IN THE UPPER TRIBUNAL **Case No HM/1690/2019 (V)**
ADMINISTRATIVE APPEALS CHAMBER

Before: The Hon. Mr Justice Nicol (sitting as a Judge of the Upper Tribunal); Upper Tribunal Judge Christopher Ward; Judge Sarah Johnston, DCP (HESC), Judge of the Upper Tribunal

Attendances:

For the Appellant:	Mr Chris Cuddihee (instructed by Alan Harris Mental Health solicitors)
For the Respondent:	Mr Neil Allen (instructed by Enable Law)

Decision: The appeal is dismissed.

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.

REASONS FOR DECISION

Mr Justice Nicol and Judge Ward

1. This is an appeal against the decision of the First-tier Tribunal ('F-tT' or 'the Tribunal') composed of Judge Mostyn Evans, Dr Charles Montgomery, the medical member and Mrs Carey Burton, specialist lay member dated 24th May 2019.

2. As required, we record that this was a remote hearing which had been consented to by the parties. The form of remote hearing was V (Skype for Business). A face to face hearing was not held because it was not practicable due to public health constraints and all issues could be determined in a remote hearing. The documents that we were referred to are in an electronic bundle, filed by the Appellant's solicitors on 11 May 2020, plus a copy of a checklist addressing the Appellant's section 132 rights (see below), provided subsequently at the request of the panel. The Upper Tribunal's decision is set out above.

3. The appeal had originally come before Judge Ward, sitting alone, in Exeter on 2 December 2019. On establishing that the Appellant's grounds did entail a direct challenge to the correctness of the decision in *VS v St Andrew's Health Care* [2018] UKUT 250; [2019] AACR 4; [2018] MHLR 337, with the agreement of both counsel he adjourned the appeal to enable the Chamber President, Farbey J., to consider whether to direct that the case be heard by a three-judge panel. On 9

January 2020 the Chamber President did so direct, considering that the case involves an important point of principle.

4. It is often unfortunately the case that respondents are unrepresented in these appeals and we appreciated the fact that this was not so in the present appeal. We are very grateful to Mr Cuddihee and Mr Allen for their written and oral submissions.

5. The Appellant had applied to the F-tT to challenge her admission under Mental Health Act 1983 ('the MHA 1983') s.2 for assessment, as a result of which she had been detained in the hospital. Her application was pursuant to the MHA 1983 s.66(1)(a). The F-tT decided that the Appellant had lacked capacity to make the application when she had made it on 15th May 2019. The Tribunal therefore struck out the application pursuant to Tribunal Procedure (Health Education and Social Chamber) Rules 2008 ('the F-tT Procedure Rules') SI 2008 No. 2699 rule 8(3) which says,

> 'The Tribunal must strike out the whole or part of the proceedings if the Tribunal
> (a) does not have jurisdiction in relation to the proceedings or part of them...'

6. With immaterial exceptions, from decisions of the F-tT there is a right of appeal on a point of law to the Upper Tribunal. Permission to appeal is necessary – Tribunals, Courts and Enforcement Act 2007 s.11.

7. On 25th June 2019 F-tT Judge Dumont granted the Appellant permission to appeal. He did so on different grounds than had been raised by the Appellant. However, before explaining those grounds, it is convenient to set out more of the factual and legal background.

8. In view of the human rights issues which had been raised by Judge Dumont in granting permission to appeal, the Secretary of State for Health was offered the chance to participate, but he chose not to do so.

The factual background

9. The Appellant was born on 23rd May 1993. According to the medical report prepared on 22nd May 2019 by Dr Gibson, a ST4 Psychiatry doctor working under the responsible clinician, Dr Cooper, who is a consultant psychiatrist, the Appellant suffers from paranoid schizophrenia.

10. Dr Gibson records that the Appellant had one previous spell in a psychiatric hospital. That had been in 2016.

11. On 7th May 2019, the Appellant was detained for assessment at the Bridford Ward of the Glenbourne Unit under s.2 of the MHA 1983. The Glenbourne Unit is run by the Respondent.

12. The application for her admission to the hospital under s.2 of MHA 1983 was dated 7th May 2019. It was supported, as required, by the opinion of two doctors: Dr Ishaan Gogaz and Dr Leanne Tozer (who were both approved under s.12 MHA 1983).

13. At that stage, the Appellant was heavily pregnant. It was estimated that by 25th May 2019 she would be 36 weeks into her pregnancy. The hospital recognised that it would be desirable for her to be transferred to a Mother and Baby Unit, but at the time of the hearing before the Tribunal there was no available space.

14. The nursing report (dated 20th May 2019) gives some further background to the circumstances of her admission to hospital. This followed deterioration in her mental health. As the nursing report commented 'Her support network of her mental health professionals, her mother and father and her community midwife had concerns regarding her mental health and her vulnerability'. The baby's father was not included in 'her support network' and elsewhere in the nursing report it is mentioned that he and she were no longer together.

15. The nursing report also noted that she was unwilling to have contact with her parents. It also said that physical intervention had sometimes been necessary to administer prescribed drugs - Lorazepam and Olanzapine. At one point the nursing report observed, 'she would like to be discharged.'

16. As we have said, she made an application to the F-tT under the 1983 Act s.66(1)(a) on 13th May 2019 (the form was dated 23rd May, but the Tribunal accepted that was an error). The application was received by the Tribunal on 15th May 2019.

17. In preparing for the tribunal hearing she had the support of Mr Rob Houghton, who was an Independent Mental Health Advocate ('IMHA'), appointed under MHA 1983 s.130A-130C.

18. The MHA 1983 s.132 places an obligation on the Respondent to take steps to explain to a detained person (among other matters) under what powers he or she is being detained and the available remedies for challenging their detention. The Code of Practice issued under MHA 1983 s.118 develops the content of the obligation (see e.g. para.4.15). The evidence about what had been done in the present case, and when, was somewhat equivocal. We were shown the form that had been completed in relation to the Appellant. Question 22 on the form asked whether Section 132 rights had been successfully completed. It

seems in the Appellant's case they had not because a date when they were to be re-attempted was given. This was 26th May 2019 which, as it happened, was after the F-tT hearing. However, Questions 2 and 6, which dealt respectively with explaining the section under which the Appellant was detained and the right to apply to the Tribunal had been ticked, indicating (according to the rubric at the top of the form) not merely that information had been imparted, but that the patient understood. It may therefore be that the reasons why Section 132 rights required to be re-attempted was because of other information requiring to be imparted and understood that is not relevant for present purposes. However, the only clear date on the form is 22 May 2019 (i.e. well after the application to the Tribunal was made). Entries in the care plan on this particular issue are limited and appear unclear as to the date as of which they are speaking while the very brief entry on the admissions documentation dated 7 May 2019 records that the Appellant was informed of her rights but gives no indication whether or not she understood them.

19. On 22nd May 2019, the nature of the Appellant's detention changed. Thereafter she was detained for treatment pursuant to MHA 1983 s.3 (instead of for assessment under s.2). No one suggested that this change affected the power of the Tribunal to consider her application (although the justification for her detention would need to be considered against the conditions in s.3). We return below to the law on this matter.

20. On 23rd May 2019, Dr Montgomery, the medical member of the Panel, conducted a pre-hearing examination of the Appellant, as required by r.34 of the F-tT Procedure Rules.

21. The hearing by the Tribunal took place on the following day, 24th May 2019. The Appellant was represented, then as now, by Mr Cuddihee. The responsible authority, Livewell Southwest, was not then represented.

22. Dr Montgomery reported to the Panel that from his pre-hearing examination he found the Appellant to have a

> 'very limited understanding that she was detained under the Mental Health Act 1983 or that the Tribunal was a body which will be able to decide whether she could be released. Indeed, he could find no evidence that she was able to understand either of these points.'

