SF v Avon and Wiltshire Mental Health Partnership NHS Trust and RB
[2023] UKUT 205 (AAC)

IN THE UPPER TRIBUNAL **Appeal No.** UA-2022-000062-HM
ADMINISTRATIVE APPEALS CHAMBER

On appeal from the First-tier Tribunal (Health, Education and Social Care Chamber)

Between:

SF (as Nearest Relative of RB)

Appellant

- v –

Avon & Wiltshire Mental Health Partnership NHS Trust

Respondent

RB

Interested Party

Before: Upper Tribunal Judge Church

Following a remote video hearing held on 20 April 2023

Representation:

Appellant:	Mr Roger Pezzani of counsel, instructed by Ms Angela Wall of Butler & Co, Solicitors
Respondent:	Not represented
Interested Party:	Not represented

DECISION

This decision may be made public (rule 14(7) of the Tribunal Procedure (Upper Tribunal) Rules 2008 (SI No 2698)).

The decision of the Upper Tribunal is to allow the appeal.

The decision of the First-tier Tribunal made on 18 November 2021 with case reference number MN/2021/14771 involved the making of an error on a point of law.

Since the patient has long since been discharged from detention and no purpose would be served by setting the decision aside, I do not exercise my discretion section 12(2)(a) of the Tribunals, Courts and Enforcement Act 2007 to set aside the decision.

REASONS FOR DECISION

What this appeal is about

1. This appeal is about RB, a woman with a primary diagnosis of autism spectrum disorder and a secondary diagnosis of complex post-traumatic stress disorder. RB was at the relevant time detained in hospital for treatment under section 3 of the Mental Health Act 1983 (the **"MHA"**).

2. An application was made to the First-tier Tribunal to review her section and it was the tribunal's job to hear evidence and argument and to decide whether the criteria set out in section 72(1)(b) MHA were satisfied. If they were not, it had to discharge her section.

3. The circumstances of this case are very distressing. By all accounts, RB was very unwell and unhappy. The witnesses from the clinical team accepted that RB needed psychosocial support, but this was not available in her current setting on an acute psychiatric ward at Fountain Way. They accepted that being on such a ward was "not beneficial" to RB's mental health. However, the witnesses from the clinical team didn't support RB's discharge because they held justifiable worries that, were her section to be discharged, RB might harm (or even kill) herself, or harm others.

4. In legal terms, the appeal is about the meaning of the requirement in section 72(1)(b)(iia) MHA that 'appropriate medical treatment' be available to a patient if she is to be liable to detention in hospital. I must decide whether the treatment that the First-tier Tribunal who heard the application found to be available to RB at Fountain Way was capable of satisfying that requirement, given its findings about the treatment that RB required.

5. It also raises an issue about whether the First-tier Tribunal should have adjourned the hearing for further information.

6. Although RB is no longer detained in hospital, her discharge has not rendered this appeal academic. That is because if what was found to be available to RB at Fountain Way was capable of satisfying section 72(1)(b)(iia) MHA on 18 November 2021, it follows that (provided that the other criteria to detention are met at the relevant time) the availability of the same treatment would be capable of justifying her detention in the future. That has clear implications for RB's future liability to detention.

7. The issue also has significance for others, especially those who are not neurotypical, who find themselves in a similar position.

Factual and Procedural Background

8. At the date of the application to which this appeal relates, RB was detained under section 3 MHA at Fountain Way, a hospital operated by the Respondent, on a mixed adult acute psychiatric ward.

9. These proceedings were brought by RB's mother, who is her 'nearest relative' for the purposes of section 26 MHA. I made RB an Interested Party in these proceedings because the proceedings are about her, about her treatment, and about her liability to be detained, so I considered it to be in the interests of justice for her to be given the opportunity to make her views known. RB chose to play no active role in the proceedings, as she was perfectly entitled to do, but it was important that she was given the opportunity to do so if she wanted to.

