DECISION OF THE UPPER TRIBUNAL (ADMINISTRATIVE APPEALS CHAMBER)

Save for the cover sheet, this decision may be made public (rule 14(7) of the Tribunal Procedure (Upper Tribunal) Rules 2008 (SI No 2698)). That sheet is not formally part of the decision and identifies the patient by name.

This decision is given under section 11 of the Tribunals, Courts and Enforcement Act 2007:

The decision of the First-tier Tribunal under reference MM/2011/07890, made following a hearing on 22 July 2011 at Three Bridges, did not involve the making of an error on a point of law.

REASONS FOR DECISION

A. The issue

1. The issue in this case is when a tribunal is under a duty to adjourn to obtain information on possible aftercare available to a patient.

B. The case before the First-tier Tribunal

2. Mr M is detained under section 37 of the Mental Health Act 1983 and is subject to a restriction order under section 41. He was detained following an indecent assault on a six year old girl. He has admitted being involved in two similar offences. His case was referred to the First-tier Tribunal by the Secretary of State for Justice.

3. Before that tribunal, Mr M was represented by Ms Shah of counsel. She argued that the tribunal should direct a conditional discharge. As part of her case, she argued that it was necessary to investigate the alternatives to detention. The Social Circumstances Report dealt with aftercare in this passage:

> 31. The London Borough of Ealing accepts responsibility for Section 117 aftercare for Mr M… Although my assessment is that Mr M… is not ready to be discharged into the community at present, if the Tribunal were to decide that he should be discharged, the only accommodation open to him at this time would be through the homeless person's unit in Ealing. Considering his history of fire setting, it is unlikely that he would be provided with his own accommodation. Nearing the stage when Mr M… will be ready to leave hospital a S. 117 meeting will be set up to identify how his after-care needs will be met.

The author of the report did not attend the hearing and the social worker who did attend could not provide any further information. Ms Shah applied twice for an adjournment so that this information could be provided.

4. The tribunal decided that Mr M should not be discharged and refused to adjourn for the information sought by Ms Shah. In summary, the tribunal found these facts. Mr M's history of mental illness dates back to 1989. He has a diagnosis of paranoid schizophrenia, but he does not accept that he is mentally ill or that he needs medication. Consequently, he does not understand why he is detained and does not engage in therapeutic work; he attends courses, but sits passively without participating. His attitude to medication prevents his responsible clinician administering the preferred medication. He claims that Allah authorised his contact with young girls and provided them for him, but that he no longer has libido. He believes that everyone is attracted to young girls. He has claimed that the girl he assaulted was attracted to him. He believes that his father and the nursing staff practice black magic on him and contaminate his food. His thoughts are delusional, not cultural.

5. On these facts, the tribunal came to these conclusions on the criteria for continuing detention under the Mental Health Act. *Disorder* – he has paranoid schizophrenia. *Protection* – if he were discharged, he would cease his medication and present a risk to others and, through self-harm, to himself. *Treatment* – there is treatment available, but this cannot be effective until he has gained some insight into his condition and, with it, some co-operation.

6. On Ms Shah's application for an adjournment, the tribunal said:

> We refused an adjournment as it was unnecessary in the light of our decision that the patient should remain detained.

7. That raises the question, formulated by Mr Pezzani at the permission hearing, whether the information sought by Ms Shah was relevant to the tribunal's determination of issues in the performance of its statutory duty under section 73 of the Mental Health Act.

C. The legal framework

8. Rule 32(6) of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 (SI No 2699) provides that:

> the responsible authority must send or deliver a statement containing the information and documents required by the relevant practice direction to the Tribunal …

9. The relevant practice direction is titled **First-Tier Tribunal - Health Education And Social Care Chamber - Mental Health Cases**. The relevant section is **E – Social Circumstances Report**. Paragraphs 16 and 17 provide, with my italics:

> 16. The statement provided to the Tribunal must, include an up-to-date social circumstances report prepared for the Tribunal.
>
> 17. This report must include the following information:
>
> a. the patient's home and family circumstances;
>
> b. in so far as it is practicable, and except in restricted cases, a summary of the views of the patient's nearest relative, unless

