Tribunal Rules

Implementing part 1 of the Tribunals, Courts and Enforcement Act 2007

Responses to the consultation on possible changes to the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 regarding pre-hearing examinations and decisions without a hearing in the case of references by the hospital or Department of Health

(22 March 2018 to 14 June 2018)

Reply from the Tribunal Procedure Committee

October 2018

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Introduction

1. The Tribunal Procedure Committee (TPC) is established under s. 22 of, and Schedule 5 to, the Tribunals, Courts and Enforcement Act 2007 (TCEA), with the function of making Tribunal Procedure Rules for the First-tier Tribunal and the Upper Tribunal.

2. Under s. 22(4) of the TCEA, power to make Tribunal Procedure Rules is to be exercised with a view to securing that:
   (a) in proceedings before the First–tier Tribunal and Upper Tribunal, justice is done;
   (b) the tribunal system is accessible and fair;
   (c) proceedings before the First–tier Tribunal or Upper Tribunal are handled quickly and efficiently;
   (d) the rules are both simple and simply expressed; and
   (e) the rules where appropriate confer on members of the First–tier Tribunal, or Upper Tribunal, responsibility for ensuring that proceedings before the tribunal are handled quickly and efficiently.

3. In pursuing these aims the TPC seeks, among other things, to:
   (a) make the rules as simple and streamlined as possible;
   (b) avoid unnecessarily technical language;
   (c) enable tribunals to continue to operate tried and tested procedures which have been shown to work well; and
   (d) adopt common rules across tribunals wherever possible.

4. In March 2018, the TPC published a consultation (the Consultation) on proposals to make two changes to the Tribunal Procedure (First-tier Tribunal) Health, Education and Social Care Chamber) Rules 2008 (the Rules) affecting certain types of case heard by the Mental Health Tribunal. The details of the proposals are set out below. The period of the Consultation was 12 weeks and an exceptionally large number of responses were received. This document sets out the TPC's conclusions following the Consultation.

The Mental Health Tribunal

5. The Mental Health Tribunal (MHT) is one of four jurisdictions within the Health, Education and Social Care Chamber (HESC) of the First-tier Tribunal.

6. The Mental Health Act 1983 (MHA) provides at s. 66 those persons who can apply for a Tribunal and the time scales for doing so. By far the greatest majority of cases are by or for persons detained under s.2 (detention for up to 28 days for assessment or assessment followed by treatment), s. 3 (detention for up to 6 months initially and then renewable for a further 6 months and then 12 months at a time), those discharged from hospital, on a Community Treatment order (CTO), those who have had their CTO revoked and are back in hospital and restricted patients. The Tribunal also hears cases that have been referred by the detaining authority because the patient has not made an application although he or she had the right to do so (s.68). Other references can be made at the discretion of the Secretary of State for Health and Social Care (the Secretary of State) in the case of persons detained in criminal proceedings (s.67 or s.71)

7. The MHT consists of a panel of three: a Judge, a consultant Psychiatrist (the medical member (MM)) and a Specialist Lay Member (SLM).

8. Prior to the hearing the MHT panel members are provided with a report from the Responsible Clinician (RC), a social circumstances report by a social worker, or Care Coordinator if there is one, and a nursing report. In s.2 cases, these are only made available on the day of the hearing.

9. Currently, all those detained under s.2 meet with the MM prior to the hearing for a mental state examination (unless they decide they do not want one) whereas others, have such an examination only if they request one. The MM then feeds back his or her provisional views to the panel and at the commencement of the MHT hearing those provisional views are fed back to the parties.

10. Occasionally, the MHT is provided with an independent psychiatric report commissioned by the patient's representative. These are more common in restricted cases. Restricted cases are persons detained as a result of criminal proceedings and where the Home Office has an interest. If a restricted patient is discharged during the currency of a sentence, he is transferred back to prison.

Background to the Consultation

11. The Consultation was prompted by the following two proposals: -

- First, there was the proposal to remove rule 34 of the Rules, which re-enacted rule 11 of the Mental Health Review Tribunal Rules 1983. Rule 34 generally requires that, in cases where a patient is detained under s.2 MHA (compulsory admission for assessment), there must be a medical examination of the patient (known as a pre-hearing examination, or PHE) by the MM of the MHT before the case is heard, unless the tribunal is satisfied that the patient does not want such an examination. In any other case, a PHE must be carried out only where one is requested by the patient or their representative, or where the MHT directs that a PHE should take place.

- Secondly, there was the proposal to change the rules on when a decision can be taken by the MHT without a hearing. The MHT currently deals with two types of cases: applications, as requested by or on behalf of detained patients; and references to the MHT by hospital managers or the Secretary of State (including approvals under s.86(3) MHA). A change is proposed only in relation to the consideration of references to the MHT. The current position is in rule 35, which requires a hearing to take place unless, in the case of a patient aged 18 or over and subject to a CTO whose case has been referred to the MHT under s. 68 of the MHA, the patient or their representative has specifically opted not to have a hearing. It is proposed that this paper review procedure should be extended to most references to the MHT by hospital managers or the Secretary of State. The default position would become that decisions, in such cases are taken without a hearing, unless one is requested by a patient or their representative – with such a request being granted as of right – or where the patient is under 18, it is a discretionary reference under s.67 or s.71 MHA, or where the MHT directs an oral hearing.

12. Following discussions between HMCTS (an executive agency of the Ministry of Justice) and the senior HESC judiciary regarding options to improve the efficiency and management of demand in the MHT, the recommended proposals were presented to the TPC by the MHT Deputy Chamber President supported by a paper signed by the Chamber President, Deputy Chamber President and Chief Medical Member. That paper is appended as Annex A.

Proposal 1 – Pre-Hearing Examination (PHE)

Further details of these proposals are set out below for the convenience of the reade

13. PHEs are currently dealt with in rule 34:

Medical examination of the patient

(1) Where paragraph (2) applies, an appropriate member of the Tribunal must, so far as practicable, examine the patient in order to form an opinion of the patient's mental condition, and may do so in private.

(2) This paragraph applies—

(a) in proceedings under s. 66(1)(a) of the Mental Health Act 1983 (application in respect of an admission for assessment), unless the Tribunal is satisfied that the patient does not want such an examination;

(b) in any other case, if the patient or the patient's representative has informed the Tribunal in writing, not less than 14 days before the hearing, that—

(i) the patient; or

(ii) if the patient lacks the capacity to make such a decision, the patient's representative, wishes there to be such an examination; or (c) if the Tribunal has directed that there be such an examination.

Also relevant is rule 39(2):

Hearings in a party's absence

(1) Subject to paragraph (2), if a party fails to attend a hearing the Tribunal may proceed with the hearing if the Tribunal—

(a) is satisfied that the party has been notified of the hearing or that reasonable steps have been taken to notify the party of the hearing; and

(b) considers that it is in the interests of justice to proceed with the hearing.

(2) The Tribunal may not proceed with a hearing that the patient has failed to attend unless the Tribunal is satisfied that—

(a) the patient—

(i) has decided not to attend the hearing; or

(ii) is unable to attend the hearing for reasons of ill health; and

(b) an examination under rule 34 (medical examination of the patient)— (i) has been carried out; or

(ii) is impractical or unnecessary

14. PHEs were first introduced pursuant to the Mental Health Act 1959, and are undertaken by the MM of the MHT, who (so far as practicable) examines the patient before the hearing to form an opinion of the patient's mental condition. If the MM's preliminary view of the patient's condition differs from that of the medical witnesses in the case (eg the responsible clinician or independent psychiatrist) then this is made known at the outset of the hearing, with the reasons for that preliminary view.

15. PHEs were the subject of a consultation by the TPC in June 2013. At that time PHEs were compulsory in all cases. Having considered the responses to that consultation the TPC concluded, in March 2014, that PHEs should become optional for patients in all cases but for those where the patient was detained under s.2 MHA. In cases of patients not detained under s.2, patients must apply to the MHT to request a PHE not less than 14 days before the hearing. A PHE is then held where requested, and in all s.2 cases, unless the patient or their representative withholds consent. The MHT can direct that a PHE take place even if the patient does not want one. In proposing the change in 2014 the TPC stated, in its response to the Consultation:

> *"We are not persuaded that preliminary examinations should be abolished altogether. The superior courts have held the procedure not to be intrinsically unfair and the overwhelming view of respondents is that they assist the tribunal to reach the right conclusion in many cases and can be an important safeguard for patients.*
>
> *There is also considerable force in the arguments that a preliminary examination enables at least some patients better to present their cases to the tribunal and that introducing an element of discretion that would require the tribunal to consider whether there should be an examination in a large number of individual cases would be expensive and give rise to appeals in contentious cases. However, we do not consider that it follows from these considerations that the rule that there should be a preliminary examination in all cases should be retained. At most, it follows that there should be a preliminary examination in all cases where the patient wants one".*

16. It is now suggested by HMCTS, with support from the senior HESC judiciary, that in the light of experience since the rules were changed in 2014, PHEs should be abolished entirely. There is a view that PHEs appear to make little material difference to the outcome of cases and, despite PHEs being requested in around 50% of non-s.2 cases, that they add little or nothing to the evidential basis on which MHTs make their decisions. It is also suggested that the proportion of patients discharged varies little, irrespective of whether a PHE is carried out, and further that a PHE may present a potentially misleading picture of the patient's condition where the patient is detained under s.2. The purpose of detention under s.2 is to allow up to 28 days for a proper assessment, and a short 'snapshot' from a PHE may assume too great a role in the assessment process and influence the tribunal to a disproportionate degree.