10. SF gave notice to the hospital managers of the Respondent of her intention to order RB's discharge from detention using her powers as nearest relative under section 23 MHA. RB's responsible clinician then issued a 'barring report' opining that RB would, if discharged, be likely to act in a manner dangerous to other persons or to herself. This had the effect of preventing SF from exercising her power of discharge for the next six months (see section 25 MHA).

11. SF made an application to the First-tier Tribunal under section 66(1)(g) MHA. The application was heard on 18 November 2021. At the hearing SF's case was that RB should be discharged from her liability to detention because appropriate medical treatment was not available to her at Fountain Way, and so the statutory criteria to detention were not met.

12. SF made a secondary application for an adjournment to obtain information about the aftercare that would be available to RB on discharge, discharge planning being inchoate.

13. RB did not attend the hearing and, while she had instructed a solicitor, she instructed the solicitor not to attend the hearing. She made a written statement to the First-tier Tribunal but in it she expressed no view on the application.

14. The Respondent resisted the application, RB's Responsible Clinician expressing particular concern about a recent "significant and severe escalation in the incidents of deliberate self-harm" (by RB) which had occurred on the ward.

15. The First-tier Tribunal refused both of SF's applications and upheld RB's section (the **"FtT Decision").**

The permission stage

16. SF applied to the First-tier Tribunal for permission to appeal the FtT Decision. Permission was refused by a judge of the First-tier Tribunal on 4 January 2022, but SF then applied to the Upper Tribunal for permission to appeal and the matter came before me.

17. Mr Pezzani produced detailed written grounds of appeal arguing that the panel which heard the Appellant's application on 18 November 2021 erred in law in two material respects:

a. It was wrong to find that appropriate medical treatment was available to the patient RB, and should instead have found that the requirement in Section 72(1)(b)(iia) MHA was not satisfied and the conditions to continued detention were not met; and

b. It was wrong to refuse the application for an adjournment to obtain information on the aftercare that would be available to RB should she be discharged.

18. In my decision granting permission I said:

> "6. The availability of appropriate medical treatment is rarely a matter of contention, but given the quite unusual circumstances in this case, which concerns a patient with a primary diagnosis of autism spectrum disorder, and a secondary diagnosis of C-PTSD, there is a real issue as to whether what is available to her in hospital has the necessary therapeutic purpose. Indeed, there was evidence before the Tribunal that continued detention in hospital could be significantly counter-therapeutic.
>
> 7. I am persuaded that it is arguable with a realistic (as opposed to fanciful) prospect of success that the Tribunal erred in law in the ways which Mr Pezzani contends that they have, and a grant of permission to appeal to the Upper Tribunal is warranted."

The oral hearing of the appeal

19. I directed a remote video hearing of the appeal. While the Respondent and the Interested Party were each notified of the hearing, only SF attended and was represented. I was satisfied that the parties had been given due notice of the hearing and had chosen not to attend or be represented, and that it was in the interests of justice to proceed.

20. Mr Pezzani made oral submissions which developed the points made in his statement of facts and grounds document and the written speaking note he had submitted in advance of the hearing. I am grateful to him for the clear and succinct way in which he put his arguments.

The Law

21. Section 72 MHA sets out the powers and duties of the tribunal when considering an application. It provides (so far as is relevant to patients detained other than under section 2 MHA):

> **"Powers of tribunals**
>
> **72.-** (1) Where application is made to the appropriate tribunal by or in respect of a patient who is liable to be detained under this Act or is a community patient, the tribunal may in any case direct that the patient be discharged, and –
>
> …
>
> (b) the tribunal shall direct the discharge of a patient liable to be detained otherwise than under section 2 above if it is not satisfied –
>
> (i) that he is then suffering from mental disorder or mental disorder of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or
>
> (ii) that it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment; or

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

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

22. Somewhat unusually, section 145(1) MHA provides an inclusive, rather than an exhaustive, definition of the term "medical treatment":

> "medical treatment" includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care".

23. This inclusive definition is to be construed in a purposive way in accordance with section 145(4) MHA, which provides:

> "Any reference in this Act to medical treatment, in relation to mental disorder, shall be construed as a reference to medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms, manifestations".