23. Dr Gibson told the Tribunal that the Appellant,

> 'did not and has never had during her admission the ability to understand what a mental health review tribunal means. He said she not fully understand what detention means, and she did not

understand that a tribunal could discharge her. He said he had discussed these matters with her at length, but she told him several times that she had not appealed.'

24. The Tribunal recorded that Mr Cuddihee said that he had explained the tribunal process to the Appellant on the morning of the hearing, but her response was that,

> 'she did not need to attend the tribunal, but just needed to leave.'

25. The Tribunal made enquiries as to whether Mr Houghton (the IMHA) could be contacted, but without success.

26. The Tribunal did consider whether to adjourn the hearing to allow further time to try to make contact with Mr Houghton. However, it decided not to do so. Its reasons were as follows:

    a. The present application had started as a challenge to an order under s.2 of the MHA 1983. However, an order under s.3 of the 1983 Act was now in place. That had two consequences:

        i. An order under s.2 lasts only for 28 days. There is therefore an urgency to the hearing which challenges the legality of a s.2 order (as we explain below). An order under s.3 can last (in the first place) for 6 months. There was therefore no longer the same need for the legality of the patient's detention to be determined before the 28 days expired.

        ii. The patient would have a further right to challenge the s.3 order (if she had the capacity to do so).

    b. The Appellant was likely to be moved to a Mother and Baby Unit imminently. That could be anywhere in the country. It was not known whether Mr Houghton would be able to attend an adjourned Tribunal hearing, wherever that might be.

    c. Because the Appellant was due to give birth very shortly, any adjournment was likely to have to be for some considerable time.

    d. If the decision was made that day to strike out the application because of the Appellant's lack of capacity to make the application, an immediate request could be made to the Secretary of State for Health to refer the matter to a Tribunal pursuant to MHA 1983 s.67 (see below). The Tribunal commented,

> ‘As she clearly does not want to be in hospital and has not had a hearing within her s.2, a referral would seem appropriate.’

27. The Tribunal was conscious of its duty under Rule 8(5) of the F-tT Procedure Rules to give the Applicant an opportunity to make representations as to the proposed striking out before taking that step. It gave Mr Cuddihee the opportunity to consult further with his client. After doing so, he reported that the Appellant,

> ‘had acquired some understanding and wanted to attend the tribunal. but he did not assert she had acquired capacity to make the decision today. As we have set out above, the relevant date for capacity is in any event the date the application form is signed.’

28. The Tribunal directed itself as to the law. It expressly took into account the Mental Capacity Act 2005 (to which we return below) and authorities of this Tribunal including, notably, *VS* (see [3] above).

29. Mr Cuddihee told us that, after the hearing in the F-tT, the Appellant had been found a place in the Mother and Baby Unit in Exeter. She had given birth to a baby girl and that mother and daughter were well.

30. Judge Dumont granted permission to appeal to the Upper Tribunal on 25th June 2019. On 30th July 2019 Dr Cooper, the responsible clinician, discharged the Appellant. In consequence, the outcome of this appeal will not have any immediate impact on the Appellant, but it appeared to us that the issues which Judge Dumont raised were of sufficient importance (because they were likely to recur) that it was useful for us to consider them nonetheless. Neither party to the appeal suggested that we should act otherwise.

31. Before turning to Judge Dumont’s permission to appeal, it is convenient to consider the legal background.

Legal Background

32. As we have said, the Appellant was initially detained for assessment under Mental Health Act 1983 s. 2.

33. By s. 2(2),

> ‘An application for admission for assessment may be made in respect of a patient on the grounds that—
>
> (a) he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a

> hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and
> (b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.'

34. The 'application' to which s.2(2) refers is an application by two doctors who confirm that, in their opinion, the conditions in s.2(2) are fulfilled. The application for admission to the hospital is, of course, to be distinguished from the application to the Tribunal.

35. Subject to an immaterial exception, detention for assessment under s.2 cannot continue for longer than 28 days (see MHA 1983 s.2(4)).

36. The MHA 1983 s.66(1)(a) provides that,

> 'Where a patient is admitted in pursuance of an application for admission for assessment ... an application may be made to the appropriate tribunal ... within the relevant period by (i) the patient.'

37. MHA 1983 s.66(1)(b) makes a comparable provision in relation to a patient who is admitted to hospital in pursuance of an application for admission for treatment.

38. By MHA 1983 s.66(2)(a) 'the relevant period' for an application within s.66(1)(a) is 14 days (we recall that there is a need for urgency because the period for which a person can be admitted under s.2 is limited to 28 days.) That same need for urgency in the case of a s.66(1)(a) application informs the obligations under FtT Procedure Rules r.37(1) to start the hearing of the application within 7 days of its receipt by the Tribunal[1]; to give 3 days-notice of the hearing, rather than the usual 14 days-notice r.37(4)(a); and for the Tribunal to give its decision within 3 days of the hearing – see r.41(3)(a). Initially, 'the relevant period' for an application concerning an admission under s.3 is 6 months – see s.66(1)(b) and (2)(b)

39. By s.66(1)(a) what founds the Tribunal's jurisdiction is an 'application'. The F-tT Procedure Rules r.32(1) states the requirements for an application. It must be

> '(a) in writing,
> (b) signed in the case of an application, by the Applicant or any person authorised by the Applicant to do so; and

[1] In fact the F-tT was not able to list the hearing in compliance with these rules. The application was received by the Tribunal on 15th May 2019. The hearing was listed for 24th May 2019 – see the listing direction of 15th May 2019.

(c) sent or delivered to the Tribunal so that it is received within the time specified in the Mental Health Act...'

40. The Tribunal may order the patient to be discharged and, in certain cases, must do so – see MHA 1983 s.72.

41. Only one application can be made in respect of admission for assessment and, in respect of a patient admitted for treatment, no more than one application in the first or second 6 month period and thereafter no more than one annually – see MHA 1983 ss.20, 66(1)(b) and (f) and (2)(b) and (f) and 77(2).

42. An application by or on behalf of the patient is one way that the Tribunal can become seized of a case, but there are two others of particular importance:

    a. By MHA 1983 s.67(1),
    'The Secretary of State may if he thinks fit at any time refer to the appropriate tribunal the case of a patient who is liable to be detained ... under Part II of this Act.' [Part II includes s.2 and s.3].

    b. By MHA 1983 s.68 the managers of a hospital have a default obligation to refer cases to a tribunal (a) within 6 months of admission if the patient has not made an application and the Secretary of State has not made a referral under s.67 and (b) if more than 3 years have passed since the case was last before the tribunal (12 months if the patient is under 18).

43. By MHA 1983 s.118 the Secretary of State is obliged to issue a Code of Practice. The current issue of the Code says of the Secretary of State's power under s.67, 'Anyone may request such a reference.' – see paragraph 37.44.

44. The Code continues,

'37.45 Hospital managers should consider asking the Secretary of State to make a reference in respect of any patients whose rights under Article 5(4) of the ECHR might otherwise be at risk of being violated because they are unable (for whatever reason) to have their cases considered by the tribunal speedily following their initial detention or at reasonable intervals afterwards.
37.46 In particular, they should normally seek such a reference where...
* The patient lacks capacity to make a reference, or
* Either the patient's case has never been considered by the tribunal or a significant period has passed since it was last considered.'