17. The role in which MMs find themselves may be noted. They carry out a medical examination and form a provisional view, based on a one to one conversation with one of the parties before the MHT, in the absence of the other party and the other members of the MHT which will decide the case. They then participate in the hearing of the case and the making of the decision. This was an issue addressed in the 2013 TPC consultation, and in the TPC's response to it. This "dual" role is also present in the Social Entitlement Chamber, where in appeals concerning Industrial Injuries

Disablement Benefit the medical member of the tribunal carries out an examination in the absence of the judge. However, in those cases a contemporaneous 'snapshot' of e.g. physical functionality may be of value.

18. It should also be noted that the MHT in Scotland does not, and never has had, a system of PHEs, and has no plans to introduce them.

19. The TPC notes that it is only three years since it accepted the case, in its reply to the 2013 consultation, that PHEs remained a desirable and valuable part of the MHT process. Nevertheless, in the light of some experience since the rules were changed in 2014, it is appropriate for the TPC to re-visit some of those same issues in the context of the current proposal. The TPC was keen to receive the views of those with a stake in the MHT process. The specific questions on which views were sought are set out later in this document.

Proposal 2 - Decisions without a hearing

20. At present rule 35 deals with this area:

Restrictions on disposal of proceedings without a hearing

(1) Subject to the following paragraphs, the Tribunal must hold a hearing before making a decision which disposes of proceedings.

(2) This rule does not apply to a decision under Part 5.

(3) The Tribunal may make a decision on a reference under s. 68 of the Mental Health Act 1983 (duty of managers of hospitals to refer cases to tribunal) without a hearing if the patient is a community patient aged 18 or over and either—

(a) the patient has stated in writing that the patient does not wish to attend or be represented at a hearing of the reference and the Tribunal is satisfied that the patient has the capacity to decide whether or not to make that decision; or
(b) the patient's representative has stated in writing that the patient does not wish to attend or be represented at the hearing of the reference.

(4) The Tribunal may dispose of proceedings without a hearing under rule 8(3) (striking out a party's case).

21. Paragraphs (2) and (4) are not relevant to a substantive hearing of a case, being concerned with procedural and post-hearing matters.

22. The present system, as can be seen, provides that an oral hearing is a requirement in all cases, unless, in the case of references for community patients over 18, the patient or representative has specifically stated they do not wish to attend or be represented at a hearing, and the MHT is satisfied that it is able to decide the matter without a hearing. The proposal is, in

essence, to reverse that situation, so that decisions on the papers become the default position in the case of references to the MHT made by hospital managers or by the Secretary of State. Under the proposal, either party would have an absolute right to request and be granted an oral hearing and, in addition, the MHT would hold an oral hearing where the patient is under 18, it is a discretionary reference under s.67 or s.71 of the MHA, or where the tribunal directs an oral hearing. It is suggested that the proposed power on the part of the MHT to direct an oral hearing on its own initiative (coupled with the right to Legal Aid without means testing in these cases), provides a strong safeguard to capture those cases where an oral hearing is necessary for a fair and just disposal of the case, and to protect the interests of patients who lack capacity to decide whether or not to ask for an oral hearing if, in the absence of an application, their cases have been referred to the MHT.

23. The change is proposed by the HMCTS (with support from the senior HESC judiciary) since at present many oral hearings are required even though a patient has not made an application to the MHT, does not wish to attend a hearing, or may have no interest or engagement with the proceedings. Even with the paper review procedure available for adult community patients, the requirement that such patients must positively ask for a paper disposal means that oral hearings must still be held for those adult community patients who are the least interested in engaging with the MHT. It is suggested that having more cases dealt with on the papers alone would greatly speed up the work of the MHT, enabling cases where the parties want a hearing to be heard more quickly.

24. The TPC notes that the procedure proposed is very similar to that which applies to the rules of the Social Entitlement Chamber, where rule 27 provides for a hearing, unless each party has consented to there being no hearing, *or has not objected to* a decision without a hearing. This has a very similar effect in enabling the tribunal to decide cases on the papers where someone has not expressed a preference, or has opted for a paper decision, leaving oral hearings for those who have actively requested one. This rule also requires the tribunal to be satisfied in all cases that it is able to decide the case – fairly and justly as required by rule 2 – without a hearing. The procedure in the Social Entitlement Chamber appears to work satisfactorily.

25. It is emphasised that the proposal concerns reference cases only. There would be no change as regards applications in cases brought by or on behalf of detained patients, where an oral hearing would remain the default position.

Purpose of the Consultation

26. The TPC formed no provisional view on the proposed changes, but in light of the representations made by the Chamber President, the then Deputy Chamber President and the Chief Medical Member, supported by HMCTS, it

felt it appropriate to go to consultation to seek the views of all interested parties before reaching a decision on whether to amend the Rules in the way proposed.

27. The questions posed in the Consultation were: -

    i. **Do you agree that the requirement that the First-tier Tribunal must conduct a PHE in all s.2 cases, and others where one has been requested, should be removed?**

    ii. **If the requirement were removed, do you consider that the First-tier Tribunal should have some discretion as to whether to conduct a PHE if it considers it appropriate?**

    iii. **Do you agree with the proposal that, with references to the Tribunal, other than the exceptions set out in paragraph 3.2 above (as opposed to applications from patients) a decision on the papers alone should become the default position, as outlined in the proposal above?**

    iv. **Are there any classes of case in which you consider that the First-tier Tribunal should always conduct an oral hearing, irrespective of whether the parties have expressed a preference?**

    v. **Do you have any other comments on the proposals made, or on the operation of the rules generally?**

Summary of Responses

28. The TPC received a total of 194 responses: 12 from NHS providers, 34 from members of the legal profession, 6 from members of the public and 123 from Tribunal members of which 46 were judges, 62 MMs and 15 SLMs. It also received responses from 15 organisations. Those organisations are: -

    1. Mental Health Policy Group
    2. Mental Health Tribunal Members Association
    3. Voice Ability
    4. Mental Health Lawyers Association
    5. The Law Society

6. The British Psychological Society

7. Age UK

8. MIND

9. The National Survivor User network

10. Medical and Mental Health Law Research Interest Group

11. Liberty

12. The Royal College of Psychiatrists

13. Rethink Mental Illness

14. The Equality and Human Rights Commission

15. The Care Quality Commission

29. The responses were overwhelmingly against the proposals. Before setting out some examples of responses, below is a summary of comments made in a significant majority of responses: -

<u>To Question 1</u> - Do you agree that the requirement that the First-tier Tribunal must conduct a PHE in all s.2 cases, and others where one has been requested, should be removed?

1. The timing of the consultation is inappropriate given the ongoing independent review of the MHA (the "Review").

2. MHT panel members were not asked their views on the proposals.

3. The proposals appear to have been motivated by financial considerations.

4. It is inappropriate to compare the English system with that in Scotland, which operates entirely differently.

5. The value of PHEs should not be measured by the rate of discharge.

6. PHEs often elicit information and evidence from the patient's medical notes which is not included in the Hospital report or may differ from the report.

7. The reports provided to the MHT are not always of good quality and may contain out-of-date information.

8. The author of the report may not know the patient very well and it may not be the same doctor that attends the hearing.

9. Hearings will be longer without a PHE.

10. In cases other than s.2 cases there may be increased use of independent psychiatric reports at greater cost to the public purse than PHEs.

11. It was established as recently as three years ago that PHEs should remain.

12. A High Court judgment has established that it is not unlawful for the MM to carry out PHEs notwithstanding that s/he is a member of the MHT panel.

<u>To Question 3</u> – Do you agree with the proposal that, with references to the Tribunal, other than the exceptions set out in paragraph 3.2 (above) (as opposed to applications from patients) a decision on the papers alone should become the default position, as outlined in the proposal above?

1. Those who have their cases referred to the MHT are among the most vulnerable people in society and the fact that they have not made an application may be because of that vulnerability. It is important that their detention is reviewed to ensure it is appropriate.

2. If, as many respondents considered likely, the paper reviews are to be conducted by a Judge alone, they are not qualified to make decisions on a patient's mental state.

3. Paper reviews will be carried out with evidence from one side only: the detaining authority

4. There are instances of patients being discharged on referred cases with the crucial evidence coming out at the hearing rather than in reports.

5. A Judge will not have sufficient information on a paper review to decide whether an oral hearing is necessary.

30. The Committee has concentrated on Questions 1 and 3 as the other questions become relevant only if the respondents favour the changes proposed in questions 1 and 3.

Question 1 - Do you agree that the requirement that the First-tier Tribunal must conduct a PHE in all s.2 cases, and others where one has been requested, should be removed?

31. The number opposed were 153 and in favour 16[1].

Some responses opposed to the proposed change

32. One Respondent (MM) said: -

> "Having been a Medical Tribunal member for the last 15 years, I have found that a PHE is a very useful tool in the inquisitorial function of the Tribunal. The PHE is in two parts: - a) reading of the records and b) interviewing the patient. It quickly reveals more information than that supplied by the Responsible Authority as to recent events, patients' views and fear of mis-representation and gauging the patient's potential reaction and risk at the Tribunal. It also minimises the time needed to explore the mental state at the Tribunal and the stress it can engender."