Discussion - Ground 1

What the First-tier Tribunal said about the availability of treatment

24. The First-tier Tribunal explained its decision making in relation to the availability of appropriate medical treatment in paragraphs [13]-[16] of its statement of reasons:

> "13. Appropriate medical treatment: The RC told us that the primary disorder should be treated with psychosocial support which could not be provided on this ward. She did however explain that "offshoots of the disorder" which included anxiety, depression, rigid thinking and more recently [RB's] behaviour in the "aftermath of the Court of Protection issues" were the subject of appropriate treatment.
>
> 14. [RB] had refused to engage with the RC since her appointment in August. The team had been able to offer some therapeutic treatment to [RB] in the form of OT and art therapy provided by a therapist. [RB] had engaged to a limited extent with one OT but refused to engage otherwise. The nurse described how [RB] was unsuccessfully prompted to take care of her personal hygiene by nursing staff daily. The nurse regularly volunteered to take [RB] on escorted ground leave, but [RB] consistently refused to engage. Some mobility aids had been provided for [RB], but these had to be risk assessed in view of her propensity to deliberate self-harm. Nonetheless, [RB] had declined to use them. [RB's] dietary intake was a matter of concern throughout the duration of this admission. To monitor her general health a food and diet chart was in place and her blood sugar levels were tested twice daily as well as her blood pressure and pulse. The treating team were guided by experts as regards the treatment of [RB's] rheumatoid arthritis. The RC told us that the stopping of this treatment was a manifestation of her primary disorder. As explained above treatment had been stopped, nonetheless, the RC remained in contact with the rheumatoid arthritis consultant. Because of the significant risks she currently presents. [RB] is currently nursed on constant 1:1 observations to reduce the risk of deliberate self-harm/death.

15. All the witnesses wanted to move [RB] on from the acute ward, but she refused to engage with this process. [RB] made it clear that she would not sign any tenancy agreement. This was a matter of great concern for the nearest relative, the community team, and the treating team. The involvement of Imagineer and a potential placement through Studio 3 was outlined in the reports, the funding for this work had been rescinded by the CCG. Nonetheless, [RB's] case remained the subject of weekly MDT's. Mrs O'Neill told us that she was working in liaison with the community social worker. It had been decided that a specialist assessor would become involved to assess [RB's] capacity surrounding accommodation. An independent assessor was deemed necessary as [RB] declined to engage with most of the professionals already involved in her care pathway and there were concerns that any decision regarding capacity should be made independently of the team.

16. All the professional witnesses who gave evidence agreed that an acute psychiatric ward was not beneficial to [RB's] mental health. This, however, was not the test we are required to apply. We fully accepted that the treatment provided to [RB] was not tailored to her diagnosis, and the essential psychosocial work was not available on this acute ward. We did, however, conclude that medical treatment for the purpose of preventing a worsening of the symptoms or manifestations of her disorder, is available, appropriate and necessary. In reaching this decision we reminded ourselves of the guidance provided in *DL-H v Partnerships in Care & SoSJ* [2014] AACR 16 and *DL-H v Devon Partnership NHS Trust v SoSJ* [sic] [2010] UKUT 102 (AAC). We decided that [RB's] refusal to engage with most of the professionals and the limited therapies available on this ward did not negate the availability nor appropriateness of that treatment. The treatment available today was OT and art therapy. Intensive 1:1 observation sought to protect [RB] against significant acts of deliberate self-harm which might otherwise prove fatal. [RB's] physical health was closely monitored because she restricted her diet. As recently as the last week she has been referred to the general ward following concerns regarding her deteriorating physical health. When appropriate, sedative medication had been administered with [sic] in the last week or so to protect [RB's] own safety but also protect nursing staff from her outbursts. Discharge planning was ongoing, it was not at all well advanced. This was due in part at least to [RB's] lack of engagement. We concluded that discharge planning was part of the treatment. The team wanted to explore the options to move [RB] on to a setting, possibly under a legal framework, where she might present fewer risks and receive a more tailored treatment in a less restrictive setting. The benefit of the inpatient treatment was to keep [RB] physically well, safe and protect those seeking to care for her. Whilst these treatments would not serve to treat the overarching autism long-term, they played an important role in her immediate treatment plan. In relation to Ms Wall's closing submissions, we decided that the current treatment did offer a therapeutic benefit to [RB] in the short term. The outcome was that [RB] had been prevented from harming herself (perhaps even fatally) and others around her were kept safe. The negative impact of this treatment was that it removed autonomy. [RB] sought to control decisions regarding her diet, well-being and treatment. Ms Wall

