IN THE UPPER TRIBUNAL
ADMINISTRATIVE APPEALS CHAMBER

Appeal No. HM/2133/2015

Appellant: MM

First Respondent: The WL Clinic

Second Respondent MHU

DECISION

1. The application for permission to appeal is refused.

2. If the Secretary of State pursues and seeks expedition of his application for permission to appeal before the Court of Appeal the decision remitting this case to the First-tier Tribunal is stayed pending the determination of that application.

REASONS

Overview

1. In my view:
   i) the background to this case ,and
   ii) the point that the grounds of appeal are not only relevant to restricted patients

   mean that the application for permission to appeal should be decided by the Court of Appeal so that if permission is granted appropriate directions can be made for expedition and in respect of the issues to be heard and determined and representation.

2. In particular, the ground of appeal relating to the ratio of the decision of the Court of Appeal in *RB v Secretary of State for Justice* [2010] UKUT 445 (AAC) and *B v Secretary of State for Justice* [2012] 1 WLR 2043 (the *RB* case) is not confined to the jurisdiction of decision makers under the Mental Health Act 1983 (the MHA) in respect of restricted patients.

3. In *Secretary of State for Justice v KC and C Partnership NHS Foundation Trust* [2015] UKUT [2015] UKUT 0376 (AAC) (the *KC* case) I rejected the argument advanced by the Secretary of State that the *RB* case is binding authority to the effect that no FTT can direct a conditional discharge of a restricted patient on conditions that, if they are put into effect, would applying the decision of the Supreme Court in *Cheshire West and Cheshire Council v P* [2014] UKSC 19 (*Cheshire West*) result in an objective deprivation of liberty of the patient outside hospital.

4. My conclusion was that the ratio of the *RB* case on the power conferred on the FTT by s. 73 of the MHA :

   i) goes no wider than the proposition that the lawfulness requirements of Articles 5(1) and 5(4) relating to a deprivation of

liberty resulting from conditions imposed on the conditional discharge of a restricted patient cannot be founded on the MHA alone, and so is that

ii) the FTT cannot when directing a conditional discharge impose conditions that when they are implemented would be a deprivation of liberty in breach of Article 5 and so unlawful.

5. The first ground of appeal advanced by the Secretary of State is that I was wrong to reject his argument and the FTT has no power to impose conditions on a conditional discharge of a restricted patient that when implemented will create an objective deprivation of liberty.

6. This jurisdictional argument was advanced before me in the *KC* case on the basis that it makes no difference whether the objective deprivation of liberty is or can be made lawful. The argument was that the MHA does not give a power to the FTT to direct a conditional discharge on terms that include and so impose conditions that when implemented will create an objective deprivation of liberty

7. It seems to me that if that argument is right:

i) the Secretary of State also has no such power under s. 42 of the MHA,

ii) a responsible clinician also has no such power and so has no power to include such conditions in a community treatment order (a CTO) under s. 17B of the MHA, and

iii) a guardian cannot pursuant to s. 8 of the MHA require a person to live at a place when his or her care plan includes conditions that objectively deprive the person of their liberty (unless such a deprivation of liberty has been already authorised under the Mental Capacity Act 2005 (the MCA) applying different tests to those applied by MHA decision makers).

8. Accordingly, it seems to me that if the argument of the Secretary of State on the ratio of the *RB* case is right it places significant difficulties in the way of implementing the underlying purpose of the MHA to:

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

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

9. Also that jurisdictional argument of the Secretary of State leads to what many would consider to be the counter intuitive result that a breach of

a patient's Convention rights thwarts the implementation of a conditional discharge or a CTO (or a direction by a guardian as to where the person should live) that:

i) is in the best interests of the relevant patient, and

ii) promotes that underlying purpose of the MHA

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

10. In my view these points need to be addressed in the consideration of the arguability of the first ground of appeal and may explain why the Secretary of State has not pursued this jurisdictional point by appealing the *KC* case or by raising it in *PJ v A Local Health Authority and Others* [2015] UKUT 0480 (AAC) (the *PJ* case).

