locks apply at each

stage that the issue arises whether a person should be, or remain, subject to the Act.

13. These provisions, and the continuity between them, have two consequences. First, the First-tier Tribunal only has jurisdiction to deal with consent to treatment if it relates to one of those three locks. Mr Evans has recognised that by arguing that lack of consent prevents treatment being appropriate and available. Second, if consent is relevant to the treatment lock under section 72, they must be relevant to that lock under sections 3 and 17A as well. Any other result would be both anomalous. But the issue of consent cannot arise under section 3, because treatment can only be authorised once the person is made subject to the Act. Consent relates to delivery of the treatment and cannot arise until that treatment has been identified and classified as both appropriate and available. And that, by definition, only happens once the treatment lock has been applied.

14. Even under sections 17A and 72, consent cannot be part of the treatment lock. The delivery of treatment, and the related issue of consent, is practically and conceptually distinct from the issue whether it is appropriate and available. Treatment may be appropriate, whether or not the patient consents. And it may be available, whether or not the patient is willing to receive it. Appropriateness and availability are issues that arise prior to the decision whether to give the treatment. It is only at that later stage that the patient's consent arises. The Act distinguishes, and provides separately for, detention or recall and treatment. Part IV deals with consent to treatment. Some of the provisions apply to community patients. There is also specific provision for consent in respect of adult community patients in sections 64B, 64C, 64D and 64G, which I have referred to above.

15. This distinction is reflected in the language and structure of the Act. For the treatment lock to apply, treatment must be appropriate and available. That indicates that it must be both suitable for, and at the disposal of, patients. Treatment, including treatment without consent, is dealt with in separate provisions, which use different language. The Act refers to *giving* treatment, which focuses on the delivery of treatment that is available and appropriate. And it is not linked into those concepts by, for example, deeming that treatment is available despite being administered without consent. The powers of the First-tier Tribunal mirror the three locks, but not the provisions for treatment. Judicial oversight *by the First-tier Tribunal* is limited to the issue whether the person should be subject to the Act. The treatment of patients under the Act is subject to judicial oversight *by the courts*, but not by the First-tier Tribunal.

16. The result is that the tribunal has the right to order the release of the patient, but no more. It does not have power to order that the patient be recalled to hospital. Nor does it have any power to direct the responsible authority to take any steps in respect of the patient's treatment, including steps to allow it to give treatment without consent. Those would be surprising limitations on the tribunal's powers, if it had jurisdiction to deal with issues of consent. The tribunal can make recommendations about treatment (as under section 72(3A)(a)), but they are powers only. It has no right to impose that recommendation on the clinical staff.

115. Upper Tribunal Judge Jacobs identifies and relies on the mirror provisions of s. 3 and s. 72, and the heart of his reasoning is his point that the appropriateness and availability of medical treatment are distinct from the issues of its delivery and thus of consent to it.

116. I do not dispute that "appropriateness" and "availability" of treatment are distinct concepts to its "delivery" or "provision". But I do not agree that the lawfulness of the provision or delivery of treatment or the circumstances in which it is provided or delivered is not a factor to be taken into account in determining whether it is or will be available (and so lawfully available), or is treatment (and so lawful) for the purposes of the application of ss. 17A(5) and 72(1)(c) of the MHA.

117. Much of Upper Tribunal Judge Jacobs' reasoning is temporal. I accept that this is appropriate in the context of consent to treatment as and when it is given but I agree with the submission made on behalf of PJ that his temporal reasoning cannot apply to an existing (or proposed) objective deprivation of liberty in breach of Article 5 because that is (or will) be an on-going state of affairs.

118. Other distinctions can be made between the issue of consent to treatment as and when it is delivered and breaches of Article 5 by reference to the provisions Upper Tribunal Judge Jacobs refers to in the MHA (namely ss. 64B, 64C, 64D and 64FA and 64G) that can authorise treatment and which mirror provisions in the MCA relating to different types of treatment (see ss. 5, 6 and 28 of the MCA). In my view, such provisions can be relied on to found the conclusion that the treatment is lawful and is lawfully available. As, for example, can MCA authorisations of an objectively assessed deprivation of liberty. Indeed it may be that ss. 64C and D and the wide definition of treatment could found the conclusion that the treatment is lawful and lawfully available and so render an authorisation under the MCA unnecessary or inappropriate. But this issue is outside the scope of this decision and is one for another day that also engages issues concerning the ratio of the decision of the Court of Appeal in *B v Secretary of State for Justice* [2012] 1 WLR 2043 and whether any MHA decision maker can specify or impose conditions that create a deprivation of liberty.