45. The Code also addresses the role of the IMHAs. It says,

> '6.12 The Act says that the support which IMHAs provide must include helping patients to obtain information about and understand the following:
> • their rights under the Act …
>
> 6.13 The Act enables IMHAs to help patients to exercise their rights, which can include representing them and speaking on their behalf, e.g. by accompanying them to review meetings or hospital managers' hearings. IMHAs support patients in a range of other ways to ensure they can participate in the decisions that are made about their care and treatment, including by helping them to make applications to the Tribunal.
>
> 6.14 The involvement of an IMHA does not affect a patient's right (nor the right of their nearest relative) to seek advice from a lawyer. Nor does it affect any entitlement to legal aid. IMHAs may, if appropriate, help the patient to exercise their rights by assisting patients to access legal advice and supporting patients at Tribunal hearings.'

46. When performing the functions in the F-tT Procedure Rules the Tribunal need to consider Rule 2. This is as follows;

> '(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.'
> …'

47. Existing caselaw establishes that in relation to questions of capacity, the FtT in its mental health jurisdiction should apply the principles and

approach set out in the Mental Capacity Act 2005 ('MCA 2005') and the Code of Practice: *YA v Central and North-West London NHS Trust and others* [2015] UKUT 37 (AAC); [2015] AACR 31; *VS* at [9]) so we therefore turn to that Act.

48. Sections 1-3 of the MCA 2005 provide,

> '1 The principles
>
> (1) The following principles apply for the purposes of this Act.
> (2) A person must be assumed to have capacity unless it is established that he lacks capacity.
> (3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
> (4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
> (5) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
> (6) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.
>
> 2 People who lack capacity
>
> (1) For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.
> (2) It does not matter whether the impairment or disturbance is permanent or temporary.
> (3) A lack of capacity cannot be established merely by reference to–
>
> (a) a person's age or appearance, or
> (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.
>
> (4) In proceedings under this Act or any other enactment, any question whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities.
> (5) No power which a person ("D") may exercise under this Act–

(a) in relation to a person who lacks capacity, or
(b) where D reasonably thinks that a person lacks capacity,

is exercisable in relation to a person under 16.
(6) Subsection (5) is subject to section 18(3).

3 Inability to make decisions

(1) For the purposes of section 2, a person is unable to make a decision for himself if he is unable–
(a) to understand the information relevant to the decision,
(b) to retain that information,
(c) to use or weigh that information as part of the process of making the decision, or
(d) to communicate his decision (whether by talking, using sign language or any other means).
(2) A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).
(3) The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.
(4) The information relevant to a decision includes information about the reasonably foreseeable consequences of–
(a) deciding one way or another, or
(b) failing to make the decision.'

49. As a result of the Human Rights Act 1998 s.3, courts and tribunals must interpret domestic legislation so far as possible compatibly with the rights under the European Convention on Human Rights which are set out in Schedule 1 to the Act. They include the right to liberty and security in Article 5 ECHR which, so far as is material, says,

'(1) Everyone has the right to liberty and security of the 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 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.'

50. The Secretary of State's Code of Practice says the following of the role of Tribunals,

> '12.3 The First-tier Tribunal (Mental Health) ('the Tribunal') is an independent judicial body. Its main purpose is to review the cases of detained and conditionally discharged patients and patients subject to community treatment orders (CTOs) under the Act ('community patients') and to direct the discharge of any patients where it thinks it appropriate. It also considers applications for discharge from guardianship.
>
> 12.4 The Tribunal provides a significant safeguard for patients who have had their liberty curtailed under the Act. Those giving evidence at hearings should do what they can to help enable tribunal hearings to be conducted in a professional manner, which includes having regard to the patient's wishes and feelings and medical condition and ensuring that the patient feels as comfortable as possible with the proceedings.'

51. The F-tT in the present case applied the test of capacity formulated by Upper Tribunal Judge Jacobs in *VS*. Judge Jacobs had said that,

> 'The patient must understand that they are being detained against their wishes and that the First-tier Tribunal is a body that will be able to decide whether they should be released.'

52. Judge Jacobs noted that the F-tT Procedure Rules provided in Rule 11 that

> '(7) In a mental health case, if the patient has not appointed a representative, the Tribunal may appoint a legal representative for the patient where—
>
> (a) the patient has stated that they do not wish to conduct their own case or that they wish to be represented; or
>
> (b) the patient lacks the capacity to appoint a representative, but the Tribunal believes that it is in the patient's best interests for the patient to be represented.'

53. Judge Jacobs argued that the test of capacity to initiate an application to the Tribunal must be less than what he described (in *VS* at [15]) as the 'demanding' test of capacity to conduct proceedings in the Tribunal, as analysed by Charles J. in *YA.* Were they the same then whenever a representative was appointed under r.11(7)(b), it would mean that there was no valid application and the application to the Tribunal would have to be struck out. That could not have been the intention. As Judge Jacobs said at [16] of *VS*,

> 'It is appropriate for there to be a minimal control over access to the tribunal and its powers to review a patient's detention. It is not necessary to resort to Article 5 of the European Convention on Human Rights to justify this approach. It has ample support in the centuries-old concern of the common law to protect the liberty of the subject.'

54. Judge Jacobs did not think that it was necessary for an applicant to understand that an application could be withdrawn. That would add to complexity and be a long way from the simple and clear approach that he thought appropriate for the initial jurisdictional hurdle.

55. We have noted that the reason for the Appellant's detention had changed by the time the hearing of the application to the Tribunal took place. She was no longer being detained for assessment under s.2 of the MHA 1983, but for treatment under s.3. This change did not deprive the Tribunal of jurisdiction to consider the application. As Collins J. said in *R v South Thames Mental Health Review Tribunal ex parte M* [1998] COD 38, what founded the jurisdiction of the Tribunal was the admission, not the actual detention. Admission occurred at a particular point in time rather than being a continuing event. A different course was taken by Stanley Burnton J. in *R (SR) v Mental Health Review Tribunal* [2005] EWHC 2913 (Admin) but that concerned a different issue and one which under current legislation no longer prevails. The decisions in *ex parte M* and *SR* were recently subjected to penetrating analysis by Judge Jacobs in *AD'A v Cornwall Partnership NHS Trust* [2020] UKUT 110 (AAC) and we respectfully agree with his conclusion, including with his view that the reasoning of *ex parte M* is sound.

The application for permission to appeal and the Grounds on which Judge Dumont granted permission to appeal

56. The application for permission to appeal to the Upper Tribunal was on the grounds that the F-tT had erred in law because:

    a. 'It failed to give appropriate weight to all available evidence about the patient's capacity and to do so should have adjourned to seek further evidence from the IMHA who helped the patient make the application and the nurse who had completed the s.132 process.

    b. In concluding that the patient failed to understand that the tribunal could release her the tribunal had not given appropriate weight to the fact that the patient attended the tribunal and gave insufficient weight to the fact that the IMHA will have completed his own capacity assessment before assisting with the application and this 'best evidence' should have been sought

before a conclusion was reached that the patient lacked capacity.'

57. Judge Dumont did not agree that the F-tT had arguably erred in law on either of these grounds, but he did grant permission to appeal to the Upper Tribunal on the following grounds,

    i) 'The case illustrates the enormous difficulties facing a mental health tribunal when issues surface for the first time at a hearing about the patient's capacity at some point in the past to make a decision about applying to the tribunal. The tribunal is faced with the forensically difficult task of reconstructing a picture of the patient's earlier capacity from various historical sources (and in the context of a presumption of capacity), an exercise which may appear to be unduly legalistic if by the time of the hearing the patient's capacity has changed (in the present case it was argued on the patient's behalf that there was greater understanding of the role of the tribunal in discharging the Section by the time of the hearing).

    ii) There is a low threshold for capacity to make application to a mental health tribunal but even this low threshold appears to sit uneasily with the government's response to the case of *MH v United Kingdom* (2014) 58 E.H.R.R. 35; (2014) M.H.L.R. 249 (at para 87) where the role of IMHAs was extended and consolidated by the Mental Health Act 2007 so that patients (including incapacitated patients) could obtain advice about their rights under the 1983 Act including making application to a tribunal. In the present case an IMHA was involved, assisted the patient with application but the application then foundered on issues of capacity.

    iii) There appears to be no duty on any person to notify the Secretary of State of a person who might benefit from a referral under Section 67 of the Act and therefore a patient such as the patient in this case does not have reliable means for the grounds of detention to be tested and challenged and is disadvantaged in relation to patients with capacity to make application.'