33. Another Respondent (an NHS Foundation Trust) commented that: -

> "The trust believes that patients should still have the right to a PHE if they wish to have one. Many patients find it much easier to express their concerns to a single independent doctor than to a panel in the hearing situation and therefore they could be disadvantaged if they do not have a PHE.
>
> This is not ideal in terms of a patients' rights as it is important to many patients that they are examined by an independent doctor who could offer a more clinically professional view to their RC. Trusts would need to give due consideration to patients lacking in capacity in this regard and ensure that they have access to proper legal advice to mitigate the risk.
>
> This initiative would remove concerns of conflicts of interest where the Tribunal doctor becomes both panel member and also witness once they have examined patient which could be a positive in terms of the legal process.
>
> A Consultant view at the Trust would be that he would be particularly unhappy if the medical member of the panel does not examine the patient on s. 2 or when requested on s. 3 and CTO. If this examination were removed, then the whole

[1] This does not comprise all of the responses due to those that responded with "no comment".

Tribunal would be based on the discussion around the Trust's evidence against the patients and lawyers position. A patient who can present well, but is not examined more thoroughly by the Tribunal doctor could be in error seen as being well (which if discharged is definitely not in their best interests nor in the spirit of the MHA).

Concern was also raised that if the medical member does not examine the patient, then there will be more questions from that member both to the RC and the patient themselves, thus making the whole process far more complicated and lengthy for all.

Another Consultant view was that there should continue to be a medical examination as default. Tribunals are weighted towards the professionals (One patient versus 2-3 "Tribunal – aware" professionals all arguing for detention) and so having an impartial medical opinion is helpful and in the patients' best interests."

34. Another (MM) said: -

"Considering the acute nature of the presentation in s. 2 cases and the usually brief reports from clinicians, who themselves may have very little knowledge of the patient, I believe it is imperative to have an expert independent review of the patients' presentation on the day of the hearing. This would ensure a very well-rounded assessment of the reasons for detention, and help the panel to make the right medico legal decision in the best interests of the patient".

35. Another MM stated: -

"The pre-hearing examination is an important inquisitorial element in many s. 2 hearings. Most s. 2 patients present in crisis, and may not be well known to services. Reports, oral evidence and patient representation can very limited. Practice ranges widely in quality, and at times may fall short of expected standards. Unnecessary detention or prolonged detention due to systemic failings in care are not uncommon. Alternatives to admission may not be properly considered. Risk assessments may be rudimentary, and undertaken by inexperienced professionals based on little knowledge of the patient. The patients' presentation may change rapidly and be quite at variance with both written and oral evidence. Even experienced legal members may struggle to elicit shortcomings in oral evidence. The PHE is therefore a very important safeguard in ensuring the proper working of this component of the Mental Health Act.

The PHE has many and complex functions in other situations. The discharge rate at the Tribunal is not the correct measure of their value and benefit."

36. Another MM commented: -

"In my opinion, in all s. 2 cases and where a PHE has been requested, the panel should have the benefit of a PHE feedback. At this early stage of the onset of the mental disorder or the relapse in s. 2 cases, the PHE assists in eliciting the

relevant information regarding the statuary criteria from the records and direct examination, with specific enquiry into the quality of the evidence base. The PHE is not just a snapshot of the current position but a complete evaluation of the relevant issues made by an experienced physiatrist with knowledge of the legal aspects. The reports and oral evidence are often inadequate given the short time scales. In other cases where one has been requested, the PHE assists the panel impartially, enabling the patient to provide information unhampered by situational stress and bias, thereby ensuring that justice is done.

37. Another MM said: -

"As a specialist medical member PHEs cause logistical difficulties when planning my availability and they reduce the number of sitting days I can offer. Despite this I still consider them to be a valuable exercise particularly in s. 2 cases. In a s. 2 the clinical team is often dealing with a previously unknown patient who may have been recently transferred from another unit. Reports are often scanty, prepared at short notice, lacking in detail (particularly about current mental state) and the PHE is an opportunity to obtain information which may be difficult to elicit in an actual hearing. It offers a forum in which the current and past mental state can be thoroughly examined in a setting that is far less intimidating than the hearing itself.

Realistically the abolition of automatic s. 2 PHEs would result in a patient who has been deprived of their liberty and who may be being forcibly treated (as is possible under a s. 2) not having easy access to a second opinion about their mental state. The short time scales mean that it is unlikely to be practical that a formal medical second opinion, legally aided, could be arranged. The medical opinions expressed at the time of sectioning may be 3 weeks old by the time of the hearing and may, in any case, have been affected by the acuity of the situation in which detention took place.

PHEs, particularly in s. 2, give the panel more information about possible risk issues in the hearing. This is particularly important when dealing with a detained person with whom the treating team may be unfamiliar.

In my opinion both the legal representative and the patient should be able to request a PHE. It can be quite inappropriate to ask detailed questions pertaining to mental state in a hearing (sensitive subjects, high arousal levels, denial etc) and if a patient wishes to be seen by the medical member in my experience they usually have good reasons to want to do so (not wanting to attend the hearing, not wanting to give evidence at the hearing, wanting another medical opinion). Obtaining a second opinion by Legal Aid is an expensive and lengthy process. I do not consider the practice of some legal representatives always requesting a PHE is appropriate. The PHE should be for a specific reason e.g. a person with learning or communication difficulties who may find the hearing overwhelming. I would suggest that a request from a legal representative in cases other than s. 2 (which I consider should always have a PHE) should be accompanied by a justification for that request.

I note the statement that PHEs are an anomalous practice when compared with other Tribunals. I am not convinced that this is a relevant point. Mental Health Tribunals deal with issues of public and individual safety, deprivation of liberty and compulsory treatment. The state is able to exercise great control over the lives of those subject to a s. (more so than in prison or Asylum centres where compulsory medical treatment is not possible) and thus my view is that the mechanisms for review of such control should be as robust and comprehensive as is possible.

I recognise the ongoing concerns about the dual role of the medical member when a PHE is carried out. Preliminary opinions are reached only about mental state not about detention. If it is truly believed that the medical member cannot accurately report back upon an interview and avoid reaching a conclusion about detention before the hearing then, rather than abolish the PHE altogether, it would surely be possible to add additional checks & balances, e.g.: the medical member formally tells the patient what they are going to say at the end of the interview (I already do this); the medical member does the feedback rather than the judge and the short adjournment for the representative to take additional instructions could be regular practice; the PHE is done in the presence of the legal representative (logistically difficult); the PHE feedback is done by a standard format and concentrates upon the patients views re: need for assessment/treatment in hospital, attitude to treatment and current mental state. I acknowledge that none of these suggestions removes the concern about the lack of cross examination. I would, however, make the point that independent reports are often presented by legal representatives in the absence of their author at the hearing."

38. Another MM stated: -

"I think the quality of scrutiny of the patients' circumstances in the hospital in which they find themselves, and the assessment of the necessity and legality of their detention will be compromised. I am not persuaded by the statistical arguments put forward by the MoJ, as they fail to examine individual cases or the evidence or the reasoning within any particular case. It must be very difficult for any patient to have to rely on the "performance" they managed to give before a more – or – less stuffy Tribunal and in front of their psychiatrist, one of their nurses and their care co-ordinator, all of whom disagree with their wish to be discharged. A PHE affords them an entirely different opportunity, which is a conversation with an independent Psychiatrist about their past history and current circumstances with whom the potential benefits and drawbacks of detention can be discussed in a neutral way. I think that this opportunity is vital in order to properly understand the patients' perspective and to hear and understand the evidence behind their case for discharge. Without a PHE the patients' sole lifeline is their solicitor and while most of them are competent and entirely professional, some are not, and this would inevitably compromise a patient being released.

An increasing number of patients seem to have some sort of traumatic history and if this hasn't been explored sensitively by the RC a PHE is an opportunity to do this and to think with the patient about their psychotherapeutic needs which are often overlooked by RCs. This is a highly relevant consideration to the question of the need for ongoing detention, as hospitals tend to focus on pharmacological as opposed to psychological therapies. The patient is being offered a short-term solution to a long-term issue and this fails to address their fundamental problem. If it is addressed, and they feel understood and heard and know that the help they really need is available, it can help them over their crisis and means they no longer need to be detained.

I am also not persuaded by the "snap shot" argument in s. 2 cases put forward by the MoJ and am rather taken aback by the statement that the PHE may assume too great a role in the assessment process. How has this been judged? What is the "correct" role of the PHE? Whose opinion is this? The quality of relevant and up to date evidence in RC reports of s. 2 cases varies markedly and the PHE often brings to light highly relevant information which has not been presented at all in the RCs report. Often in s. 2 cases the patients' mental state is in a state of flux. Sometimes the RC might have seen the patient shortly after admission but not recently. A PHE for such a case will generally have been undertaken on the day before or on the day of the Tribunal and this up to date assessment of the patients' mental state is highly relevant to the question of whether the criteria for detention are met on the day of the Tribunal."

39. A SLM said: -

"In cases where I have sat, and where I have sat where a decision to discharge has been made, contrary to the treating teams recommendation, the PHE has been an essential part of the decision-making process. Closer questioning and examination of the patient in a formal hearing environment is not only inappropriate but unfair.

40. A Judge said: -

"In my experience the Pre- Hearing Examination is valuable because of the knowledge of the patient and his/her notes which the medical member can bring to the Tribunal. That information assists identification of and pursuit of relevant lines of enquiry that might assist the patient or the protection of the public. One example I can give is striking in context. In this case the RC was recommending the discharge of the patient, who was subject to a s. 37/41 hospital and restriction orders made the previous year. We were concerned about risk to others. We persuaded the hospital to seek an adjournment because our medical member pointed out to the RC that he might have made the wrong diagnosis and if so, be giving incorrect medication. It had been a pre- hearing examination which had informed the medical member and thus us all of the problem."