119. Accordingly, I do not agree that in considering what Upper Judge Jacobs refers to as the three locks the tribunal is precluded from considering the lawfulness of the provision or delivery of the treatment. If it was, it would found the illogical conclusion that in making their decision on those locks:

    i) the earlier MHA decision makers can and indeed should consider issues relating to consent and any breach of Convention rights because it is acknowledged that challenges to those parts of their decisions can be made in other courts, but

    ii) the tribunal cannot do so and so cannot consider the lawfulness of those parts of the decisions that are challenged before the tribunal.

120. For those reasons I disagree that the jurisdiction of the tribunal is limited in the way and to the extent found by Upper Tribunal Judge Jacobs.

121. Further, in my view his reasoning and conclusion are flawed by the fact that he makes no mention any of the matters set out in paragraph 96 hereof.

The exercise of the discretion conferred by s. 72(1)

122. This is addressed in the *GA* case and then in the *NL* case that applies the *GA* case to a breach or possible breach of Article 5.

123. These cases are founded on the conclusion that the tribunal has the limited jurisdiction found in the *SH* case and so on the basis that, when applying s. 72(1)(c), the tribunal cannot consider whether medically appropriate treatment is being or will or can be provided lawfully and on that basis has concluded that such treatment is, or can be made, available. So, if I am right, and that conclusion on the limited jurisdiction of the tribunal under the MHA is wrong, the basis for the Health Board's perversity argument, based on the conclusions in the *GA* and *NA* cases disappears.

124. However, on the assumption that the jurisdiction of the tribunal is so limited I do not agree with the conclusions reached in the *GA* and *NL* cases.

125. In the *GA* case, the patient GA was represented by Mr Mant (counsel for PJ), and it was argued that the CTO should have been discharged because it was unlawful at common law and contrary to Article 8. Argument based on the impact of the HRA was put in writing, there was no hearing and no mention is made in the decision of the relevant provisions of the HRA.

126. The analysis and conclusion is based on an assumption that GA did not give informed consent and the judge acknowledges that in exercising its discretion under s. 72(1):

   i) the tribunal can have regard to matters relating to consent to treatment (see paragraph 21), and so it seems to me

   ii) issues relating to the impact of such consent and thus the lawfulness of the condition relating to treatment.

127. Accordingly, Upper Tribunal Judge Jacobs:

   i) recognises that in exercising its discretion the tribunal has the jurisdiction to consider breaches or potential breaches of Convention rights, and so expressly recognises that

ii) the limits that his conclusion on the tribunal's jurisdiction in the *SH* case puts on the tribunal are confined to the application of s. 72(1)(c).

128. However, he reintroduces those limits or effectively reintroduces them in concluding that it would be perverse for a tribunal to exercise its discretion to discharge a CTO if it was satisfied that the mandatory grounds for its discharge did not exist. He does this in paragraphs 22 and 23 where he says:

> 22. Mr Allen hit the point when he used the concept of perversity. The discretionary power is not limited by the three key factors of mental disorder, protection and treatment that are found in section 72(1)(c). It may be exercised even if those conditions for detention remain satisfied. Indeed, it is only relevant if those conditions are satisfied. To emphasise: the discretionary power only arises when the patient requires treatment and should be subject to recall by the responsible clinician. If the tribunal is nonetheless to justify discharge, logic requires that it must be satisfied that the identified needs for treatment and protection can be properly catered for. Any other decision would be self-contradictory and perverse.
>
> 23. A tribunal exercising its discretionary power must act consistently with the logic of its reasoning. Having decided that the patient does require treatment and should be subject to recall, it will have two options. One is to refuse to discharge the patient, who then remains subject to the 1983 Act and the powers of recall, leave and treatment under that Act. The other option is to discharge the patient under the discretionary power. That allows the authorities: (i) to detain the patient again under the 1983 Act; or (ii) if the patient lacks capacity to consent to treatment, to make arrangements for treatment under the Mental Capacity Act 2005. I can see no point in (i), which is a more cumbersome way to achieve the same effect as recall. As to (ii), the tribunal could only properly exercise its discretion to leave a patient to be dealt with under the 2005 Act if satisfied that the patient did lack capacity and would be treated under the powers of that Act. If the tribunal were to direct discharge without those factors being satisfied, it would act inconsistently with the logic of its reasoning that the patient required treatment. It would potentially leave the patient and the public without the protection that it had decided was required.