58. Mr Cuddihee had not applied to renew the grounds on which Judge Dumont had declined to grant permission to appeal. We consider that this was sensible since we agree with Judge Dumont that neither of them was a reasonably arguable basis for alleging that the F-tT had erred in law. In those circumstances, Mr Cuddihee agreed that his original grounds were only of historical interest.

59. We turn now to the points raised by Judge Dumont's first indent. It is convenient to subdivide the points he raises.

Prior Notice of the issue of capacity

60. It is worth stressing that the legislative structure does *not* require an automatic review of every decision to detain a mental patient as soon as, or shortly after, it comes into effect. The patient can choose to apply. The Secretary of State may refer a case to the Tribunal. As we have explained, there can come a time when the hospital managers are obliged to refer the case to the tribunal, but where it is the patient who takes the initiative, it is the patient's application which is the foundation of the tribunal's jurisdiction.

61. Mr Cuddihee emphasised that neither the legislation nor the F-tT Procedure Rules say anything about the applicant needing to have capacity to apply. While that is true, and while it is also true that the F-tT Procedure Rules r.8(4) expressly lists other grounds on which an application may be struck out, we do not think that the point goes anywhere. We do not think it surprising that the legislation and rules should be silent on a matter which would be taken for granted.

62. We sympathise with the Tribunal which, as we agree, had no choice but to address the issue of the Appellant's capacity once their concerns were raised. After all, irrespective of whether the Respondent took the point, this was a matter which went to their jurisdiction and, as such, it could not be ignored.

63. However, if at all possible, the hospital should have alerted the Appellant and Mr Cuddihee in advance of the hearing that there were concerns as to her capacity to make an application. And there were signs that there might be these concerns. We have already mentioned the equivocal impression to be derived from the available paperwork and it is certainly not possible to feel confident from it that at the relevant time anyone had informed the Appellant of the matters to which for present purposes her capacity needed to extend and that she had understood. Her lack of capacity is referred to in the nursing report of 20th May 2019. Dr Gibson completed his report on 22nd May 2019. He, too, had concerns about the Appellant's capacity.

64. Whilst acknowledging the tight timescale on which all have to work in s.2 cases, had the Appellant been given notice of these concerns, it is possible that greater efforts would have been made to contact the IMHA, Mr Houghton, and secure his attendance at the Tribunal. We therefore agree with Judge Dumont that it was unfortunate that the issue of the Appellant's capacity was only raised at the hearing.

Forensic difficulty in reconstructing capacity in the past?

65. We do not, however, agree that the issue could be avoided because of the difficulty of trying to decide what the Appellant's capacity had been at the time that she completed her application to the Tribunal. No doubt it is difficult to reach a determination as to someone's mental capacity in the past, but we are not persuaded that it is inherently more difficult than other factual decisions which courts and tribunals have to make all the time and which all relate to matters in the past.

66. The forensic difficulty might be eased if, at the time the application form was submitted, a contemporary record was made as to the medical and nursing staff's opinion of the patient's ability to understand that she was detained and the ability of the Tribunal to direct her release. We note that form T132, which has to be completed by the Mental Health Act Administrator contains a question going to capacity for other purposes (whether the patient has capacity to decide that he/she does not want the nearest relative involved), and perhaps it could be modified to address capacity to apply to the Tribunal also. There may also be scope for hospitals to review the paperwork discussed at [18] above or its equivalent so that it could carry greater evidential value on this issue.

Change in capacity between application and hearing

67. We are not sure that this was the situation in the present case. There certainly was no positive finding by the F-tT that the Appellant had regained capacity by the time of the hearing. The opinion of Dr Gibson was that she had not at any time during her detention had the understanding required by *VS* and Dr Montgomery (the medical member of the F-tT panel) saw her only once and that on the day before the hearing. His view was that she did not then have capacity.

68. The F-tT was right to say that what mattered was the patient's capacity when the application was made. However, if in a future case, the Tribunal did believe that the applicant had attained capacity at the time of the hearing which he or she had lacked when the original application was made, we consider that it would be perfectly consistent with the rules for the Tribunal to invite the applicant to complete and deliver a fresh application and abridge any notice for the new application to be heard there and then.

Judge Dumont's second indent: whether the test of capacity in VS should be reduced further?

69. We raised with the parties whether the F-tT had properly applied the presumption in favour of capacity (as required by the MCA 2005 s.1(2)). We had in mind paragraph 29 of its decision where the F-tT said,

> 'We have, and still find that there is no evidence that the Appellant had any idea that a tribunal had power to discharge her at the time the application form was completed or at any time up until the day of the hearing. She clearly wanted to leave, but there is no evidence that she understood that she was detained and merely said that she intended to leave.'

70. Because a person is presumed to have capacity, it was inappropriate, as Mr Allen for the Respondent conceded, for the Tribunal to speak of the absence of positive evidence of capacity. What would have been material (because of the presumption) would have been evidence of *incapacity*. However, Mr Allen persuaded us that it was wrong to look at this one paragraph in isolation. He submitted that looking at the decision as a whole, it was plain that the Tribunal had not misdirected itself as to the effect of the presumption. We agree.

71. As we have shown, the test in *VS* has two parts: does the applicant understand that she is detained; and does she understand that the Tribunal has power to discharge her?

72. As to the first part of the test, this might be re-phrased as 'Does she realise that she is not free to leave the hospital?'

73. The second part of the test certainly does not require a sophisticated understanding of the nature of the Tribunal's powers. It requires only an understanding that the Tribunal can authorise her to leave the hospital. This is perhaps just as well. In the course of summarising Dr Gibson's evidence, the Tribunal said,

> 'He discussed these matters with [the Appellant] at length, but she told him several times that she had not appealed.'

74. As Mr Allen accepted, on this point the Appellant was quite right: she had not appealed. The Tribunal's jurisdiction is original and not appellate. Judge Jacobs in *VS* noted that the same mistake had been made by one of the F-tT judges in that case. But, as Judge Jacobs also said at [27],

> 'Understanding the nature of a tribunal is only required to the extent that it represents a way to obtaining release from detention.'

75. Mr Cuddihee submitted that the two-part test in *VS* was unworkable. It should be sufficient that the applicant wants to leave the hospital. He argued:

    a. The test needed to be as simple as possible.

b. It was particularly important to have a straightforward test where the detention was under MHA 1983 s.2 because of the need for a particularly speedy resolution of the hearing. The detention under s.2 could last a maximum of 28 days. The hearing had to take place within 7 days of the application being received by the Tribunal.

c. The Tribunal had a special expertise, but that could not be brought to bear if the application was struck out for want of capacity. As the House of Lords said in *MH v Secretary of State for Health* [2005] UKHL 60 at [23],

> ‘Given that the Convention is there to secure rights that are “practical and effective” rather than “theoretical and illusory” this is a powerful argument. But it does not lead to the conclusion that section 2 is in itself incompatible with the Convention or that the solution is to require a reference in every case. Rather, it leads to the conclusion that every sensible effort should be made to enable the patient to exercise that right if there is reason to think that she would wish to do so.’