(having consulted the patient) the person compiling the report thinks it would be inappropriate to consult the nearest relative;

c. in so far as it is practicable, the views of any person who plays a substantial part in the care of the patient but is not professionally concerned with it;

d. the views of the patient, including his concerns, hopes and beliefs in relation to the Tribunal proceedings and their outcome;

e. the opportunities for employment and the housing facilities available to the patient;

f. what (if any) community support is or will be made available to the patient and its effectiveness, if the patient is discharged from hospital;

g. the patient's financial circumstances (including his entitlement to benefits);

h. an assessment of the patient's strengths and any other positive factors that the Tribunal should be aware of in coming to a view on whether he should be discharged; and

i. an assessment of the extent to which the patient or other persons would be likely to be at risk if the patient is discharged by the Tribunal, and how any such risks could best be managed.

10. Although both rule 32(6) and the practice direction are mandatory, they are qualified by rule 7:

7 Failure to comply with rules etc.

(1) An irregularity resulting from a failure to comply with any requirement in these Rules, a practice direction or a direction, does not of itself render void the proceedings or any step taken in the proceedings.

(2) If a party has failed to comply with a requirement in these Rules, a practice direction or a direction, the Tribunal may take such action as it considers just, which may include—

(a) waiving the requirement;

(b) requiring the failure to be remedied;

(c) exercising its power under rule 8 (striking out a party's case);

(d) exercising its power under paragraph (3); or

(e) except in mental health cases, restricting a party's participation in the proceedings.

(3) The Tribunal may refer to the Upper Tribunal, and ask the Upper Tribunal to exercise its power under section 25 of the 2007 Act in relation to, any failure by a person to comply with a requirement imposed by the Tribunal—

(a) to attend at any place for the purpose of giving evidence;

(b) otherwise to make themselves available to give evidence;

(c) to swear an oath in connection with the giving of evidence;

(d) to give evidence as a witness;

(e) to produce a document; or

(f) to facilitate the inspection of a document or any other thing (including any premises).

11. The Code of Practice is also relevant. Paragraphs 27.7-27.9 deal with aftercare:

> 27.7 When considering relevant patients' cases, the Tribunal and hospital managers will expect to be provided with information from the professionals concerned on what after-care arrangements might be made for them under section 117 if they were to be discharged. Some discussion of after-care needs, involving LSSAs and other relevant agencies, should take place in advance of the hearing.
>
> 27.8 Although the duty to provide after-care begins when the patient leaves hospital, the planning of after-care needs to start as soon as the patient is admitted to hospital. PCTs and LSSAs should take reasonable steps to identify appropriate after-care services for patients before their actual discharge from hospital.
>
> 27.9 Where a Tribunal or hospital managers' hearing has been arranged for a patient who might be entitled to after-care under section 117 of the Act, the hospital managers should ensure that the relevant PCT and LSSA have been informed. The PCT and LSSA should consider putting practical preparations in hand for after-care in every case, but should in particular consider doing so where there is a strong possibility that the patient will be discharged if appropriate after-care can be arranged. Where the Tribunal has provisionally decided to give a restricted patient a conditional discharge, the PCT and LSSA must do their best to put after-care in place which would allow that discharge to take place.

12. Rule 32(6), the practice direction and the code of practice are all important. Nothing I say hereafter diminishes that importance. But, important as they are, they must be set in their context. That context is case management. Their purpose is to ensure that, as far as practicable, the hearing is effective. But once the hearing begins, the case passes from the case management phase to the decision-making phase. The generalities of the rules, the practice direction and the code of practice give way to the practicalities and realities of the individual patient and the evidence. To take an obvious example, the patient's representative may tell the tribunal that detention is not disputed, but the tribunal is being invited to make a non-statutory recommendation. In those circumstances, it does not matter whether or not the practice direction has been complied with. Rule 7 provides the powers that a tribunal may need once the transition has taken place from case management to decision-making. In the example I have just given, it allows the tribunal to waive any failure to comply with the practice direction.

13. I tried to develop this idea in a series of questions that I posed in my grant of permission. Mr Pezzani has made his final submissions in answer to those questions. So they provide a convenient framework for analysis. I am grateful to Mr Pezzani for his oral and written arguments, which as always were helpful and thought provoking.