129. In reaching his conclusion based on perversity (or irrationality), he does not return to address the relevance of the factor which he has accepted can be investigated by the tribunal, namely whether the relevant condition concerning treatment should not have been imposed because it was unlawful at common law or in breach of Article 8.

130. In the *NL* case, Upper Tribunal Judge Jacobs was concerned with whether the discretionary power to discharge a guardianship should be exercised on the basis that NL was being deprived of his liberty (unlawfully because he did not consent to it) at the placement where the guardian required him to live. The First-tier Tribunal decided not to discharge the guardianship and Upper Tribunal Judge Jacobs upheld that decision. He did so on two bases. Firstly because the guardianship did not create the deprivation of liberty. As I said in the *KD* case it is at least strongly arguable that this is not a valid analysis because, in my view, a guardian must take into account the care

regime before directing a person to live at a placement and what matters is whether the effect of the care regime and its conditions is a lawful or unlawful deprivation of liberty (see paragraphs 30 and 60 of the *KD* case). I now go further and record that in my view that analysis is wrong because what matters is the position on the ground caused by the implementation of the care regime which the MHA decision maker has to take into account (see paragraphs 10 and 77 hereof and paragraphs 60 to 64 of the *KC* case).

131. Secondly, on the relevance of the *GA* case he concluded at paragraph 20 that:

> 20. The tribunal was right to apply the reasoning of *GA* to the context of guardianship. I there reasoned from the logic of the structure of the legislation and the need for coherence in fact-finding and decision-making. Those considerations apply as much to guardianship as they do to community treatment orders or, for that matter, detention in hospital. Given the importance of the welfare of those suffering from a mental disorder and of the need for protection of other persons, it is difficult to imagine a case in which the tribunal could properly exercise its discretion to discharge without there being appropriate safeguards to ensure the necessary treatment and protection.

132. In that paragraph he extends his analysis and conclusion on perversity (or irrationality) to effectively all applications of the exercise of a discretion by the First-tier Tribunal. He does so largely by reference to his "protection key" (see the *SH* case) and by the last sentence of the quoted paragraph equates the perversity conclusions in the *NL* case to those in the *GA* case. Accordingly, distinctions between treatment (Article 8) and deprivation of liberty (Article 5) and other unlawful (or possibly unlawful situations) are irrelevant to his perversity (irrationality) analysis and conclusion.

133. Again, he makes no reference to the relevance of the lawfulness of the existing situation on the ground, which applying the *GA* case, he accepted was something the tribunal had jurisdiction to consider when exercising its discretion. So the effect of his conclusion is that when exercising its discretion :

i) the tribunal has jurisdiction to consider and decide whether the situation on the ground for the applicant results in his or her unlawful deprivation of liberty, but

ii) if it does so it should leave it to others to do something about any unlawfulness it finds to exist and so, apart possibly from founding a recommendation, its consideration of whether the patient is or would be unlawfully deprived of his liberty would be academic.

134. I disagree that an exercise of the discretion either (a) with the aim of bringing to an end, or (b) to end to an unlawful situation, can be said to be contradictory and perverse (or irrational).

135. In my view, the analysis and approach to the exercise of the discretion in the *GA* and *NL* cases is flawed because it ignores the obligations of the tribunal under ss. 6 and 7 of the HRA and its result creates what to my mind is a surprising result that the tribunal:

    i) that has been given responsibility under the MHA to address whether the three keys identified by Upper Tribunal Judge Jacobs, including the protection key, have been correctly and lawfully applied by the earlier MHA decision makers, and

    ii) which in terms of Article 5(4) is the primary court in which a patient can challenge the lawfulness of his or her detention under the MHA,

    effectively ignores a breach of the patient's Convention (and so Article 5) rights.

Conclusion on the exercise by the tribunal of its discretionary power in s. 72(1) and to adjourn the hearing.

136. I consider that to comply with ss. 6 and 7 of the HRA and the positive obligations in Article 5, the First–tier Tribunal and so the MHRT must when exercising their discretion under s. 72(1) and in respect of their conduct and so possible adjournment of the hearing :

    i) take into account whether there is a breach of Convention rights, and

    ii) if it concludes that there is such a breach exercise its powers with the aim of bringing it to an end and when necessary to bring it to an end.