Mr Cuddihee submitted the *VS* test was not compatible with ‘every sensible effort being made’ to enable a patient in the Appellant’s position to exercise her right of challenge to her detention.

d. The House of Lords had held in *MH* that there had been no violation of Article 5(4) of the European Convention on Human Rights, but the Strasbourg Court took a different view in *MH v United Kingdom* (2014) 58 EHRR 35. In advance of that adverse judgment, the MHA 1983 had been amended by the Mental Health Act 2007 to introduce Independent Mental Health Advocates (‘IMHAs’). In the present case the IMHA had assisted the Appellant to complete the application and yet still her application had been struck out for want of capacity.

e. In *MH v UK* the Strasbourg Court had emphasised the importance of remedies being practical and effective. It had said (at [76]),

> ‘Nevertheless, Article 5 § 4 guarantees a remedy that must be accessible to the person concerned and must afford the possibility of reviewing compliance with the conditions to be satisfied if the detention of a person of unsound mind is to be regarded as “lawful” for the purposes of Article 5 § 1 (e) (see *Ashingdane v. the United Kingdom*, (1985) 7 EHRR 528, 28 May 1985, § 52, Series A no. 93). The Convention

> requirement for an act of deprivation of liberty to be amenable to independent judicial scrutiny is of fundamental importance in the context of the underlying purpose of Article 5 of the Convention to provide safeguards against arbitrariness. What is at stake is both the protection of the physical liberty of individuals and their personal security (see *Varbanov v. Bulgaria*, no. 31365/96, BAILII: [2000] ECHR 457, § 58, ECHR 2000-X).'

At [77(e)] it went on to make the point that

> 'special procedural safeguards may be called for in order to protect the interests of persons who, on account of their mental disabilities, are not fully capable of acting for themselves.'

76. Mr Allen submitted that the *VS* test of capacity was correct. He argued:

    a. It would not be sufficient simply to have a test that the applicant wanted to leave the hospital:

        i. It was important to distinguish voluntary from involuntary patients, but a test solely based on a wish to leave the hospital would not do that. It was necessary to include an appreciation that the patient was detained against her will.

        ii. The second part of the *VS* test was also important. The patient had to appreciate that the Tribunal could order her release. The MCA 2005 was concerned with decisions. The relevant decision here was to apply to the Tribunal and what was in issue was whether the Appellant had the capacity to make that decision. A wish (for instance, to leave the hospital) was not a decision. The MCA 2005 carefully distinguished between wishes and decisions: see for instance the reference to the person's wishes in s.4(6)(a).

    b. In *N v A Clinical Commissioning Group and others* [2017] UKSC 22, [2017] AC 649 the Supreme Court had emphasised that the Mental Capacity Act was concerned with decisions which it was open to the person concerned to take. In that case, the Clinical Commissioning Group had not been willing to offer what the parents of the individual wanted to achieve. Their approach could be challenged only by judicial review and not via the MCA. Mr Allen argued likewise the Appellant's wish to leave the hospital could not be achieved unless the Responsible Clinician

discharged her or the Tribunal ordered her discharge. Her bare wish to leave the hospital was nothing to the point.

77. In our judgment the test of capacity formulated in *VS* is accurate and appropriate. Our reasons are as follows:

    a. We repeat that the present legislative structure does not include an automatic referral to the Tribunal to test the legality of the patient's detention. In *MH v UK* the Strasbourg Court rejected the proposition that such an automatic referral was required by Article 5(4) of the ECHR.

    b. Instead the system chosen by our legislature depends in the first place on there being an 'application' to the Tribunal.

    c. It is the case, as we have said, that there is no express requirement for the person who makes such an application to have capacity. However, we draw no conclusion from this. It is entirely unsurprising that that sort of matter should have been left to implication.

    d. The making of an application has consequences. Only one application under s.66(1)(a) can be made. Under s.66(1)(b) only one application can be made every 6 months. We consider it sensible and appropriate that there should be *some* test of capacity for an 'application' to have those consequences.

    e. The test of capacity in *VS* is deliberately couched at a low level. That is consistent with what Lady Hale in *H* (at [4]) described as the 'very limited capacity required to make an application'. As Judge Jacobs said, it would not be appropriate for the test as to capacity to initiate an application to be the same as the test of capacity to conduct the application. That would be too demanding. It would also, as Judge Jacobs also said, (though rather more diplomatically) make a nonsense of the power to appoint a representative for a patient who became incapacitated after starting the application.

    f. It may be thought that those who have been subjected to detention under the MHA 1983 will be more likely, because of their mental ill health to lack capacity. That may be, but plainly there is not an automatic equation between the two.

    g. Measures have been taken to assist patients who are detained so that they do have sufficient understanding of what is involved to make an application. (As Judge Dumont observed in granting permission to appeal, the government's response to the judgment in *MH v UK* drew attention to the provisions for IMHAs

in the Mental Health Act 2007). Notably these include the mandatory explanation of rights under MHA 1983 s.132 and the assistance which can be (and was in the present case) offered by an IMHA.

h. However, Parliament has stopped short of giving an IMHA the power to make an application to the Tribunal on behalf of an incapacitated patient. That omission must have been deliberate. The difficulty faced by an incapacitated patient was apparent from the *MH* litigation (which had reached the House of Lords, if not the Strasbourg Court, by the time the Mental Health Bill 2007 was before Parliament) and the 2007 Act did specifically address the issue of incapacitated patients in other respects (see, for instance MHA 1983 s.130B(4) and s.130C(4A)). We note that *Modernising the Mental Health Act: increasing choice, reducing compulsion: the Final Report of the independent review of the Mental Health Act 1983* (2018) p.124 recommended giving IMHAs such a power, but so far that legislative change has not yet been made.

i. In the present case there was the added complication of the Appellant's pregnancy. In our view the F-tT gave perfectly rational reasons why it decided against adjourning the hearing to see whether it could hear evidence from Mr Houghton, the Appellant's IMHA.

j. We agree with Mr Allen that the legislation does distinguish between 'wishes' (which may, for instance, include a wish to leave the hospital) and decisions. We also agree that the relevant decision in the present case was the decision to make an application to the Tribunal. We cannot see how the test for capacity to make that decision could be less than Judge Jacobs analysed in *VS*.

k. In our view the test for capacity to make an application under s.66(1)(a) (where the issue will be whether the patient could be detained under MHA 1983 s.2) must be the same as the test for capacity under s.66(1)(b) (where the issue will be whether the patient could be detained for treatment under MHA 1983 s.3). After all, in both paragraphs the legislation refers to 'an application' and, in accordance with the usual canons of statutory interpretation, one would expect Parliament to have intended that the same word had the same meaning in the two paragraphs.

l. There are alternative ways by which the Tribunal can have jurisdiction to determine the legality of detention. Notably, there is the Secretary of State's power to make a reference under

MHA 1983 s.67. In the present case no one raised that possibility with the Secretary of State. We will return to that topic when we turn to Judge Dumont's third indent.

m. The legislative scheme with which we are concerned has significant differences to that which governs situations where it is thought necessary to deprive someone of their liberty. Both situations may involve people with mental ill health, but the legislative structures differ. Thus, there is scope for the legality of detention to be reviewed by the Court of Protection. Such a review may be triggered by the person concerned, but it may also be initiated by the 'Relevant Person's Representative' -see Mental Capacity Act 2005 Schedule 1A paragraph 102(3)(b). We respectfully do not consider that the second of the two limbs of para.86(1) of *RD* can bear the weight Judge Johnston seeks to place on it; it is discussing what the position is where the patient does not have capacity, rather than indicating when she should be taken to have it, and is a reflection of the existence of the role of Relevant Person's Representative with its attendant responsibilities. Because of these differences, we have not found the analogy with the situation in the Court of Protection to be particularly helpful.