11. I acknowledge that the points made above support the contention in paragraph 8 of the notice of appeal that if it is arguable this jurisdictional ground of appeal is one of importance not only in the application of ss. 37 and 41 of the MHA but in respect of other important provisions of the MHA (including s. 42 under which the Secretary of State can discharge a restricted patient from hospital on conditions) and provisions relating to CTOs and guardianship.

12. If I had concluded that it was appropriate for me to determine this application, to enable me to address the arguability of the first ground I would have invited submissions from the Secretary of State on how he maintains that decision makers under the MHA can achieve its purpose set out in paragraph 8 above in respect of restricted patients, CTOs and guardianship if as he contends they have no power to include conditions that would create an objective and lawful deprivation of liberty.

Background

13. This appeal to the Upper Tribunal raised the point whether for the purposes of Article 5 a restricted patient who has the capacity to do so can give a valid consent to the terms of a conditional discharge that, when implemented, will on an objective assessment create a deprivation of the patient's liberty.

14. It was therefore a follow up to my decision in the *KC* case which related to a restricted patient who lacked the relevant capacity to consent to the conditions of his conditional discharge, his care package and any deprivation of his liberty that would arise from their implementation in which I concluded the FTT could impose such terms provided that any

deprivation of liberty was authorised under the MCA. I also set out obiter views on the position of a restricted patient who had capacity.

15. In the *PJ* case I concluded that it would not be appropriate to convert those obiter conclusions in the *KC* case to ratio stating that there was little doubt that an appeal would be made in which, if they were followed, they would be ratio.

16. This was such an appeal.

17. The *PJ* case related to the approach of the FTT to the discharge of CTOs. I joined both the Welsh Ministers and the Department of Health because it was obvious that the case raised issues of general importance. These related to:

    i) the underlying problem whether the conditions that are necessary to protect the public and the patient, and so conditions that are needed on a proper application of the tests set by the MHA to protect the patient or the public, can be lawfully included by the MHA decision maker (the responsible clinician) in the CTO if they create an objective deprivation of liberty, and

    ii) the approach to be taken by FTTs if the conditions of a CTO created an objective deprivation of liberty.

18. On the approach to be taken by FTTs to the Convention rights of the patient and in particular to those under Article 5 earlier authority in the Upper Tribunal was that the FTT could effectively ignore a breach of Article 5. In those cases and before me it was not argued that the *RB* case meant that the MHA decision maker had no power under the MHA to impose any such conditions.

19. The Welsh Ministers and the Department of Health took no part in the *RP* case. I gave permission to appeal for the reasons I set out and do not know whether any such appeal has been brought and so whether on that appeal the jurisdictional point based on the *RB* case that the responsible clinician has no power under the MHA to include conditions in a CTO that will create an objective deprivation of liberty has been taken by the Government Departments in any such appeal.

20. ***Appeal of the KC case.*** As mentioned in paragraph 7 of the grounds of appeal in the written argument the Secretary of State stated that he considered that the *KC* case was wrongly decided and I was told that he might pursue those argument on an appeal. But in my view that paragraph does not provide a full background picture of the approach that has been taken by the Secretary of State in pursuing a

jurisdictional point which he now asserts is one of considerable importance (see paragraph 8 of the grounds of appeal).

21. I was told that the Secretary of State had not appealed my decision in the *KC* case on the jurisdiction of the FTT because he was content with the result so far as *KC* was concerned. I did not understand that stance because the result in the *KC* case was that the Secretary of State should invite the FTT to reconsider *KC*'s application applying my conclusion on its jurisdiction.

22. In my judgment I recorded that this stance may have been because the incident referred to in paragraph 25 of my decision in the *KC* case had rendered such a re-consideration unnecessary. But I later found out that this was not the case when the *KC* case came before me on 7 December 2015 in the Court of Protection. I then found out that after the hearing in this case (29 September 2015) the *KC* case had been reconsidered by the FTT on 28 October 2015. It applied my decision in the *KC* case (so far as I am aware without any point being made that it was wrongly decided) and effectively confirmed its earlier decision and approach.