137. It is not enough to say that alternative remedies of judicial review or habeas corpus are available in other courts. This is because in not discharging and so in practice upholding a CTO that gives rise to a deprivation of liberty in breach of Article 5 a MHRT or a First-tier Tribunal would be failing to act to bring an end to (and so effectively perpetuating) a deprivation of liberty in breach of Article 5. This is an unlawful breach of the HRA.

138. In the context of Article 5(4) it would be remarkable if the tribunal could or should not act in this way. That Article requires that the access to a court must be practical and effective. The MHRT and the First-tier Tribunal are especially designed to be accessible to patients and, as mentioned in paragraphs 16(ii) and 56 to 58 hereof, it has been recognised that they are tribunals which satisfy Article 5(4) because in them patients are entitled to speedily challenge the lawfulness of their detention and obtain an order for release if it is not lawful. In the tribunals, there is a statutory entitlement to periodic review and the hospital managers are required to ensure that patients are informed of their right to apply to the tribunals (see s.132A of the MHA); special

leaflets are produced, support is available and the hearings take place in hospital; patients are entitled to non-means tested legal aid and the tribunals can appoint a legal representative to act for them. Taken together these measures ensure that access to the tribunal is effective and they are not effectively replicated in respect of judicial review or a habeas corpus application.

The second issue: conclusion and its consequences

139. The MHRT erred in law in concluding in the alternative that if PJ was deprived of his liberty in breach of Article 5 that the CTO framework must take precedence over any human rights issues.

140. In:

i) construing and applying the test set by s. 72(1)(c) of the MHA, and

ii) in exercising their discretion to adjourn proceedings or under s. 72(1) the First-tier Tribunal and the MHRT

must take into account whether the implementation of the conditions of a CTO will or may create a breach of Article 5 (or any other Convention right).

141. In my view, if the tribunal concludes that the relevant medical treatment is not being and could not be provided without a breach of the patient's Convention rights and so lawfully:

i) the tribunal would not be satisfied that lawful and appropriate medical treatment was or would become lawfully available under the CTO, and so s. 72(1)(3)(c) satisfied, and

ii) if my construction and application of s. 72(1)(c) is wrong the tribunal should nonetheless exercise its discretion to bring an end to that unlawful situation by discharging the CTO.

142. The position is different if:

i) an issue remains to be decided on whether there is a breach of a Convention right, for example, on whether objectively there is a deprivation of liberty or whether a breach of Article 5 or Article exists, or could be avoided by or would not exist during an authorisation under the MCA (or under the MHA in respect of treatment) or whilst it was consented to by the patient, and further or alternatively

ii) the tribunal was of the view that the terms of the CTO could be changed so as to avoid a breach of Convention rights (e.g. by avoiding an objectively assessed deprivation of liberty).

143. In those circumstances the underlying purposes of the MHA to support moves from hospital to the community and the obvious strength of the points made, for example, in paragraph 23 of the *GA* case (and which I suspect understandably underlay the conclusion of the MHRT on the impact of human rights) to the effect that if, subject to issues of its lawfulness, there is treatment that satisfies ss. 17A(5) and s. 72(1)(c) the CTO should be upheld, point powerfully in favour of the tribunal providing an opportunity for the patient, MHA decision makers and the providers of the patient's care and support regime to take steps to provide that the implementation of the relevant conditions is lawful.

144. That opportunity could and in my view generally should be provided by the grant of an adjournment with directions as to what should be addressed and possibly the giving of a non-statutory direction.

145. On that basis, it would only be in cases in which the problems relating to breach of Convention rights could not be resolved that the tribunal would have to discharge the CTO with the possible consequences that (a) the patient would have to remain in or be returned to hospital and so be deprived of a route towards a return to the community, or (b) the patient would leave hospital on a different basis.

146. Issues equivalent to those mentioned in paragraphs 45 to 49 and 60 to 66 of the *KD* case, and in paragraphs 58 to 73 of the *KC* case may well arise in connection with whether there should be an adjournment and if so what directions or recommendations should be made by the tribunal. As those passages show:

i) if the Court of Protection is to be involved there is a need for the MHA decision maker to identify the terms of any care regime and, in particular, what is needed to protect the public,

ii) issues may arise on who should determine relevant issues of capacity and Rule 2 of the Tribunal Procedure Rules 2008 is likely to be relevant to their determination, and

iii) although the First-tier Tribunal and the MHRT are investigative tribunals the parties have the primary duty to provide and advance the relevant evidence and argument.