Judge Dumont's third indent: whether someone should have the responsibility for suggesting that the Secretary of State might make a referral to the Tribunal and, if so, who?

78. It is a striking feature of this case that the legality of the Appellant's detention was never considered by a Tribunal. There are, as we have just said, alternative means for engaging the Tribunal's jurisdiction, but none of them were triggered. In part, of course, that is because the Appellant was discharged on 30th July 2019. That meant that the default obligation on the hospital managers to refer a detained patient's case to the Tribunal under MHA 1983 s.68 never arose: the Appellant was discharged long before she had been detained in the hospital for 6 months.

79. Yet the general point raised by Judge Dumont's third indent is highly pertinent. The Tribunal itself recognised the value of such a step. It said,

> 'As she clearly does not want to be in hospital and has not had hearing within her section 2, a review would seem appropriate.'

80. Before us the parties considered the possibilities that either the IMHA or the hospital managers should have raised the issue with the Secretary of State. As between these two, we recognise that the IMHA would seem the more appropriate since it is the IMHA who advises the patient and will have had an opportunity to understand her wishes. On the other

hand, the Code paragraph 37.45-37.46 specifically says that the hospital managers should raise the matter with the Secretary of State inter alia where the patient lacks capacity to do so herself.

81. However, in our view there is a third alternative, namely that the Tribunal itself should in circumstances such as these, raise with the Secretary of State the possibility of making a referral. After all, as we have just recalled, the Tribunal itself felt able to assess that the Appellant did not want to be in hospital. Unless she was detained in hospital for 6 months, the hospital managers would not have an obligation to refer her case to the Tribunal. The only other way that there could be a review would be if the Secretary of State exercised his powers of referral under MHA 1983 s.67.

82. The Secretary of State's Code of Practice (paragraph 37.44) says that 'anyone' may raise with the Secretary of State the possibility of making a reference and, if the Tribunal itself did so, it would minimise delay.

83. We have considered whether the Tribunal should consider adjourning the hearing for a short period to allow the Secretary of State, if he chose to do so to make a reference. In other cases that might be an option for the Tribunal to consider. In the present case, an adjournment would have been impracticable for the same reasons as the Tribunal gave for not adjourning to allow the IMHA, Mr Houghton, the opportunity to give evidence to them.

Conclusion

84. In our view, there was no error of law in the F-tT's decision and, accordingly we dismiss the appeal. Because the Appellant had been discharged long before the hearing before us, the appeal has no immediate practical relevance to her.

85. However, we are grateful to Mr Cuddihee and Mr Allen for their submissions which have allowed us to respond to the more general issues which Judge Dumont considered that the case raised.

86. Procedure:

    a. Wherever possible the applicant and her representatives should be alerted that her capacity to make the application may be an issue. In the present case the Respondent knew from the Nursing Report and the report of Dr Gibson that that might be so and in consequence the Respondent should have alerted the applicant.

    b. If the Tribunal considers that the applicant's capacity has fluctuated and, while she did not have capacity at the time of the

application, she does have capacity at the time of the hearing, the Tribunal should consider inviting the applicant to make a fresh application, abridging any of the procedural obligations and proceeding to consider the substance of the application. We accept that there is no basis for contending that this was the situation in the present case.

c. Otherwise, the F-tT was correct that what matters is whether the applicant had capacity at the time the application was made. Making a decision as to that issue may be difficult, but it is no different from the task that courts and tribunals are regularly called to make about events in the past.

87. The test for capacity:

a. We agree with and endorse the test of capacity in *VS v St Andrew's Health Care*. In summary the applicant must have sufficient understanding that she is detained and that the Tribunal has the power to release her from that detention.

b. Like Judge Jacobs in that case, we emphasise

i. The test is less demanding than that required for the conduct of an application.

ii. It is not necessary that the patient has a sophisticated understanding of the powers of the Tribunal: it is sufficient if she understands that the Tribunal can order her release.

88. Suggesting a referral to the Secretary of State:

a. The Code says that hospital managers should raise this possibility with the Secretary of State if, among other reasons, the patient lacks capacity to do so herself.

b. However, the Code also says that anyone can make such a suggestion to the Secretary of State. The IMHA who will have seen the patient and had the opportunity to assess their wishes would be well suited to make the suggestion to the Secretary of State, if the IMHA considered that the patient wished to leave but lacked capacity to make an application to the Tribunal.

c. A third possibility would be the Tribunal itself. In a case, such as the present, where the Tribunal had found (a) that the patient lacked capacity, but (b) wished to leave the hospital, it would have been very sensible for the Tribunal to have done so.

d. Indeed, in other cases (uncomplicated by the patient's pregnancy and imminent confinement in this case) a combination of these factors may well lead the Tribunal to consider whether, before striking out the application, it would be sensible to adjourn for a short period to see if the Secretary of State wished to make a reference so that the Tribunal could consider as expeditiously as possible whether the statutory conditions for detention were made out.

89. Judge Johnston contemplates that there might have been a procedural error in that the F-tT did not appoint Mr Cuddihee as the Appellant's representative under F-tT Procedural Rules r.11(7)(b) or because it did not hear directly from the Appellant. However, as Judge Johnston says, if these were errors, they did not form any part of Mr Cuddihee's grounds of appeal. No permission was granted to argue them and no application was made at the hearing for those additional grounds to be advanced. Because the points were not raised at the hearing, Mr Allen did not have the opportunity to respond to them. We share her view that it would not be fair to the Respondent to allow these points to be taken into account in the disposal of the appeal. In other circumstances, unfairness of this kind can be cured by holding a further hearing and then giving the party against whom the point is made an opportunity to respond. In the present circumstances, neither a third hearing nor a further round of written representations would be proportionate, particularly when the Appellant has now been discharged. We agree with Judge Johnston to this extent, that if these circumstances were to be repeated, and if the Tribunal was to find that an applicant lacked capacity to apply to the Tribunal, the Tribunal might wish to consider either exercising its powers to appoint a representative under r.11(7)(b) or hearing from the applicant directly.

Judge Johnston

90. I agree with the reasoning of the Hon. Mr Justice Nicol and Upper Tribunal Judge Ward in relation to the first and third of the grounds of Judge Dumont's permission to appeal in so far as they do not conflict with my opinion set out below.

91. Where I part from them is in relation to their agreement with Judge Dumont's decision that the F-tT did not err in law and that the test for capacity to make an application to the First Tier Tribunal (Mental Health) as formulated in *VS v St Andrew's Health Care* [2018] UKUT 250 (AAC). The test sets the bar for making such an application under section 66 too high in my opinion as it creates an unjustified hurdle for detained patients to exercise their rights.

92. In my reasoning, I have relied on the accepted purpose of the FtT (Mental Health) which is to ensure speedy access to a court consistent

with Article 5(4) of the European Convention on Human Rights. The FtT (Mental Health) is flexible and informal in its processes and should be accessible to all and any prospective users.

93. In her seminal book Mental Health Law, which is now in its Sixth Edition, Lady Hale describes flexibility and accessibility as intrinsic to the fair operation of law in the Mental Health Tribunal, whilst noting at page 284 that "it is unusual for a tribunal to be deciding questions of personal liberty." (para 8-002) She refers to The Leggatt Report Tribunals for Users (Leggatt 2001) which led to the Tribunal Courts and Enforcement Act 2007 and states that:

> "…(Tribunal) membership can be tailored to the particular problem and their more flexible and informal procedures to the peculiarities of the subject-matter and people involved."
>
> She says of Tribunals that "they are not stuck in the adversarial model of British court procedure and can adopt elements of a more inquisitorial approach."