41. Another Judge responded: -

"I strongly disagree. I have been a member of the Tribunal since November 1988 and have sat regularly. I find the information gleaned by the medical member at PHE is invaluable. Such hearings are always necessarily hastily convened and sometimes the RC sends a deputy to speak who has not seen the patient for more than a few minutes. The medical members are all very experienced and although may not have seen a patient for a lengthy interview they are well able to make an assessment and often know much more than the RC or his/her representative. They often find information which the RC etc have not done and sometimes the patient is more open with them as they do not regard them as the person who caused them to be in hospital."

42. Another Judge said: -

"No – I don't agree. I do not agree with the way "outcomes" have been used to justify a change. It is not right to use "outcomes" in MHT cases as a measure of worth in this way. Let's face it, if we relied on outcomes, there would be an argument to get rid of Tribunal hearings (whether paper or oral) or for the Legal Aid Commission to stop funding legal representation because relatively so few patients are discharged by Tribunal. It should be about allowing patients the opportunity to be heard, about increasing accessibility and dealing with cases fairly and justly.

S. 2 cases

1. The patient may not have been seen by the RC for several days. This can be compounded by the fact that the patient may not be known to the author of the social circumstances report and the nurse giving evidence may only have had cursory contact with the patient. The PHE gives valuable updating of information, both from perusal of records and from interview with P, leading to hearings being dealt with fairly and justly.

2. Example - in a recent s. 2 case, a patient had been transferred to a general hospital for treatment of physical problems a few days before the hearing and was unable to attend, but wished the hearing to proceed in his absence. He sought discharge of the s. and wished to transfer to a respite care home, where he had spent time previously. Disappointingly, he had not been seen by the professional team for days, although they had updates from liaison psychiatry team members, one of whom supported continued detention and the others suggested that the patient could be managed in the community. Fortunately, the medical member had gone "the extra mile" and had seen the patient in the general hospital and viewed the records. It was obvious to the medical member that the patients mental state appeared to much improved and that it was questionable whether the degree of the mental disorder was still made out. The hearing had already been postponed once so adjourning was not a viable option. The professional team still argued for detention based on degree. Had the medical member not seen the patient in the PHE, the evidence of improvement would have been scant at least. Transfer to a respite care home had not been mentioned in the reports. The

care coordinator confirmed that the patient had been in respite care home previously, had done well and had not left prematurely. The Tribunal discharged the section.

3. Example – in a recent s. 2 hearing the reports were a "bit thin" on the issue of risk. The medical member had read the electronic notes during the PHE which referred to a significant history of suicide attempts, which were not mentioned in the reports. The professional team was not aware of the full history and without this information the Tribunal may have discharged the section.

Non- s. 2 cases where a PHE has been requested because: -

i. "Patients are some of the most vulnerable people to come before the courts/tribunals with a range of problems, including learning difficulties, abusive backgrounds and poor emotional regulation, resulting in impulsive and unpredictable behaviour when challenged. It is obvious that some patients with such difficulties will find it intimidating to give evidence in a Tribunal setting, in front of a number of people, some of whom the patient will not have seen before. Or a patient may have an intense dislike of the RC or treating team, feeling that they never listen, which may make it difficult for the patient to give evidence without becoming agitated. The medical member can see the patient at a PHE in more informal circumstances when the patient may feel more able to express themselves and have a better opportunity to be heard.
ii. The PHE is particularly important when P does not attend the hearing which is relatively common. Without the PHE disproportionate weight can be given to the professional teams' evidence and there is no real counterbalance, in the absence of an independent report, which would be even more costly.
iii. I do not accept the argument that the medical member cannot be cross examined as a valid point supporting the abandonment of PHEs.
iv. We are an inquisitorial Tribunal – we rely on the expertise of our members. If patient does not attend, the legal representative is often the only person who can report the patients' intentions and comments on matters in the reports. The legal representative cannot be cross examined but that does not mean that we do not listen. Tribunals have different rules; hearsay evidence is admissible. The Tribunal is made up of skilled and experienced members who are well able to weigh up the feedback from the medical member as a "snapshot" and to determine what weight to attach to it.
v. If a legal representative cannot advise a patient to request a PHE, or request one themselves if the patient lacks capacity, there may be more likelihood of a legal representative requesting a independent report"

43. The above quotes are an example of views shared by the vast majority of individuals who responded to the consultation opposed to the proposal.

44. Additionally, the organisations who responded were also overwhelmingly against the proposal.

45. In a lengthy and considered response MIND explained that it is wholly against the proposal. It makes the point that the criteria for detention under the MHA is largely based on medical opinion which is why the existence of a medical member is essential. As the patient's application rests largely on medical opinion, it is essential that there is an effective challenge to the evidence put forward by the detaining authority. While other members of the panel can challenge matters of fact they are unable to assess the validity of the responsible clinician's evidence in the way the medical member can. It makes the point that the MM's presence itself is insufficient to ensure a fair hearing because the MM must also be informed and that is what the PHE provides. By assessing the patient and considering the medical notes the MM has at least some background evidence on which to challenge the evidence of the RC. The PHE also allows the patient to be seen in a more relaxed setting than in the MHT where their presentation may be better. With regard to the suggestion that the rate of discharge varies little whether or not a PHE has taken place MIND notes that there have been no statistics to support that claim. It also makes the point that discharge is not the only positive outcome of MHTs for patients, particularly in terms of recommendations, either statutory recommendations or non-statutory recommendations. It points out that it would be an error for the TPC to look at the PHE only through the lens of discharge rates.

46. The Royal College of Psychiatrists in a similarly considered and detailed response also expresses itself to be wholly against the proposal either to abandon PHEs or for hearings to proceed without the presence of a psychiatrist.

47. The Mental Health Lawyers Association indicated in its response that the topic had been discussed in depth by the membership and committee and that the Association is against the proposed change. Its response reads as follows: -

> "S. 2 cases
>
> In many such cases this will be the first time the client has been detained subject to the MHA. It is a frightening and bewildering experience.
>
> The timescales are tight for Tribunal applications and hearing dates which means it is not unusual for the client to spend more time with the Tribunal doctor in the PHE than to have spent with their allocated RC. Similarly, the Tribunal doctor may have greater familiarity with the client's notes and thus be in a stronger and

more informed position to question the RC, nurse and Social Worker/CPN on diagnosis, prognosis and treatment.

Case Example

For example, in the case of Mr A, the RC suggested emerging schizophrenia. The social worker had not met the client; the nurse had only met with the client briefly and the RC had only had one 1 to 1. The Tribunal doctor suggested drug related (and short term) psychosis. The client was discharged.

Because it is a frightening experience being detained, many clients do not trust their RC, especially at the start of a short-term section. or if they feel the RC is "to blame" for their detention. They are better able to have a full and frank discussion with a doctor whom they consider independent, rather than the one with the power to keep them detained.

Longer term sections (including forensic cases)

With the best will in the world, the diagnosis and appropriate treatment pathways for patients detained on long term sections can become accepted. Mistakes in previous diagnoses, mistakes in the client's history can become set in stone. (institutionalised folklore, as Lord Mumby described it) The PHE can assist in identifying and challenge this problem if it arises.

This does not always mean that the PHE will suggest a more liberal approach, rather that it will ensure a more thorough examination of the evidence.

Case Example

The MHLA wish to highlight the homicide inquiry report (chaired by Sir Louis Blom- Cooper QC), "The Falling Shadow". This inquiry focused on the homicide of a mental health professional, by a patient. It is notable that, in the lead up to the homicide there was a Tribunal and a PHE did not take place and the RC diagnosis and viewpoint was not subject to another psychiatrist's scrutiny. Specific mention of the omission of the PHE was made in this report.

CTO

If the client is doing well on their CTO, they will rarely meet with their RC. The PHE gives the opportunity for a thorough psychiatric examination.

Recommendation (statutory and non-statutory)

The PHE, with its access to progress notes, can help to identify problems which could be detrimental to a client's progress. Statutory recommendations, for example for increased leave or for a transfer to another hospital, can have a significant impact on the chances of future

discharge.

Children

It seems obvious that all our concerns raised above and elsewhere in this response (for example regarding stress, fear, difficulties in communicating and the need for privacy) apply with even more urgency to the cases of detained children. The PHE enables the child to meet in more relaxed surroundings, prior to the hearing and discuss their needs om a 1 to 1 basis. Then, when they attend the hearing at least one member of the panel is someone they have met.

In General

Having a PHE makes better use of the Tribunal's time. The Tribunal doctor's briefing to the other panel members prior to the hearing means their questioning can be more incisive. This can shorten the hearing, which is always a stressful time for clients. Also, the fact the client has met with one of the panel members, allowing some degree of familiarity can help relieve their stress.

The hearing is often also considerably shortened by the PHE due to what is in the medical member's disclosure to the Tribunal. If, for example, the representative is to advance the case and the criteria are not met because the client is remaining as a voluntary patient and yet (in the PHE) the patient has very clearly informed the medical member that, if the section is discharged, the patient will leave immediately – then the representative is unlikely to further advance that argument. This then allows the Tribunal to focus on the remaining potential arguments that the criteria are not met.

Many clients, understandably, prefer a private discussion (notably if there is a difficult in-depth offence to discuss) and are likely to be more open and honest, rather than evasive because of embarrassment/distress.

The PHE can also highlight any disagreements within the clinical team. For example, from reading the notes and meeting with the client.