23. At the Court of Protection hearing on 7 December 2015 counsel for the Secretary of State (who was and is counsel in this case):

    i) took no point that, contrary to my view in the *KC* case, the FTT had no jurisdiction to make the decision it did and that the Court of Protection was being invited to make a welfare order based on a decision that the FTT had no power to make, and did not

    ii) indicate that the Secretary of State was appealing this case on the basis that the *KC* case was wrongly decided (or seeking permission out of time in the *KC* case to appeal).

    Rather the Secretary of State supported the application for the welfare order sought in respect of a care plan including the conditions required by the FTT that created a deprivation of liberty and at my request advanced argument on the process / procedure that should be adopted in such cases so that I could give some guidance on that with a view to setting out a procedure under which such cases would be dealt with speedily by the Court of Protection.

24. The Secretary of State also sought and ordered that he should be informed in advance of any proposed changes in the care plan that reduced the restrictions imposed by the FTT. He argued that this was needed to enable him to assess whether *KC* should be recalled to

hospital and that I should include such a provision in my order under s. 16 MCA because a person with capacity could decide that he wanted the Secretary of State to be so informed.

25. This does not fit easily with the second ground of appeal in this case.

26. It appeared to me from this approach (it seems wrongly) that the Secretary of State:

i) was no longer considering an appeal in this case on the basis that the *KC* case was wrongly decided, and that he was

ii) proceeding on the basis that the Court of Protection was making its decisions because if P had capacity he could make the same decisions himself.

27. Going back in time, in discussion during the hearing of this case I indicated that if the time for appealing the *KC* case had not by then expired I would extend it until a defined time after giving judgment in this case. On checking I discovered that the time limit for appealing the *KC* case had expired and so did not mention it in my judgment.

28. I was told that the Secretary of State was not submitting to FTTs that my conclusion on the ratio of the *RB* case was wrong but was proceeding on the basis that at present my decision on that ratio was the law, although he might challenge it on an appeal in this case if I decided it against the Secretary of State.

29. In paragraphs 7 to 9 of my judgment I expressed views on this approach.

Comment

30. I accept that, by reference to what I said in paragraph 8 of the judgment in this case, the Secretary of State (as he is entitled to do) is now "putting up".

31. Paragraph 8 of that judgment does not indicate that I considered that the jurisdictional point I decided in the *KC* was suitable for determination by the Court of Appeal. Indeed, as pointed out above under the heading "Overview" I am not persuaded of its arguability.

32. If it is sufficiently arguable, paragraphs 8 and 9 of my judgment in this case and what I have said in other cases show that I accept that the point is important and has wide implications.

33. If that jurisdictional point is not sufficiently arguable, I am also not persuaded that the "consent" point is sufficiently arguable unless it is also being said that the Court of Protection cannot for the same reasons authorise the deprivation of liberty on behalf of a P who does not have capacity. However, if that is being said I acknowledge that others have expressed different conclusions on the ability of a person (and so a court on his behalf) to give a valid consent.

34. In any event, the delay and equivocation of the Secretary of State in appealing the *KC* case and the omission from the grounds of appeal of any mention of the wider implications of his argument on the ratio of the *RB* case in respect of CTOs, directions by Guardians and the achievement of the underlying purposes of the MHA do not give me confidence that if I gave permission:

    i) he would pursue his intended application for expedition with vigour or success,

    ii) he would ensure that the court is aware of any appeal in the *RP* case and would invite the court to consider hearing them together,

    iii) the Court would be alerted to the wider implications of the grounds of appeal and so be given the opportunity to make appropriate directions.

35. In my view, if permission to appeal is given the wider implications on the day to day operation of the MHA warrant directions being given to ensure that so far as possible they are covered by the appeal. The funding and so representation difficulties for individuals like MM in arguing such wider issues are notorious.

36. If permission is given the uncertainties this will cause in the implementation of the MHA by hospitals and tribunals will be considerable. This could have a damaging impact on a number of patients and so if the Court grants permission I invite it to ensure that the appeal is expedited.

37. Also I invite the Court to raise with the parties whether any of them would seek to reserve a challenge to the decision of the Supreme Court in *Cheshire West* in the context of decisions made under the MHA or more generally.

Dated 21 January 2016

Signed on the original

Mr Justice Charles
President of the UT(AAC)