D. My questions

Question 1

14. My first question was:

> One thought that I explored at the [permission] hearing was that it was clear to the tribunal that Mr M could not be managed in the community. On the face of it, he was not a strong candidate for a conditional discharge. He did not understand why he was detained. He took no part in therapy. He believed that his father and the hospital staff were practicing black magic and contaminating his food, which he was able to counteract by reciting from the Koran. In those circumstances, was it worth exploring further?

15. Mr Pezzani's answer is: yes. Detention must be a course of last resort. Detention for patients who lack insight must not be assumed to be lawful. Information about aftercare is essential. It can cover a broad variety of measures for which lack of insight need not be an impediment. Mr M was entitled to sufficient information about possible aftercare to show whether or not detention was necessary.

16. I broadly agree with Mr Pezzani's arguments. Where I differ is in taking account of the practicalities of Mr M's case. The witnesses for the detaining authority are familiar in general terms with the sort of aftercare that may be available and how effective it may be, and they know the patient. The panel hearing a mental health case is an expert one. It is entitled to use its own knowledge and expertise. Indeed, it is required to do so. It will form its own opinion of the patient and what is feasible for that patient. The tribunal's decision, including its approach to adjournments for further information, should be informed by its knowledge, expertise and assessment of the possibilities. In that context, I do not accept that it is essential for the tribunal to have specific information about aftercare in every case. It is an individual judgment to be made in the circumstances of the particular case.

Question 2

17. My second question was:

> Another thought was that the extent to which aftercare had to be planned depended on how realistic it was that a patient might be released. If the staff did not consider this a realistic prospect in the near future, they would not devote valuable time to investigating. They would, of course, not be working in the dark. They would know the sort of aftercare that might be available if a patient were released.

18. Mr Pezzani's answer is that, given the adversarial nature of the proceedings, it is dangerous for one party to be allowed to decide what information should be put before the tribunal. Everyone is entitled to a fair hearing. As Lord Pearce said in *Rondel v Worsley* [1969] 1 AC 191 at 275:

> It not infrequently happens that the unpleasant, the unreasonable, the disreputable and those who have apparently hopeless cases turn out after a full and fair hearing to be in the right. And it is the judge's (or jury's) solemn duty to find that out by a careful and unbiased investigation.

19. I accept that, in practice, there may well be disagreement between the patient, the detaining authority and, in a restricted case, the Secretary of State. That does not, though, make the proceedings adversarial. The tribunal is charged by statute with deciding whether the conditions for detention are satisfied. In that sense, the proceedings are inquisitorial: *Jenkins v Livesey* [1985] AC 424.

20. This does not detract from the substance of Mr Pezzani's point. There is a risk in relying on a party who takes an opposing view to filter the information that is available to the tribunal. I accept that everyone is entitled to a fair hearing. The question is: what does a fair hearing require? That question is, in the language often used under the Human Rights Act 1998, fact sensitive. In other words, it depends on the individual case.

21. The argument is that, in order to ensure a fair hearing, the tribunal should have adjourned for more information on aftercare. The power to adjourn a hearing is conferred by rule 5(3)(h) of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care) Rules 2008 (SI No 2699):

> **5 Case management powers**
>
> (1) Subject to the provisions of the 2007 Act and any other enactment, the Tribunal may regulate its own procedure.
>
> (2) The Tribunal may give a direction in relation to the conduct or disposal of proceedings at any time, including a direction amending, suspending or setting aside an earlier direction.
>
> (3) In particular, and without restricting the general powers in paragraphs (1) and (2), the Tribunal may—
>
> …
>
> (h) adjourn or postpone a hearing; …

This is a power that must be exercised judicially and consistently with the overriding objective in rule 2:

> **2 Overriding objective and parties' obligation to co-operate with the Tribunal**
>
> (1) The overriding objective of these Rules is to enable the Tribunal to deal with cases fairly and justly.
>
> (2) Dealing with a case fairly and justly includes—

(a) dealing with the case in ways which are proportionate to the importance of the case, the complexity of the issues, the anticipated costs and the resources of the parties;

(b) avoiding unnecessary formality and seeking flexibility in the proceedings;

(c) ensuring, so far as practicable, that the parties are able to participate fully in the proceedings;

(d) using any special expertise of the Tribunal effectively; and

(e) avoiding delay, so far as compatible with proper consideration of the issues.

(3) The Tribunal must seek to give effect to the overriding objective when it—

(a) exercises any power under these Rules; or

(b) interprets any rule or practice direction.