Case Example

In the case of Ms F (following a recall), the Tribunal doctor could see that the previous RC who had known the client for 10 years had in fact requested unescorted leave which the MoJ had refused. The new RC, who did not know the client well, had declined to make a further request for leave. Also noted was that the nursing staff supported unescorted leave and indeed discharge, something not entirely clear in the reports."

Some responses favouring the proposed change

48. A MM agreed with the abolition of PHEs except in the cases where it is clear that the patient (not just the representative on their behalf) wants to be seen because they do not want to attend the MHT but they do want to speak to a member of the panel on their own. Some patients find it too difficult to attend hearings but do want to directly address the panel. The signature requesting a PHE, however, should be from the patient. The member went on to say that she had had requests that purportedly had been made by patients who she subsequently found to be so unwell that they could not possibly have requested a PHE.

49. A Fee Paid Judge commented that he supposed PHEs were desirable rather than essential, except for references under s. 68(6) where they are essential. However, he goes on to say that he would be reluctant to discharge a patient if neither he nor any other panel member had seen the patient.

50. Another MM agreed that the requirement for PHE in all s. 2 cases and other cases where one has been requested should be removed. However, no reasons were given.

51. One Mental Health NHS Trust supported the abolition of all PHEs on the basis (notwithstanding the view of the High Court) that is contrary to the principles for natural justice for the medical member to be both a judge and a witness.

52. Another Judge commented that the PHE adds little to the MHT process and potentially places the MM in a difficult position as they can effectively give evidence but they cannot be cross examined.

53. Another NHS Foundation Trust agreed they should be removed as the PHEs can be distressing for patients who are acutely unwell and if the evidence is that PHEs do not have an effect on the outcome then they should be removed. He says that the fact that they do not exist in Scotland supports this.

54. Three Salaried Judges of the Tribunal were in favour of removing PHEs saying: -

> "PHEs are not a pre- requisite to a fair and just hearing; hearings where there have been no PHEs are no less fair and just than those with and no other mental health jurisdiction, as far as we are aware, adopts this practise.

> We are not aware of any evidence to indicate that PHEs in any way affect the Tribunal's decisions and in our experience, they do not.
>
> Some patients may feel more comfortable in attending a hearing knowing that they have spoken to one member of the panel in advance but we are confident in the absence of PHEs Judges will continue to use their great expertise in managing hearings in such a way as to promote everyone's participation."

55. The three Judges were also not in favour of the MHT retaining a discretion regarding conducting a PHE as they did not accept that there would be cases where the MHT could not use its own expertise in order to conduct a fair and just hearing without one of its members having to interview the patient first (and invariably in the absence of their legal representative).

56. They said that the MM's preliminary view of a patient's mental state cannot be determinative in the MHT's decision-making and that issues regarding a patient's participation in the hearing can properly be facilitated by the Judge as is the case in other jurisdictions.

57. Another Judge who agreed with the proposal indicated that she had been opposed to the change in the rules which made PHEs optional in cases other than in s. 2s but has since found that in practice it has made much less difference than she thought it would:

> "The quality of PHEs is variable – sometimes they are very useful but often they do not add a great deal to the Tribunals ability to deal with cases fairly. The position of the medical member as a witness is also anomalous. The requirement for PHEs is stretching resources and reduces the number of sitting days for which medical members are available".

<u>Question 3 -</u> Do you agree with the proposal that, with references to the Tribunal, other than the exceptions set out in paragraph 3.2 (as opposed to applications from patients) a decision on the papers alone should become the default position, as outlined in the proposal above?

58. The number opposed were 129 and in favour 28[2]

<u>Some responses opposed to the proposed change</u>

59. A Judge commented that he felt very strongly that a reference to MHT should not have a default position of decisions on the papers. She pointed

[2] This does not comprise all of the responses due to those that responded with "no comment".

out that the reason referrals exist is to ensure that those patients that were in the past forgotten about, and languished in psychiatric hospitals without independent scrutiny is avoided.

> "Reference Tribunals made by hospital managers and the Secretary of State are a critical safe guard against the inappropriate and unlawful detention of mental health patients for who fundamental rights are at stake. The proposal that a patient may be detained for up to 3 years without any independent review other than a paper hearing is a step backwards to the pre- 1983 act. I do not know how a Tribunal can satisfy itself that a patient is at the material time i.e. the day of the hearing, "suffering from mental disorder"?
>
> I am unaware of any evidence to show the number of patients discharged following an oral hearing compared with the decisions made on the papers alone. There can be no proper testing of the evidence if the default position is a decision on the papers.
>
> It is particularly concerning for those patients that lack capacity as a reference to the Tribunal is the only opportunity to review and scrutinise their ongoing detention as they do not have the ability to make their own application. For long-stay patients this would mean only once every 3 years. Most importantly it is the only time that they would have access to legal representation, especially if they lack the capacity to instruct a legal representative. Not all patients wish to be discharged; however a legal representative may be able to consider other options for them such as requesting statutory recommendations such as moving through different levels of hospital security or recommendations for leave. These are highly unlikely to be considered without an oral hearing.
>
> Please note I would agree to paper hearings subject to safeguards, for some cases such as long term forensic cases where patients have been detained for many years, for example in maximum security. As a representative I have had clients who are in the middle of long term therapies who do not wish to be discharged and are working with their clinical teams. Often these patients do not want to attend a 3-year reference Tribunal. Provided these patients have received robust legal advice and their representative had a had an opportunity to scrutinise the reports and medical records, these sorts of cases could be subject to paper hearings."

60. The response of the Medical and Mental Health Law Research Interest Group did not agree with the proposal and that was the overwhelming view of those who volunteered their views. They state: -

> "There can be little doubt that a live hearing is the most advantageous (and therefore fairest) means of determining whether the statutory criteria are made out to justify the continuation of a detention order or community treatment order. Reasons to support their position include: -

Live evidence is invariably of a better quality than evidence presented on paper because it can be evaluated and interrogated in ways that are simply not achievable on paper;

Reports prepared for Tribunal hearings are often not up to date with the risk that the Tribunal has determined cases before it on evidence which does not reflect the patients' current clinical presentation or risk. The oral hearing enables the "up-to-date" picture to be presented by the authors of the reports and provides the opportunity for errors in those reports to be corrected. Also, the condition of patients often changes between the submission of the written reports and the hearing. The ability to consider such changes will not be available to the Tribunal under the proposed change to the rule. Decisions on papers alone will surely impede the exercise of the inquisitorial and Judicial function and make it more likely that decisions will be produced on the written evidence of the RC."

Many expressed the view that all MHT hearings are an important patient safeguard with patients more likely to perceive the paper review as a "rubber stamping" of their RCs decision to interfere with their liberty and that the proposals would reduce the current "rigorous review" involving patient representation and depth of discussion."

61. One MM in his response stated: -

"Patients whose cases are referred are often the most disabled and disadvantaged that we see. Many are in long term placements and no other automatic overview of their care. Some private providers may have a perverse incentive to take a leisurely time- scale when it comes to discharge planning. I have also noted that whilst most CCGs are proactive, not all are. For these reasons I believe that all references should have an oral hearing."

62. A SLM said that he strongly disagrees with this proposal: -

"Many references contain patients who are disadvantaged in certain respects, for example patients with a learning disability, who may lack capacity to make a decision as to whether they should request an oral hearing. How will the rights of such patients be protected? Not all will lack the relevant capacity, but decisions on the papers in such cases appear to have encountered a Government Policy since Winterbourne."

In paragraph 3.3 of the consultation document, it is pointed out that many oral hearings take place when a patient has not requested one, does not wish to attend a hearing, or may have no interest or engagement with the proceedings. While this may be true of certain patients, such as a community patient, subject to a CTO, in my experience most patients do engage by appointing a representative and by attending the hearing. The

crucial distinction is that community patients are not being deprived of their liberty. Many references concern patients whose CTO has been revoked by their RC and who then are subject to either a s. 3 or less commonly s. 37. These patients are deprived of their liberty at the stroke of the RCs pen. In my submission, it is therefore essential that these patients are automatically referred for an oral hearing. This is an important safe guard for vulnerable patients.

At paragraph 3.3 it is asserted (without any supporting evidence) that having more cases being dealt with on the papers alone. Great to speed up the work of the Tribunal but in my submission this fails to take into account the regular deficiencies in the reports prepared by the treating team. However, this deficit is usually overcome easily at an oral hearing, as the Tribunal panel uses its expertise to fill in the missing/inadequate information in the reports. In situations where the reports do not meet the requirements of the practice direction, a decision being made on the papers alone could run into serious difficulties but it might be necessary to make further directions regarding the reports, creating an unnecessary delay which most likely would not have occurred if it had been dealt with at an oral hearing.

At paragraph 3.4 comparison is made with the rules of the Social Entitlement Chamber. It is respectfully submitted that this is a false and unfair comparison for the following reasons: -

> The default position in that jurisdiction is that there is an oral hearing. My understanding is that the vast majority of cases is still dealt with by way of an oral hearing. Decisions in that jurisdiction do not relate to depriving people of their liberty.

A decision on the papers alone means that only one side of the argument will be considered, with all 3 professionals in most cases supporting detention. How can a fair and just decision be reached in such circumstances? How will the evidence of the detaining authority be tested?"