> submitted that the adverse effects of the inpatient setting greatly outweighed its benefits. The professional witnesses did not agree with this view. Mr Prochazka told us that the detention and the treatment provided on the ward superseded the alternative which was a 'risk of death'. We accepted the evidence of the professionals as articulated by Mr Prochazka. We decided that the benefits of inpatient treatment outweighed the adverse effects."

25. The first thing to say about the criteria in section 72(1)(b)(1)-(iii) is that if any of them is not satisfied the tribunal must discharge the patient from liability to detention. While in the majority of cases the availability of appropriate medical treatment in hospital is uncontroversial, and the requirement for it receives little attention, it is nonetheless a crucial element of the protections provided by the MHA. Indeed, section 3 MHA (the section to which RB was subject at the relevant time) is headed "Admission for treatment", and all but one of the limbs of the criteria in section 72(1) relates to the treatment of the patient's mental disorder (whether its appropriateness (in sub-paragraph (i)), its necessity (in sub-paragraph (ii)), or its availability (in sub-paragraph (iia))).

26. The First-tier Tribunal made a clear finding (based on its acceptance of the evidence of RB's clinical team) that "the treatment provided to [RB] was not tailored to her diagnosis, and the essential psychosocial work was not available on this acute ward" (see paragraph [16] of the decision with reasons).

27. This is a striking finding indeed. What amounts to 'appropriate medical treatment' for mental disorder must differ from patient to patient, according to their individual circumstances and needs.

28. When deciding whether 'appropriate medical treatment' was available, the First-tier Tribunal had to do so in the context of what it knew about RB's mental disorder, and its symptoms and manifestations. If all that was required by section 72(1)(iia) was for the tribunal to be satisfied that generic medical treatment, not tailored to the particular patient, was available, it would provide no meaningful protection, and the word 'appropriate' would add nothing.

29. The First-tier Tribunal found that the following interventions were available to RB:

a. OT;
b. art therapy;
c. intensive 1:1 observation
d. close monitoring of RB's physical health;
e. administration of sedative medication; and
f. discharge planning

30. The First-tier Tribunal correctly took the purposive approach to the assessment of the treatment on offer that section 145(4) MHA required of it. It made clear findings of fact about what the intent of the treatment was:

> "Intensive 1:1 observation sought to protect [RB] against significant acts of deliberate self-harm which might otherwise prove fatal. [RB's] physical health was closely monitored because she restricted her diet. As recently as the last

> week she has been referred to the general ward following concerns regarding her deteriorating physical health. When appropriate, sedative medication had been administered with [sic] in the last week or so to protect [RB's] own safety but also protect nursing staff from her outbursts" (paragraph [16] of the decision with reasons).

31. Each of the First-tier Tribunal's findings as to the purpose of the interventions provided relates solely to concerns for RB's physical health or for her physical safety and the physical safety of those attempting to care for her. The First-tier Tribunal acknowledged this in paragraph [16] of its decision with reasons:

> "The benefit of the inpatient treatment was to keep [RB] physically well, safe and protect those seeking to care for her. Whilst these treatments would not serve to treat the overarching autism long-term, they played an important role in her immediate treatment plan … The outcome was that [RB] had been prevented from harming herself (perhaps even fatally) and others around her were kept safe".

32. The First-tier Tribunal didn't need to be satisfied that the treatment available would "serve to treat the overarching autism long-term", but it did need to be satisfied that the treatment available at least had the purpose to "alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations" (section 145(4) MHA).