94. This flexibility of approach is supported in the Tribunal Procedure Rules by the overriding objective in rule 2 which differs from the equivalent provision in the CPR and the Court of Protection Rules and states that the rules must be applied so as "to enable the Tribunal to deal with cases fairly and justly."

95. Justice and fairness in this context explicitly includes:

> …
> (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; …

96. I agree with the facts set out in the majority decision and would add the following:

i) The Tribunal accepted the patient wanted to leave. At paragraph 24 they say: "As she clearly does not want to be in hospital and has not had a hearing.."

ii) The Tribunal accepted she wanted to attend and says at paragraph 28: "Mr Cuddihee did say after seeing his client during this break that (the patient) had acquired some understanding and wanted to attend the tribunal but he did not assert that she had acquired capacity to make the decision today."

iii) In the Appellant's Statement of Facts and Grounds dated 15 June 2019 Mr Cuddihee says: "The patient's Counsel also stated that after advising her regarding the role of a tribunal that morning his view was the patient appeared to understand enough to meet the very basic, low standard required in *VS* and indeed that was supported by the fact that she had walked from her ward unsupported by staff to the waiting room outside the tribunal room in order to participate in the hearing."

iv) The Tribunal did not appoint Mr Cuddihee under Rule 11(7)(b) of the Tribunal Rules or hear directly from the patient who was waiting outside the Tribunal room.

97. It is against this background that the test in *VS* has set the bar to apply to a Tribunal too high, and is inconsistent with proper application of the overriding objective that applies in Mental Health Tribunal cases. This is particularly so in this case where the patient is outside the Tribunal room waiting to participate in the hearing.

98. The test in *VS* is in two parts (see paragraph 62 of the majority judgment.) The first is, "Does the applicant understand that she is detained?" or as re-phrased as "Does the applicant realise she is not free to leave". The second part of the test in *VS* is "Does she understand the Tribunal has power to discharge her?" For the reasons below the test should be, "Does the patient want to be free to leave?"

Compatibility with Article 5(4) of the European Convention

99. In *MH (by her litigation friend, Official Solicitor) (FC) (Respondent) v. Secretary of State for the Department of Health (Appellant) and others* [2005] UKHL 60 the court decided unanimously that Article 5(4) had not been violated. MH was initially detained on section 2 and was incapacitated. She did not exercise her right to apply to a Tribunal. The Court found that Article 5(4) was not violated as it required a right to "take proceedings" and MH had that right. In *MH* the patients Nearest Relative had applied for discharge. Proceedings were launched in the County Court to displace her. These proceedings had dragged on but a violation of Article 5(4) was not found by the House of Lords as the Secretary of State under section 67 has the power to refer MH to the Tribunal and this had happened in the case.

100. The Strasbourg Court disagreed with the decision for the first period of the patient's detention under section 2. It decided on the facts of that case that special safeguards were required under Article 5(4) for "incompetent mental patients" who lacked the means to challenge the lawfulness of their detention.

> "Pursuant to section 66(1)(a) of the 1983 Act, while the applicant was being detained under section 2 of that Act, she could have applied for discharge to the Mental Health Review Tribunal ("the Tribunal") within fourteen days. She did not do so because she lacked legal capacity to instruct solicitors. After the fourteen-day period had expired, she had no further right to apply to the Tribunal." (para.11)

101. The Court found that Article 5(4) of the European Convention was violated because the applicant did not:

> "at the relevant time … have the benefit of effective access to a mechanism enabling her to "take proceedings" of the kind guaranteed to her by Article 5 § 4 of the Convention. The special safeguards required under Article 5 § 4 for incompetent mental patients in a position such as hers were lacking in relation to the means available to her to challenge the lawfulness of her "assessment detention" in hospital for a period of up to twenty-eight days." (para.86)

102. The UK remedied this breach in section 130A of the Mental Health Act 2007 by the introduction of Independent Mental Health Advocates (IMHAs). Section 130B(2) sets out that the help available to a "qualifying patient". Section 130C defines a qualifying patient as one who is detained under the Act. Section 130C defines the help available to the patient from the IMHA. Section 130C(2) says:

> "The help available under the arrangements to a qualifying patient shall also include—
>
> (a) help in obtaining information about and understanding any rights which may be exercised under this Act by or in relation to him; and
>
> (b) help (by way of representation or otherwise) in exercising those rights."

103. Turning to the Code of Practice to the MHA 1983:

> "6.13 The Act enables IMHAs to help patients to exercise their rights, which can include representing them and speaking on their behalf, eg by accompanying them to review meetings or hospital managers' hearings. IMHAs support patients in a range of other ways to ensure they can participate in the decisions that are made about their care and treatment, including by helping them to make applications to the Tribunal."

104. The appellant in this case, M, had the help of an IMHA. The application was signed by M but she was enabled to do this with the help of an IMHA. That was exactly what the introduction of the IMHA in satisfying the judgment in *MH* was designed to do. If the test in this case is "did the patient want to be free to leave?", the application was properly made. The introduction of the provision of an IMHA to help a detained patient exercise their rights under the Mental Health Act was the UK government putting into place the procedural safeguards to remedy the violation of Article 5(4) in *MH v UK*. The fact that there is no automatic referral to the Tribunal for a section 2 patient, and the possible violation of Article 5(4), is remedied by the provision of the help of an IMHA. Reading the primary and subordinate legislation with section 3 of the Human Rights Act and the Code of Practice the test "Do I want to be free to leave" ensures the Mental Health Act and the Procedural Rules are compatible with Article 5(4).

The information relevant to the decision in Section 3 of Mental Capacity Act.

105. Section 3 of the Mental Capacity Act sets out that:

> "…a person is unable to make a decision for himself if he is unable-
>
> (a) to understand the information relevant to the decision,
> (b) to retain that information,
> (c) to use or weigh that information as part of the process of making the decision, or
> (d) to communicate his decision (whether by talking, using sign language or any other means).
>
> (2) A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).
>
> (3) The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.
>
> (4) The information relevant to a decision includes information about the reasonably foreseeable consequences of—
> (a) deciding one way or another, or
> (b) failing to make the decision.

106. In this case the *relevant information* is that M is in a place that she wishes to be free to leave. She understood she could not. Weighing the

information that she was not free to leave she said I need to leave. She was able to communicate this decision and did so verbally and consistently by her behaviour throughout her admission including on the day of the Tribunal where she was in the waiting room outside the Tribunal waiting to participate. The only way she would be able to be free to leave was to apply for a Tribunal. This she also did helped by the IMHA.

107. In *VS* the solicitor appointed by the Tribunal said she was concerned that *VS* did not have the capacity to apply to the Tribunal. She reported that he told her the following:

> • that he wanted to be discharged to have a cigarette;
> • he could not understand that he was being held in hospital; and
> • he could not retain information about the purpose, procedure and powers of the tribunal.

108. Upper Tribunal Judge Jacobs sets out that this issue came before Judge Fyall on 13 December 2017. He says at para 5:

> "The judge had the letter from the responsible clinician. These are the relevant passage among the judge's reasons:
>
> > 9. … when [the solicitor] met with him on 23rd November, Mr S… was still expressing to her that he wanted to be discharged because he was unhappy with the restrictions placed on him by being detained, on that day the limits on his freedom was to smoke.
> >
> > 10. … I do not think that Mr S…'s inability to retain that he is being held in a hospital is ultimately fatal to a finding that he has capacity, as he is able to clearly retain the understanding that he is being held somewhere he does not want to be, and he has 'repeatedly demonstrated' his unhappiness with that. …
> >
> > 11. I equally do not find that the processes and powers of the Tribunal are 'relevant information' as to whether a patient wants to appeal; what is relevant is that he wants to be discharged from the place where he is being kept against his wishes. The reality for a patient such as Mr S… is that the only way of achieving that against clinical advice will be via the Tribunal."