63. An MHT Judge commented that: -

"If cases are decided on papers alone, I can see little point in having those cases referred to the Tribunal. I have done a number of paper hearings and they are unsatisfactory. When a patient does not have legal representation, I do not think it is appropriate for one of the treating team to make the decision about their capacity and for it then not to be challenged when they write that the person neither wants a lawyer nor wishes to challenge the section under which they are detained. The issue of capacity is poorly understood and decisions are often found to be inaccurate if the professional making the assessment is closely questioned. Patients may not oppose their detention because of a sense

of hopelessness, rather than because they are genuinely not opposing it. On a paper hearing where there is no legal representation it is impossible to determine the patients' views."

64. The overwhelming majority of respondents to the Consultation shared the views outlined above.

Some responses favouring the proposed change

65. A solicitor in favour of the proposal indicated that he was in favour given that many oral hearings are required even though a patient has not made an application to the MHT, does not wish to attend the hearing or may have no interest or engagement with the proceedings. Further, he believes the proposal contains sufficient safeguards against injustice in the form of the patient or representatives right to request a hearing and the Tribunals power to direct a hearing.

66. Three Salaried Judges in favour of the proposal stated: -

> "Many referrals are not contested and there will be no disadvantage to any party given the proviso that an oral hearing could be requested as of right. A further safeguard would be in the Tribunal's ability to direct an oral hearing.
>
> It is appropriate that all patients have the same right to determine how proceedings affecting them are dealt with and this rule change will give parity to detained patients and those subject to CTOs.
>
> The Tribunals' workload is increasing and its resources (in terms of panel availability) is limited. The proposed rule change will therefore also benefit all patients if, as it should, it creates greater capacity to list oral hearings more quickly."

67. Given the overwhelming rejection of the proposal by the consultees, the TPC does not feel it necessary to record the responses to the remaining questions as they inevitably fall away in light of the responses to questions 1 and 3.

68. Most respondents shared the views of a Judge whose additional comments were: -

> "The rules are working well, the proposed amendments are unnecessary and unfair. It may well be that these proposals are driven by efficiencies to be made and the need for saving money. This jurisdiction deals with ill people whose cognition and comprehension may be compromised. They are vulnerable people who are deprived of their freedom and their right to

consent to treatment. Their ability to challenge the restrictions on their liberty should not be compromised. These are extremely important safeguards which should not be undermined because of financial considerations."

The TPC's Reply

69. The TPC has given careful consideration to the responses. We of course afford great respect to the views of the Chamber President, the then Deputy Chamber President and Chief Medical Member. However, given the overwhelming response against any change, supported by cogent reasons and evidence of direct experience, the TPC is not persuaded that it is appropriate to make the proposed changes.

70. It is clear that almost all of those who responded, including some large representative organisations and including those on the "other side of the table", being NHS Trusts or the Royal College of Psychiatrists, believe that the PHE does add value to the MHT. It provides a second, independent psychiatric opinion. is also clear that the majority of MHT panel members who responded do not support the proposals.

71. The TPC notes in particular the following points which were advanced against the proposals: -

- The PHE provides for greater participation in the process by the patient.
- The PHE reduces stress and anxiety at the hearing for the patient who will not need to be asked distressing questions.
- The PHE allows the patient to talk about their situation privately to a person not involved in their detention.
- The PHE allows for information missing from reports to be picked up.
- The PHE is a lesser cost to the public purse than independent psychiatric reports.
- The High Court has confirmed that there is no reason why the MM cannot carry out a PHE, provided the findings are disclosed at the outset of the hearing as they are currently.
- Having a second medical opinion to assist the panel reduces the possibility of the wrong decision being made, thus reducing the risk to both the patient and the general public.

- The system in England is not comparable to the Scottish system which operates in a fundamentally different way.

- In Wales PHEs are carried out in every case and there are no current plans to alter that.

- The outcome of MHTs cannot be measured by the numbers discharged but by whether the patient and their representative are satisfied that the case has been properly scrutinised with all relevant evidence before it.

- Those who have their cases referred to the MHT are the most vulnerable members of society, often lacking the mental capacity to make an application to the MHT.

- Disposals without a hearing would mean that the MHT panel would have evidence from only one party.

- The MHT panel would not have adequate information to decide whether an oral hearing is appropriate.

- There are a significant number of examples of MHTs reaching a decision on referred cases based on evidence that came out at the hearing and not contained in the reports.

Conclusion

72. The TPC has therefore concluded it is not appropriate to amend the Rules. The TPC acknowledges that the timing of the consultation has run in parallel with the ongoing independent review of the MHA chaired by Sir Simon Wessely (the Review). However, given that the Review is undertaking a "root and branch" consideration of the entire mental health and mental capacity system, the TPC does not believe it is necessary to await the Review's final report. The TPC consultation is about the MHT process rather than the law underpinning it and the TPC has decided against making any changes.

Annex A

Representations to the Tribunals Procedure Committee from the Chamber President, Deputy Chamber President and Chief Medical Member (HESC).

In the document "Judiciary Matters: Our Part in reforming the Courts and Tribunals", the Lord Chief Justice and Senior President of Tribunals set out a vision for modernisation and reform that provides an appropriate context for the necessary reform of, and improvements to, certain processes for determining cases in the mental health jurisdiction of the Health, Education and Social Care Chamber (HESC).

This paper is presented jointly by the Chamber President (HESC), the Deputy Chamber President with responsibility for the mental health jurisdiction, and the jurisdiction's Chief Medical Member. It builds on the experience of earlier changes to the Chamber Rules relating to pre-hearing examinations (PHEs) and paper reviews, and is the logical next step in an ongoing process of modernisation and reform. Our vision chimes with the aspirations set out in 'Judiciary Matters' including:

- New and alternative processes for resolving disputes that will enable many to be resolved without a contested hearing;
- Reducing the amount of judge time needed;
- New ways of working that are comprehensible, proportionate and swift, whilst providing for the needs of users in a more cost-effective way;
- Enabling decisions to be made at the most appropriate level and ensuring that valuable (and expensive) judicial time is used in a proportionate and effective way;
- Creating a system in tribunals that enables people to manage and resolve a dispute fairly and speedily, and involving fewer hearings. This will involve simpler processes, resolving cases out of the hearing room where possible;
- Faster resolution of those cases that do enter the system through a more proportionate approach - supported, where appropriate, by technology;
- Creating a system that is financially viable through a more cost-effective infrastructure (physical and digital) and streamlined working practices;
- Reducing complexity in systems, processes and language and using judicial time in a more proportionate way through simplification, reducing hearing times, and possible changes to panel composition in tribunals;

- The business case for reform includes a £76m annual saving in judicial costs (uprated for inflation) and savings will be achieved through a combination of measures, including reducing the number of fee-paid sitting days.

We therefore present these requests for amendment to the Chamber Rules, as a key part of our contribution to the HMCTS Programme for Modernisation and Reform.

The caseload of the mental health jurisdiction can be divided into a number of easily identifiable categories – for example:

- patients who are detained for a very short, time-limited, period under S. 2 Mental Health Act 1983 (MHA) - principally for assessment of any mental disorder. In these cases, the length of time left by the time a tribunal convenes, is usually between 21 and 7 days, with (on average) just 14 days left to run;
- patients who are detained in hospital for medical treatment including compulsory treatment, for several months or years;
- patients who have not applied for a hearing but whose cases are automatically referred because of the passage of time;
- patients who have not applied for a hearing but whose cases are referred under discretionary powers by the Secretary of State, or due to a specific event;
- patients who have applied for an oral hearing of their case.

The mental health jurisdiction sees merit in the Senior President being able to have regard to the category of case when determining panel composition.

However the requirement for a PHE in all S.2 cases, and any case where a PHE is requested, removes all potential for flexibility on panel composition in **all** cases, since a PHE (as opposed to an on-ward visit by, say, a judge) needs to be carried out by a Medical Member who then, in effect, becomes a quasi-witness giving potentially disputed evidence before the panel of which they are, themselves, a judicial member.

Thus, although panel composition is likely to remain a matter for the Senior President, the compelling arguments in favour of changes to panel composition in relation to some categories of case (particularly paper reviews and S.2 cases) directly affect the submission to the Tribunals Procedure Committee in relation to PHEs.

In short, any potential or possible obligation to carry out a PHE at any stage leads to a requirement to always include a Medical Member in the panel, thereby preventing any flexibility in this regard, in relation to tribunal panel composition.

S. 2 PHEs

Patients detained under S. 2 are liable to be detained under the Act for a maximum of 28 days, and principally for assessment rather than compulsory medical treatment. On average, by the time a tribunal convenes, the length of time a patient remains liable to be detained under their S. 2 order is just 14 days. It may be a mere 7 days or less, and it is rarely more than 21 days. Moreover, the principal reason for a S.2 detention is for assessment although, if necessary, treatment may commence.

Given the short period of time involved, and the principal purpose of the detention under S.2, we consider that, as a proportionate means of judicial determination, all applications by patients subject to S.2 could be dealt with by a judge alone.

This would also represent a more flexible and effective use of scarce judicial resources, especially given the need to deploy judicial decision-makers in such cases at very short notice, and to anywhere in England. The current Chamber Rules, rightly, impose an obligation on the tribunal administration to achieve two things.

First, there is a legal duty to convene extremely quickly (Rule 37(1)). Second we must give the parties a reasonable time to prepare (Rule 37(4)(a)). The combination of these two imperatives limits the tribunal to, quite literally, one possible day for listing (two at the most) – regardless of whether there is a full panel available in the relevant area. Particularly given the shortage of Medical Members across the country, this can present serious problems, with the only solution being either to delay the hearing until a full panel can be found, or to curtail the time the parties have to prepare.