33. The First-tier Tribunal found that RB's self-harming and violent behaviour were symptoms or manifestations of her mental disorder (see paragraph [11] of its decision with reasons). It was entitled to do so, but was it entitled to find that the interventions available on the ward (described above) satisfied limb (iia) of the criteria in section 72(1) MHA?

34. In *PM v Midlands Partnership NHS Foundation Trust* [2020] UKUT 69 (AAC); [2020] AACR 23, at paragraph 8.3, I considered whether monitoring of a patient could, of itself, amount to 'medical treatment':

> "Monitoring would not, in and of itself, necessarily qualify as "medical treatment" for the purposes of section 145(1) MHA (as construed in accordance with section 145(4) MHA). For example, if monitoring were by way of observation of a patient via a CCTV feed, that monitoring (as opposed to any intervention made in response to what was observed) could not be said to be done with therapeutic intent. Such monitoring would fall into the category identified by Stanley Burnton J. in *R. (on the application of O'Reilly) v Blenheim Healthcare Ltd* [2005] EWHC 241 (Admin) at [14] as "acts carried out for the purpose of treatment, or with a view to deciding on treatment", rather than treatment itself."

35. While the monitoring detailed in the treatment plan does not, of itself, amount to 'medical treatment', it is adequately clear that the monitoring was carried out with a view to staff intervening should they see something of concern, i.e. signs of RB engaging in self-harming behaviour (including restricting her diet) or violence towards people or property, and it is clear that staff have intervened when they have seen such signs. The question then arises whether the interventions available on the ward are made for the purpose of preventing a worsening of the self-harming and violent behaviours which the First-tier Tribunal found to be symptoms or manifestations of

RB's autism spectrum disorder, or whether their purpose was merely to contain the risk of harm resulting from those behaviours?

36. Restraint, whether physical, mechanical or chemical, can form a legitimate part of a patient's treatment plan, but that doesn't necessarily mean that it amounts to "medical treatment" in the MHA sense. To do so it must have the purpose of (at a minimum) preventing a worsening of relevant symptom or manifestation (in this case RB's urge to harm herself or others). In the case of a neurodiverse patient such as RB such an outcome does not seem likely. Indeed, such an intervention is likely to exacerbate a neurodiverse patient's frustration and need for control and to increase their anxiety.

37. While the definition of 'medical treatment' in the MHA hinges on the purpose for which it is administered rather than its effect, as I commented in *SLL v (1) Priory Health Care and (2) Secretary of State for Justice (Mental Health)* [2019] UKUT 323 (AAC) at [47]:

> "it is difficult to see how a form of medical treatment which is not believed to have any realistic prospect of achieving any therapeutic benefit to a patient whatsoever could properly be considered "appropriate" for him even if it fell within the MHA definition of 'medical treatment'.

38. If the requirement for appropriate medical treatment could be satisfied simply by confining someone with mental disorder in a way that prevents them from engaging in risky behaviour arising from a symptom or manifestation of their mental disorder, this would mean that all manner of interventions would amount to treatment in and of themselves, such as confinement in a soft room, sedation, and mechanical restraint, and nothing else would be required.

39. If such 'treatment' satisfied section 72(1)(iia) then there is no reason why it shouldn't continue to do so for as long as the symptoms or manifestations persist. If such 'treatment' stands no real prospect of achieving any therapeutic purpose beyond preventing physical harm, then this could result in indefinite detention (subject to periodic review under sections 66, 68(2) and 68(6) MHA)).

40. Context is important when engaging in statutory interpretation. As Toulson LJ put it in *An Informer v A Chief Constable* [2012] EWCA Civ 197; [2013] QB 579, para 67:

> "Construction of a phrase in a statute does not simply involve transposing a dictionary definition of each word. The phrase has to be construed according to its context and the underlying purpose of the provision."