109. I am in agreement with the reasoning of Judge Fyall and observe that Judge Jacobs whilst appearing to accept her reasoning went further when he introduced the second part of the test. The relevant information

is “Does the patient want to be free to leave.” Judge Fyall found that the Tribunal’s processes and powers are not relevant to whether *VS* had capacity to apply to the Tribunal. His wish to be discharged from the place where he was kept against his wishes was enough. I agree with her reasoning.

110. Mr Allen relied on the case of *N (Appellant) v ACCG and others* [2017] UKSC 22 to establish that the focus should not be on the wishes of M but the decision she had to make.

111. The facts in N are set out in paragraph 8 of the judgment of Lady Hale:

> “8. Thus, by the time of the hearing, the issues between the CCG and the parents had narrowed to two. First, the parents wished for MN to come and visit them in their home, some six miles away from his care home. An occupational therapist had assessed the home and concluded that it could accommodate MN and his wheelchair for a short visit. But trained carers would have to go with him, be allowed into the home to settle him down, and wait outside while he was there (the parents have been reluctant to allow professionals into their home). One of the carers would have to be trained to administer emergency medication if required. Only the care home manager and her deputy were willing to do this, “the rest of her staff fearing that the parents would not co-operate, would interfere with the care they provided for MN and would be aggressive and intimidating towards them”. Hence the care home was unwilling to facilitate MN’s visits to the family home, which would therefore require alternative carers to be trained and paid to do so.”

112. The case was decided on the grounds that the Court of Protection has no greater power to make a decision, than the patient if he had full capacity. That is a different question than the one before us. Even if N had had capacity he would not have been able to say the care home had to fulfil these functions. This was not a decision open to him. Paragraph 38 of the judgment says:

> “…It is perhaps unfortunate that the issue was described in the Court of Protection as one of “jurisdiction” and that term was used in the statement of facts and issues before this Court. The issue is not one of jurisdiction in the usual sense of whether the court has jurisdiction to hear the case.”

113. N is much more closely aligned to a mental health case *R (on the application of H) v Secretary of State for the Home Department* [2003] UKHL 59. In this case the Tribunal gave a deferred conditional discharge to a restricted patient. The Health Authority was unable to

procure a Consultant Psychiatrist to look after H. The court found the obligation on the Health Authority was to use their best endeavours to secure compliance with the conditions but they had "no power to require any psychiatrist to act in a way which conflicted with the conscientious professional judgement of that psychiatrist" (per Lord Bingham at para 29).

114. The decision "I want to be free to leave" is a decision that can be reached, and therefore different in essence from the decisions in *N* and in *H*. "I want to be free to leave" is a decision, not a wish that cannot be realised, and the only mechanism available to achieve this, in the absence of the RC discharging the patient, is the Tribunal.

115. There is support for this test in the judgment of Baker J in *RD v Herefordshire Council* [2016] EWCOP 49. He said at para 86(1):

> "…that the capacity to bring proceedings in the Court of Protection 'simply requires P to understand that the court has the power to decide that he/she should not be subject to his/her current care arrangements. It is a lower threshold than the capacity to conduct proceedings.'…
>
> "…(b) If P does not have such capacity, consider whether P is objecting to the arrangements for his/her care, either verbally or by behaviour, or both, in a way that indicates that he would wish to apply to the Court of Protection if he had the capacity to ask." (para. 86)

116. In *RD*, Baker J refers to paragraph 60 of the judgement of the European Court in *MH* where they referred to the rights guaranteed by Article 5(4):

> "The judicial proceedings referred to in Article 5(4) need not, it is true, always be attended by the same guarantees as those required under Article 6(1) for civil or criminal litigation. Nonetheless, it is essential that the person concerned should have access to a court and the opportunity to be heard either in person or, where necessary, through some form of representation, failing which he will not have been afforded 'the fundamental guarantees of procedure applied in matters of deprivation of liberty'. Mental illness may entail restricting or modifying the manner of exercise of such a right but it cannot justify impairing the very essence of the right. Indeed, special procedural safeguards may prove called for in order to protect the interests of persons who, on account of their mental disabilities, are not fully capable of acting for themselves." (para 26)

117. Whilst I agree that the Court of Protection is dealing with a person who lacks capacity the access to justice point remains and the reasoning of *RD* persuasive. Even putting *RD* aside, the relevant information required to be understood, retained, used and weighed and communicated by the appellant is that the patient wanted to be free to leave. In my opinion given the facts in this case, the flexibility of the Tribunal procedures and the overriding objective set out below, she had the capacity to make the application. She had consistently objected to being in hospital. She did not have the capacity to understand the tribunal has the power to decide that she should not be subject to detention. However, her behaviour consistently indicated that her decision would be to leave if she could and the only avenue to achieve this was the application to the Tribunal. Indeed, after some further consultation with Mr Cuddihee, the Tribunal were told that the appellant wanted to attend the Tribunal and that she was in the waiting room outside. She was not invited in or questioned by the panel.

The consequences of an early application for detained patients

118. Mr Justice Nicol and Judge Ward referred to the potential adverse consequences of an early application in their support of *VS*. I disagree. The patient is entitled to make an unwise decision (Section 1(4) MCA 2005). Having a case speedily determined by a court ensures compliance with Article 5(4).

The application of the Tribunal Procedure Rules

119. When performing the functions under the Rules the Tribunal should apply the overriding of objective of fairness and justice. Dealing with cases justly and in Rule 2 includes:

> "(b) avoiding unnecessary formality and seeking flexibility in the proceedings; and
> (c) ensuring, so far as practicable, that the parties are able to participate fully in the proceedings; …"

120. It is hard to countenance that the law would operate to deny the opportunity for a hearing to a patient with a mental disorder who is waiting outside the Tribunal and is ready to participate. Justice would not be served.

121. In my view striking out an application on the formal basis that the patient does not understand the Tribunal is a body who can discharge the applicant is not in keeping with the application of the overriding objective. There would be a duty to strike out an application if it was not properly made, for example, if the patient had already made an application in the specified period, or if it was an application made for detention under the wrong section. Even in the latter case it is the

Tribunal's practice to ask for an amended application to be made to facilitate access to justice. It would not justify the striking out of M's application were it not for the test in *VS*. If the test is "I want to be free to leave" and the only avenue for this is an application to the Tribunal, striking out the case is not in accordance with the overriding objective.

122. Having set out what the test to apply to the Tribunal should be, it is unnecessary to consider in this case whether someone should have had the responsibility to suggest that the Secretary of State might make a formal referral to the Tribunal under section 67. Where an application is not made, and a patient is unable to make such an application with the help of an IMHA, I agree with the opinion of Mr Justice Nicol and Upper Tribunal Judge Ward that the IMHA would be well suited to suggest this to the Secretary of State.

The application of Rule 8

123. If the patient lacked capacity to make an application did she have the capacity to instruct a representative? This was not a ground of appeal put forward by Mr Cuddihee and not responded to by Mr Allen. We have not heard from either on this point. I agree with Mr Justice Nicol and Judge Ward that it would be unfair to the Appellant and Respondent to allow this point to be taken into account in the disposal of the appeal.

124. I would only say that if the patient lacked capacity to make the application,(which I say she did not) the Tribunal might wish to consider either exercising its powers to appoint a representative under r.11(7)(b) or to hear from the patient directly.

125. Accordingly, I would allow the appeal for the reasons set out above.

The Hon. Mr Justice Nicol
(sitting as a Judge of the Upper Tribunal)

Upper Tribunal Judge Christopher Ward

Judge Sarah Johnston, DCP (HESC);
Judge of the Upper Tribunal

12 June 2020