As they accumulate years of service, mental health judges become experts in their field and are well able to assess medical, nursing and social evidence, just as judges in other jurisdictions do within their fields of expertise. Judges sitting alone at a similar level of the judicial hierarchy,

(e.g. in the Immigration and Asylum Chamber, or in the Magistrates' Court) have far greater powers to deprive a person of their liberty.

Clearly it will not be possible to invite the Senior President to consider a degree of flexibility in relation to S.2 cases (or any other categories of case) if there continues to arise any sort of requirement for a PHE by a Medical Member.

When the Rules in relation to PHEs were first amended, the tribunal saw some merit in retaining PHEs for all S.2 cases. In the light of experience, however, we have come to the firm conclusion that PHEs offer little positive assistance on S.2 cases and may be in fact present a potentially misleading picture. We say this because, given that the purpose of detention for up to 28 days is to conduct a proper assessment, there is a real danger that the 45-minute (or so) snapshot of a PHE assumes too great a role in the assessment process and influences the panel to a disproportionate degree. Moreover, having now lived without PHEs in around 50% of non-s. 2 cases, we believe that PHEs add little or nothing to the evidential basis upon which tribunals make their judicial decisions. In these cases, we have not found that PHEs make any significant difference to outcomes, and we do not believe that the demands that PHEs make on judicial time and financial resources can now be justified.

Other PHEs

In terms of requests for PHEs, we have seen only one pattern – namely that some legal representatives ask for PHEs in all cases, others hardly ever do, and some areas of the country are more prone to PHEs than others. But we have not seen evidence that legal reps are using the right to ask for a PHE in a considered or selective way. There are no indications that PHEs are being requested in those cases where the patient may derive any benefit from it – assuming that there is any benefit to be derived. Nor have we seen any significant affect on outcomes in the 50% of cases where there is no PHE, compared with those where a PHE has been carried out.

The Mental Health Tribunal in Scotland manages perfectly well without PHEs.

We also continue to have no proper answer to the obvious concern that the PHE is a judicial anomaly. There is no other jurisdiction we know of where one member of a three person judicial panel may have a private one-to-one conversation with one of the parties, in the absence of their

legal representative, and in the absence of any other parties. In all other jurisdictions, this would be regarded as a breach of natural justice.

Abolition of Rule 34 and Rule 39(2)(b) and Replacement with a Power to Visit.

Thus, we consider that Rule 34 in its present form should be abolished.

This would also require the removal of Rule 39(2)(b), which requires that an attempt at a PHE be made, should the patient be unable or unwilling to attend the hearing. We have not found that patients or panels consider this to be beneficial, and (if the PHE goes ahead, which it rarely does in such circumstances) then the tribunal panel can get behind with their day's work, and run late – with inconvenience to other patients.

We would like to replace these Rules with a provision that, following representations on the point, or on their own initiative, the panel has discretion to decide that one or more members of the tribunal panel may visit a detained patient on the ward, immediately prior to, or during, the hearing. But such discretion would only arise if the patient is unwilling or unable to attend the hearing and the panel considers that such a visit is necessary for the fair and just disposal of the case. We stress, however, that the purpose would not be an impromptu medical examination, and the visit could be by a judge or specialist lay member, or any combination of panel members, depending on the circumstances and reasons why a visit is appropriate and necessary.

Paper Reviews

The tribunal's experience of paper reviews has been positive, save that we still need to convene a full panel when, in our view, the paper review could be dealt with by a judge alone, and save for complications arising due to the fact that Rule 35(3) requires a positive request not to have a hearing from patients who, almost by definition, do not wish to engage with the tribunal process. Ironically, therefore, we find that we still have to convene for a full oral hearing for the most disinterested patients.

We consider that the default position should be that unless a party requests an oral hearing - such request being granted as of right - and subject to particular exceptions (see below) all referrals should start life as a paper review by a single judge, with the judge having unfettered power to

refer the case for an oral hearing before a full panel should this be considered necessary for a fair and just disposal of the case.

This provides a number of safeguards, including a safeguard for those patients who may lack capacity to decide to ask for an oral hearing. The reviewing judge would have the benefit of all the reports, and would be in a good position to take all necessary steps to ensure that the case was dealt with fairly and justly, including the making directions, or referring the case for an oral hearing before a full panel. As a further safeguard, all patients have entitlement to free, non-means tested and non-merits tested legal aid. We therefore consider that extending the paper review procedure to most referrals, and making the paper review the default starting-point, strikes the right balance, and ensures regular and timely reviews by a judge, whilst also ensuring a full oral hearing is given to all patients who want one, or need one.

Proposal to amend Rule 35

A paper review should be the default position for ALL references to the tribunal by Hospital Managers or by the Secretary of State for Justice unless:

a) any party makes a written request to the tribunal for an oral hearing; or

b) at the date of the reference the patient is under the age of 18; or

c) the reference is a discretionary reference by the Secretary of State made under S. 67(1); S. 71(1) of the Mental Health Act 1983; or

the tribunal decides that an oral hearing is necessary for the fair and just disposal of the case. The Chamber President, Deputy Chamber President and Chief Medical Member would be willing to meet with the Tribunals Procedure Committee at any time to discuss this submission further.

HH Judge Phillip Sycamore (Chamber President)
Judge Mark Hinchliffe (Deputy Chamber President)
Dr Joan Rutherford (Chief Medical Member)

March 2017

Annex B

List of Respondents

David Pickup	**Pickup & Scott Solicitors**
Dr R.L Symonds	**Tribunal Service (Mental Health) - Medical Member**
Emma Silburn	**David Gray Solicitors LLP**
Simon Burrows	**Mental Health Tribunal - Judge**
HH Judge Stephen Eyre QC	**Judge sitting on Restricted Patients Panel (RPP)**
Brian Linfield MBE JP	**Mental Health Tribunal - Specialist Member**
Dr Riadh Abed	**Mental Health Tribunal - Medical Member**
Margaret Stevenson	**Mental Health Tribunal - Judge**
John Moran	**Tribunal Lay Member**
Dr Lester Sireling	**First-tier Tribunal (Mental Health) - Medical Member**
Toolan	**Judicial Member - Judge**
Dr Neil Boast	**Mental Health Tribunal - Medical Member**
Ian Harris	**First-tier Tribunal (RPP) - Judge**
Keith Dudleston	**Mental Health Tribunal - Medical Member**
Clare Chambers	**First-tier Tribunal (Mental Health) - Medical Member**
Fade Ibitoye	**Tribunal Service (Mental Health) First-tier Tribunal - Medical Member**
Dr Martin Gee	**Mental Health Tribunal - Medical Member**
HH Judge Richard Parkes QC	**Circuit judge - RPP judicial member**
Anne Golding	**Mental Health Review Tribunal - Judge**
Brian Cairns	**Mental Health Tribunal - Specialist Lay Member**
Dr Robin Arnold	**Mental Health Tribunal – Medical Member**
Elizabeth Fistein	**Mental Health Tribunal – Medical Member**
Russell Parkes	**Mental Health Tribunal - Judge**
Dr Sarah Markham	**Sussex Partnership NHS Foundation Trust**
Richard Ebley	**Retired – Member of the public**
Kirsty MacMillan	**Anthony Collins Solicitors**
Rebekah Sambrooks	**Anthony Collins Solicitors**
Sue Pitt	**Mental Health Tribunal - Judge**
Malcolm Coward	**Mental Health Review Tribunal – Specialist Lay Member**
Jane Marston	**First-tier Tribunal (Mental Health) - Judge**
Robert Holt	**Tribunal Judge**
Dr Suresh Chari	**Tribunal Medical Member**
Dr Anne Moynihan	**Tribunal Medical Member**
Robert Gregory	**Cartwright King Solicitors**
Judge Deborah Postgate	**First-tier Tribunal (Mental Health) - Judge**
Dr Erika Harris	**Medical Member**
Ahmed Waqar	**National Health Service**
Lucy Caswell	**Mental Health Review Tribunal – Lay Member**
Cheyvonne Buffonge	**Inyama & Co – Legal Professional**
Linda Montague	**First-tier Tribunal (Mental Health) – Medical Member**
Sophia Withers	**Bishop & Light Solicitors Ltd (Solicitor)**