41. I must therefore construe the phrase 'appropriate medical treatment' in the wider context of the MHA as a whole and according to the underlying statutory purpose behind making the availability of appropriate medical treatment a criterion for lawful detention for treatment. Taking that approach, I am sure that parliament cannot have intended that the kind of stasis I have described in paragraph [38]-[39] above should be permitted. If it was intended that detention for the sole purpose of ensuring physical safety were to be permitted then there was no need for section 72(1) MHA to make any reference to medical treatment at all. Rather, it could have said that the tribunal shall direct the discharge of a patient liable to be detained otherwise than under section 2 if it is not satisfied:

a. that he is then suffering from mental disorder or from mental disorder of a nature or degree which makes it appropriate for him to be liable to be detained, and

b. that it is necessary for the health or safety of the patient or for the protection of other persons that he should be detained, and

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

42. The fact that section 3 is headed "Admission for treatment", and the fact that the purpose of treatment runs through all but the last of the criteria in section 72(1), indicates that to interpret the provisions as permitting detention where the only treatment available is provided for the purpose of maintaining physical safety, without treating the mental disorder itself, would be to frustrate parliament's statutory purpose.

43. That leaves us with OT, art therapy and discharge planning, which the First-tier Tribunal found to form part of the treatment available at Fountain Way.

44. OT and art therapy are interventions that are capable of amounting to 'medical treatment' for the purposes of the MHA, but does the First-tier Tribunal make sufficient findings about RB's needs and the intent of the OT and art therapy to permit it to conclude that these interventions amount to 'appropriate medical treatment' for what it describes as 'offshoots' of RB's mental disorder (anxiety, depression, rigid thinking and challenging behaviour)?

45. Unfortunately, it does not say very much about these matters at all. There is an account in paragraph [14] of the decision with reasons of the attempts made to engage with RB but little in the way of explanation of how these interventions fit into RB's treatment plan.

46. It is insufficiently clear to me from the First-tier Tribunal's reasons what, other than the containment of the physical risks that I have addressed above, it found that the OT and art therapy were intended to achieve and how that related to RB's needs in the context of her mental disorder, its symptoms and its manifestations. This must be viewed in the context of the First-tier Tribunal's stark finding that:

> "the treatment provided to [RB] was not tailored to her diagnosis, and the essential psychosocial work was not available on this acute ward" (paragraph 16 of the decision with reasons).

47. The remaining item in the First-tier Tribunal's list of available treatment is discharge planning. The First-tier Tribunal says:

> "Discharge planning was ongoing, it was not at all well advanced. This was due in part at least to [RB's] lack of engagement. We concluded that discharge planning was part of the treatment. The team wanted to explore the options to move [RB] on to a setting, possibly under a legal framework, where she might present fewer risks and receive more tailored treatment in a less restricted setting" (paragraph 16 of the decision with reasons).

48. The context for this is that RB had, by the date of the hearing before the First-tier Tribunal, been detained in hospital for nearly 18 months on a ward which the witnesses

for the detaining authority accepted was "not beneficial to [RB's] mental health" (paragraph [16] of the decision with reasons). While the First-tier Tribunal reached the conclusion that discharge planning was "part of the treatment" it is by no means clear what was actually being done by way of preparing for RB's discharge. If discharge planning had reached stasis then it is difficult to see how it can be said to have been "available".

49. In any event, the First-tier Tribunal does not appear to have placed significant reliance on the availability of OT, art therapy or discharge planning, as its explanation of the purpose and outcome of RB's treatment is limited to maintaining her physical health and safety and the safety of those around her:

> "The benefit of the inpatient treatment was to keep [RB] physically well, safe and protect those seeking to care for her … The outcome was that [RB] had been prevented from harming herself (perhaps even fatally) and others around her were kept safe" (see paragraph 16 of the decision with reasons).

50. 'Appropriate medical treatment' can only mean treatment that is appropriate to the relevant patient's particular needs. While it is accepted that to satisfy the requirement in section 72(1)(b)(iia) the treatment available need not be the best or the most comprehensive treatment that could be provided, but it cannot be the case that treatment that is wholly inadequate for a patient's needs can satisfy that test.

51. This case is unusual in that the First-tier Tribunal reached a clear finding of what treatment RB required (psychosocial support) and an equally clear finding that such treatment was not available at the hospital in which she was detained. Importantly, the First-tier Tribunal characterised that treatment as 'essential'. 'Essential' does not mean 'ideal', or 'desirable' or 'the most appropriate'. It means that nothing else will do. If treatment that was 'essential' was not available, it must follow that the treatment that was available was not, by itself, 'appropriate'.