(4) Parties must—

(a) help the Tribunal to further the overriding objective; and

(b) co-operate with the Tribunal generally.

22. In this case, the argument was that Mr M could be managed in the community. That raises two questions, one general and the other specific. The general question was this: was it possible to provide aftercare that would manage someone who showed no insight into his condition and represented a danger to himself and others, particular young girls? I will assume for the sake of argument that it is possible and that such aftercare was available. The specific question was this: would such an arrangement work in Mr M's case? Given its findings on Mr M's condition and attitude, no tribunal could properly have answered this question in his favour without some specific evidence that an arrangement could work. The best way of providing this evidence would be through the experience of (unescorted) leave. The tribunal was aware of this possibility as a first step towards a possible discharge in the future. But it decided that it was not feasible until Mr M showed some insight:

> Unescorted leave would be a step in the right direction but it requires Mr M… to obtain some insight and/or become settled upon his new medication so as to eliminate his paranoid ideas.

Having reached that conclusion, the tribunal was able to answer the specific question, and its answer rendered the general question redundant.

23. No doubt, the tribunal relied on the expertise of its members in forming its conclusion. In doing so, it was able to be flexible in its approach to the proceedings by not insisting on compliance with the practice direction and it avoided delay without compromising a proper consideration of the issues that were determinative of the case. It thereby dealt with the case fairly and justly and ensured that Mr M had a fair hearing of the issues determination of his case.

Question 3

24. My third question was:

> A third thought was that there is a spectrum of cases. At one end are those in which the staff consider that the patient is on the verge of being ready for discharge. Those patients will justify a great deal of specific planning. At the other extreme are cases in which the staff consider there is no prospect of discharge. Those patients will receive minimal aftercare planning. If the tribunal considers that discharge might be possible, it can adjourn for information to be obtained. In the middle are those cases in which the staff consider that discharge is a possibility but not imminent. Those patients would justify general planning. The information provided initially will depend on where the patient is on the spectrum.

25. Mr Pezzani's answer is the information provided should be as specific as possible and referable to the patient's individual circumstances in order to ensure that decision-making is soundly based and that unnecessary adjournments are avoided. I accept that argument. I would add that, as well as the terms of rule 32(6) and the practice direction, rule 2(4) requires the parties to co-operate with the tribunal and help it further the overriding objective.

Question 4

26. My fourth question was:

> Behind that thought [ie my third question] is this point. It must be very difficult for a social worker to set out the aftercare in a vacuum. If the social worker does not believe that there is any prospect of managing a patient in the community, what sort of aftercare should the report contain? Would it not be more appropriate to leave it to the tribunal to identify possible methods of management and then investigate whether they might be achieved?

27. Mr Pezzani's answer is that if the social worker cannot answer a question in a vacuum, it is just as difficult for a tribunal. Leaving it to the tribunal to ask the question would be contrary to the rules. I accept these points. However, social workers cannot always anticipate every possibility that a tribunal may wish to explore. It is only realistic to expect that tribunals will sometimes have to ask for further information.

E. The tribunal did not assume what it had to decide

28. Mr Pezzani has made the further point that the tribunal's reason for refusing the adjournment assumed what it had to decide. In other words, the information was relevant to whether or not detention was necessary, but the tribunal had decided it was not relevant as he should remain detained. That is certainly how they appear, but that appearance is deceptive. The tribunal was not setting out in sequence the steps by which it came to its decision. That is not how tribunal decisions are written. What the tribunal was doing was explaining the decision it had already made. It set out its conclusion first and then set out

its reasons. Just as decisions of the Upper Tribunal contain the decision at the beginning and then the reasons for that decision. That arrangement does not show prejudgment.

F. Conclusion

29. The social work evidence before the tribunal may have been incomplete, even inadequate, but that did not affect the tribunal's ability to give Mr M a fair hearing and to deal with his case fairly and justly. On the tribunal's findings, Mr M had not yet progressed to the point where the issue of aftercare that was actually available would arise. Without some acceptance or insight, Mr M could not progress to the point where his management in the community could even be tested by unescorted leave, let alone where he could be conditionally discharged.

Signed on original
on 8 October 2012

Edward Jacobs
Upper Tribunal Judge