A check list for First-tier Tribunals and MHRTs when an issue arises whether the implementation of the conditions of a CTO that are needed to protect the patient or the public will cause a breach of Article 5 and thus an unlawful deprivation of liberty

147. In the application of my conclusions on the jurisdiction of and approach to be taken by tribunals, I suggest that it is likely to assist the determination of such a case if the tribunal address the following questions.

148. *Whether the implementation of the conditions will on an objective assessment result in a deprivation of the patient's liberty?* This assessment is to be carried out by applying the guidance given by the majority decision in *Cheshire West.*

149. *If there is or may be such a deprivation of liberty whether the patient does or does not have capacity to consent to the relevant conditions and care regime and the deprivation of liberty it creates?* This assessment is carried out by reference to those specific decisions applying the MCA. The *YA* case could be of assistance by analogy, and issues may arise on whether the tribunal should determine capacity or adjourn to enable it to be decided by the Court of Protection. If there is an adjournment for that purpose the tribunal will need to consider what directions and decisions it should make to define the terms of the care regime (upon which the welfare order made by the Court of Protection or a DOLS authorisation will be based) that should be determined by the MHA decision makers and so the terms needed to protect the public and/or the patient.

150. *If the patient does have that capacity does his or her consent avoid a breach of Article 5?* This assessment will engage competing obiter views of the Upper Tribunal and whether reliance can be placed on s. 64C of the MHA that I have identified in this decision as issues for another day.

151. *If the patient does not have capacity can any objectively assessed deprivation of liberty be authorised by the Court of Protection or under the DOLS in the MCA?* The way these work is described generally in paragraphs 33 to 41 and paragraphs 94 to 113 of the *KC* case. Paragraphs 3 and 4 of Schedule 1A apply to Case C and so in a CTO case as well as to a restricted patient. The Court of Protection can by making a welfare order authorise any deprivation of liberty that the implementation of the care plan creates or may create and so, in many cases, the Court of Protection need not spend time and effort on determining borderline issues on whether objectively there is or is not a deprivation of liberty. And, in my view a DOLS authorisation can be given if there may be a deprivation of liberty. These points may be relevant to whether the tribunal should determine arguments on the existence of an objective deprivation of liberty. If there is an adjournment to enable proceedings in the Court of Protection to take place or for a DOLS authorisation the tribunal need to consider what directions and decisions it should make to define the terms of the care regime (upon which the welfare order made by the Court of Protection or a DOLS authorisation will be based) that should be determined by the MHA decision makers and so the terms needed to protect the public and/or the patient.

152. *If the patient lacks capacity can s. 64D of the MHA be relied on to avoid a breach of Article 5?* I have not heard argument on or expressed a view on this in this decision. This possibility may render it

unnecessary to involve the Court of Protection or the DOLS. But it engages issues concerning the ratio of the decision of the Court of Appeal in *B v Secretary of State for Justice* [2012] 1 WLR 2043 (see paragraph 118 hereof).

153. *How the conclusions on the above should be taken into account in the determination of whether there should be an adjournment and if not whether it should discharge or uphold the CTO?*

154. On that final question and on the relevance of a number of the questions posed above I have disagreed with and so not followed the decisions in the *SH*, *GA* and *NL* cases. I have discussed the approach to an adjournment in paragraphs 141 to 146 hereof. On the substantive issues, as appears from my reasoning and conclusions (see in particular paragraphs 96 and 97, 111 to 113, and 136 to 138 hereof), I have concluded that the bottom line is that the tribunal must take breaches and possible breaches of Convention rights into account. See paragraph 140 hereof where I state:

> In:
>
> i) construing and applying the test set by s. 72(1)(c) of the MHA, and
>
> ii) in exercising their discretion to adjourn proceedings or under s. 72(1) the First-tier Tribunal and the MHRT
>
> must take into account whether the implementation of the conditions of a CTO will or may create a breach of Article 5 (or any other Convention right).

Dated 4 September 2015

Signed on the original

Mr Justice Charles

President of the UT(AAC)