52. My interpretation of the proper meaning of 'appropriate medical treatment' in MHA is consistent with the approach that the Grand Chamber of the European Court of Human Rights took in *Rooman v Belgium* [2019] ECHR 105 (***"Rooman"***) when it considered the requirements of Article 5(1)(e) of the European Convention on Human Rights in the context of the detention of mental health patients. The court emphasised that the deprivation of liberty contemplated by Article 5.1(e) has a "dual function":

> "on the one hand, the social function of protection, and on the other a therapeutic function that is related to the individual interest of the person of unsound mind in receiving an appropriate and individualised form or therapy or course of treatment" (see paragraph [210] of *Rooman*)

53. The court said that "real therapeutic measures" were required:

> "Mere access to health professionals, consultations and the provision of medication cannot suffice for a treatment to be considered appropriate and thus satisfactory under Article 5 …"
>
> Rather, what was required was:

> "… an individualised programme … taking into account the specific details of the detainee's mental health with a view to preparing him or her for possible future reintegration into society (see paragraph [209] of *Rooman*).

54. This leads me to the conclusion that the First-tier Tribunal erred in law in deciding that 'appropriate medical treatment' was available to RB at Fountain Way because its decision was based on two misunderstandings:

a. that interventions which had the purpose merely of containing risk of physical harm, were capable of amounting to 'medical treatment'; and

b. that medical treatment may be 'appropriate' even where it is "not tailored to [the patient's] diagnosis", and where treatment that is "essential" is not available.

Ground 2

55. The second ground of appeal relates to the First-tier Tribunal's refusal of the Nearest Relative's application for an adjournment. The Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 (the **"FtT Procedure Rules"**) give tribunals very broad case management powers, including the power to adjourn. Generally, the Upper Tribunal is very reluctant to interfere with the case management decisions of the First-tier Tribunal.

56. The First-tier Tribunal found itself in an invidious position. It had heard evidence from each of the witnesses for the detaining authority to the effect that the ward was not a suitable environment for RB and they couldn't give her the treatment she needed, but if she were discharged the consequences for her were likely to be dire, and possibly fatal. Given its obvious discomfort about the unsatisfactory nature of the situation, it is perhaps surprising that it didn't take the opportunity to agree to the adjournment application to explore whether the risks to RB's safety could be managed more appropriately in the community with appropriate aftercare. Had it not reached the firm findings that it did (about what was 'essential' treatment and what was available in hospital) such a decision would have been open to it. Indeed, it would have been entitled to adjourn of its own motion to seek such information.

57. In the absence of such findings, it would also have been open to the First-tier Tribunal to make a recommendation (including for transfer to another hospital) to RB's responsible clinician with a view to facilitating discharge on a future date, and to consider RB's case again should the recommendation not be complied with.

58. However, the First-tier Tribunal did make those findings and, having made them, it should have concluded that 'appropriate medical treatment' was not available where she was detained. Having reached this conclusion, it would have had no option but to order discharge as section 72(1)(b) MHA requires.

59. Since any analysis of the First-tier Tribunal's decision-making on the adjournment application would require me either to assume that it didn't make the findings that it made, or that it was entitled to come to conclusions based on those findings that I have said it shouldn't have come to, it don't think that it would be very helpful for me to rule on whether it erred in law in how it dealt with the application. It is enough that I have found that it erred in the way described in Ground 1.

Disposal

60. For the reasons explained above I am satisfied that the First-tier Tribunal erred in law in a way which was material.

61. Section 12(2) of the Tribunals, Courts and Enforcement Act 2007 gives me a discretion whether to set aside a decision which I have found to involve an error of law.

62. Given that RB has already been discharged from detention, I do not consider it to be appropriate to exercise my discretion to set aside the FtT Decision. As Mr Pezzani conceded, in the circumstances the interests of justice require only that I identify and explain the error.

Thomas Church
Judge of the Upper Tribunal

Authorised for issue on

16 August 2023