Mike Bishop	**David Gray solicitors, Newcastle upon Tyne**
Judge Stephen Waine	**Mental Health Review Tribunal - Judge**
Dr Andrew Easton	**First-tier Tribunal (Mental Health) – Medical Member**
Dawn O'Rooke	**Mental Health Tribunal – Specialist Lay Member**
Judge Felicity McCarthy	**Tribunal Judge**
Dr Glen Berelowitz	**First-tier Tribunal (Mental Health) Medical Member**
Tam Gill	**Gledhill Gill Solicitors (Principal Solicitor)**
Holly Paulsen	**Mental Health Policy Group**
Anthony Holton	**Tribunal Member**
Janet Carrick	**Mental Health Tribunal – Medical Member**
Dr Hazim Obaydi	**Mental Health Review Tribunal – Medical Member**
Anonymous Patient	**Evenlode Oxford Health (member of the public)**
Michael Chalmers	**Barnet, Enfield and Haringey Mental Health NHS Trust**
Robert Lizar	**Robert Lizar Solicitors**
Shamim Dinani	**First-tier Tribunal – Medical Member**
David Owen	**Mental Health Judiciary - Judge**
Judge Iris Mayne	**Mental Health Tribunal - Judge**
Patrick Keown	**NTW NHS Foundation Trust**
Judge Rupert Mayo	**First-Tier Tribunal (HESC) Mental Health - Judge**
Dr Mark Roberts	**HMCTS- Tribunal Medical Member**
Dr Robert Adams	**First Tier Tribunals (Mental Health) – Medical Member**
Justin Hay	**MOJ - Mental Health directorate – Medical Member**
Dr Sajida Nabi	**West London Mental Health NHS**
Helen Reynolds	**Worcestershire Health & Care NHS Trust**
Ita O'Keeffe	**Mental Health Tribunal – Lay Member**
Judge Therese Kamara	**First-tier Tribunal – HESC (Mental Health) - Judge**
Josephine Richards	**Mental Health Review Tribunal – Lay Member**
Alison Ward	**Cartwright King Solicitors**
Kenneth Wood	**Mental Health Review Tribunal – Medical Member**
Hansi Smythe	**Needham Poulier Solicitors**
Judge Neil Robinson	**Mental Health Tribunal - Judge**
David McLaughlin	**Edwards Duthie, Solicitors**
Melanie Lidstone-Land	**Swain & Co Solicitors - Mental Health Team**
Judge Hamish Hodgen	**Mental Health Tribunal - Judge**
Karen Wolton	**Wolton and Co (Legal Profession)**
Andy Howarth	**T Jones Solicitors**
Robert Beech	**Hogans Solicitors**
Basmah Sahib	**Bindmans LLP (Legal Profession)**
Zoe Payne	**Mental Health Tribunal Members Association (MHTMA)**
Phillippa Ashcroft	**VoiceAbility**
Rhian Williams-Flew	**First Tier Tribunal - HESC (Mental Health) - Judge**
Diana Fewlass	**Mental Health Tribunal - Judge**
Mark Osborne JP	**First-tier Tribunal (Mental Health) – Specialist Lay Member**
Dr A M Dearden	**First Tier Tribunal (HESC) Mental Health – Medical Member**
Ciara Panayiotou	**Curwens LLP Solicitors - Solicitor**
Kay Sheldon	**Mental Health Tribunal - Specialist Lay Member (responding as an individual)**
Alison Clark, Duncan Birrell, Judith Foster	**First-tier Tribunal (Mental Health) – Salaried Tribunal Judges**

Rebecca Ellison	**Abbotstone Law and Steel and Shamash Solicitors – Consultant Solicitor**
Shoni Newell & Burke Niazi	**Burke Niazi Solicitors & Advocates**
Sam Rowlands	**JD Sellars Solicitors**
Kate Mercer	**Kate Mercer Training**
Khee Guan Tan	**Oxford Law Group**
Carolyn Taylor	**Mental Health Tribunal Judge, a solicitor representing patients at Mental Health Tribunals and a member of the advisory panel of the government's Independent Review of the Mental Health Act**
Angela Wall	**Butler & Co Solicitors**
Judge T Prestbury	**First-tier Tribunal (Mental Health) - Judge**
Northumberland Tyne and Wear NHS Foundation Trust, Mental Health Legislation Team	**NHS Provider**
Tonia Forster	**Northumberland Tyne & Wear NHS Foundation Trust - Nurse Consultant- Approved Clinician/Family Therapist - Children & Young Peoples Service**
Patrick Keown	**Northumberland Tyne & Wear NHS Foundation Trust**
Dr Andrew Cairns	**Northumberland Tyne & Wear NHS Foundation Trust - Consultant Perinatal Psychiatrist**
Tam Gill (Chair) on behalf of Mental Health Lawyers Association	**Mental Health Lawyers Association**
Anselm Benedict	**The Law Society**
John D Sellars	**John D Sellars Solicitors**
John Watts	**First-tier Tribunal (HESC) Mental Health – Medical Health**
John Horne	**Fee-paid Judge – North East**
Jamie Nelson	**CartWrightKing Solicitors – Independent Solicitor**
Alison Clark	**British Psychological Society**
Dr Prakash Raviraj	**Tribunal Medical Member and Consultant Forensic Psychiatrist**
Judge Anthony Talbot	**First-tier Tribunal - Judge**
Paul Weems	**Mental Health Tribunal – Lay Member**
Peter Scanlon	**Mental Health Tribunal – Lay Member**
Emily McCarron	**Age UK**
Robert Houghton	**seAp Advocacy**
Deborah Robinson	**Legal Professional**
Tanya Thomas	**Judge**
Ruth Sagovsky	**First-tier Tribunal (Mental Health) – Medical Member**
Michael Henson-Webb	**MIND – Head of Legal**
Dr C Cruickshank	**Tribunal Medical Member (responding as an individual)**
HH Jonathan Teare	**Mental Health Tribunal – Restricted Patient Chairman**
Simon Newton	**Donovan Newton Solicitors**
Bondada Kurmarao	**Mental Health Tribunal – Medical Member**
Simon Smeardon, JP	**Mental Health Tribunal – Lay Member**
Sarah Yiannoullou	**National Survivor User Network – Managing Director**
Judge Skelton	**Mental Health Tribunal - Judge**
Judge Sarah Spear	**First-tier Tribunal (Mental Health) - Judge**
Dr G Spoto	**Consultant Psychiatrist and First-tier Tribunal (Mental Health) Medical Member**
Pamela Charlwood	**First-tier Tribunal (HESC) Mental Health - Specialist Lay Member**
Dympna Ryan	**Medical Member**

Judge D M J Warren	**Mental Health Tribunal - Judge**
Judge Caroline Byram	**Tribunal Judge**
Dr Gillian Elizabeth Moss	**Medical Member of the Mental Health Tribunal and was a Consultant Psychiatrist from 1988 to 2012**
Miss Alex Simpson	**Patient**
Eamon Greville	**Tribunal Lay Member**
Dr Hugh Series	**First-tier Tribunal (Mental Health) – Medical Member**
Dr Peter Jarrett	**Medical Member**
David Dodwell	**Tribunal member- Ministry of Justice**
Dr JJ Scanlon	**First-tier Tribunal (Mental Health) – Medical Member**
Judge Corinne Singer	**Mental Health Tribunal Judge and Consultant Solicitor specialising in mental health**
Carole Burrell	**Medical and Mental Health Law Research Interest Group (MELRIG), Northumbria University**
Peter Edwards	**Peter Edwards Law**
Dr Paul Divall	**Mental Health Tribunal – Medical Member**
Sarah Cannell	**First-tier Tribunal (HESC) – Specialist Lay Member**
Sophy Miles	**First-tier Tribunal (Mental Health) – Legal Member**
Dionne Allen	**First-tier Tribunal (Mental Health) - Judge**
HHJudge Daniel Pearce-Higgins QC	**Mental Health Tribunal – RPP Chairman**
Dr Chris Jones	**Tribunal Medical member**
Judge Philippa Graham	**Mental Health Tribunal - Judge**
Sam Grant	**LIBERTY**
Robert Atherton	**Mental Health Tribunal – Legal Member**
Sean Maskey	**Mental Health Review Tribunal – Medical Member**
Judge Robert Robinson	**First-tier Tribunal - Judge**
Amy McGregor	**Royal College of Psychiatrists**
Anthony Elleray QC	**Exchange Chambers**
Dr A G Patel	**Mental Health Tribunal - Medical Member**
Judge C Hughes OBE	**Tribunal Judge (civil cases)**
Kate Luscombe	**Abbotstone Law**
Will Johnstone	**RETHINK**
Clare Chambers	**Medical Member**
Dr. Terence Michael Reilly	**Mental Health Tribunal – Medical Member**
Kerry-Anne Effiom	**Avon and Bristol Law Centre**
Alexandra Day	**First Tier Tribunal (Mental Health) – Lay Member**
Rosaleen Leonard	**Barrister**
Caroline Sullivan	**First-tier Tribunal (Mental Health) - Specialist Member (Medical)**
Dr S M Knightly Seneviratna	**Mental Health Tribunal – Medical Member**
Dr Mark Allsopp	**First-tier Tribunal (Mental Health) – Medical Member**
Dr. Manoj Sukumaran	**Forward Thinking Birmingham and Medical member on First-tier Tribunal (Mental Health)**
Judge Simon Gledhill	**Mental Health Tribunal - Judge**
Philippa Dawson	**Deputy Trust Mental Health Law Manager - Camden and Islington NHS Foundation Trust**
Tim Gunning	**Equality and Human Rights Commission**
R.J. McGregor-Johnson	**Tribunal Judge**
Judge Alison Callcott	**Mental Health Tribunal - Judge**

Martin William Donovan	**Mental Health Tribunal – Medical Member**
Dr Elizabeth Parameshwar	**First-tier Tribunal (Mental Health) – Medical Member**
Dr R Ramana	**Medical Member**
Dr Shanker Waghray	**Mental Health Tribunal – Medical Member**
Clifford Piarroux JP	**Mental Health Review Tribunal – Specialist Lay Member**
Dr Peter Hindley	**Mental Health Tribunal – Medical Member**
P C Naik	**Mental Health Tribunal – Medical Member**
Dr Clive Britten	**Mental Health Tribunal – Medical Member**
Nicola Mulderig	**Tribunal Panel Member**
Judge Robert Orme	**Mental Health Tribunal - Judge**
Angela Barney	**First-tier Mental Health Tribunal – Lay Member**
Maria Broughton	**First-tier tribunal (mental health) – Lay Member**
Dr Jonathan Cripps	**First-tier Tribunal – Mental Health and Social Security Child Support Tribunals – Medical Member**
Mat Kinton	**Care Quality Commission**
Paul Gantley	**Mental Health Tribunal – Specialist Lay Member**
Paige Newell	**ABR Solicitors**
James McAulay	**ABR Solicitors**