Case No: HM/2362/2016

IN THE UPPER TRIBUNAL
ADMINISTRATIVE APPEALS CHAMBER

Before UPPER TRIBUNAL JUDGE KNOWLES QC

DECISION

Save for the cover sheet, this decision may be made public [rule 14(7) of the Tribunal Procedure (Upper Tribunal) Rules 2008]. That sheet is not formally part of this decision and identifies the patient by name.

This decision is given under section 12(2)(a) of the Tribunals, Courts and Enforcement Act 2007.

Although the decision of the First-tier Tribunal (Mental Health) on 1 June 2016 involved the making of an error on a point of law, it is NOT SET ASIDE.

REASONS FOR DECISION

The Issue in this Appeal

1. The issue in this appeal was how the First-tier Tribunal (Mental Health) ["the tribunal"] should react when, during the course of a tribunal hearing, it appeared that the patient no longer had capacity to appoint or instruct his solicitor. The Appellant patient ["the patient"] criticised the tribunal for (a) refusing to review his capacity during the hearing and, in particular, after he left the hearing and (b) failing to give adequate reasons for its refusal to review his capacity during the hearing.

2. I have concluded that the tribunal erred in law by failing to give adequate reasons for its decision not to review the patient's capacity to give instructions to his legal representative during the hearing. However I do not set that decision aside because the patient was neither disadvantaged by either the representation he then received nor by the process the tribunal followed having refused to review his capacity.

Relevant Factual Background

3. I have had the benefit of reading the notes prepared by the tribunal judge on the issue of capacity which arose on the day of the hearing.

4. The patient had an accepted diagnosis of schizophrenia. His admission to hospital and detention under the Mental Health Act 1983 ["the Act"] began on 22 May 2000 after a period of non-compliance with medication led to the breakdown of his supported community placement. His current detention pursuant to section 3 of the Act began on 8 April 2009 and he had been placed on a ward within an open specialist rehabilitation unit since January 2012.

5. About two weeks prior to the tribunal hearing on 1 June 2016, the patient's mental health had become more unsettled. Nevertheless, on a number of different occasions, the patient had been able to give instructions to his legal representative and had the capacity to do so prior to the tribunal hearing. However, the day before the tribunal hearing, the patient's legal representative was told by the Responsible Clinician ["RC"] that the patient lacked capacity to instruct a legal representative. Likewise, the tribunal Medical Member conducted a pre-hearing examination that same day and, as a result, he too became concerned about the patient's capacity. The patient told him that he had not made an application for discharge and did not want to attend the tribunal.

6. The fluctuation in the patient's capacity prompted a preliminary enquiry from the tribunal on the morning of the hearing. The patient's legal representative confirmed that instructions had been previously given when the patient had capacity. That morning, he reported that he had met with the patient who wanted the tribunal hearing to go ahead; wished to attend and wanted to be discharged. The RC confirmed that he had assessed the patient some 45 minutes earlier and was of the opinion that the patient had "capacity for the tribunal" and was clear about what he wanted and that he wished to attend.

7. At the start of the hearing and during the evidence given by the RC, I was told by the patient's legal representative that the patient had been obviously responding to auditory stimuli unheard by anyone else and appeared to be distressed. This is not recorded in the Statement of Reasons or in the tribunal judge's notes. The tribunal then suggested that it hear from the patient earlier in the hearing than had originally been intended. I have no reason to mistrust the account of the patient's behaviour given by the legal representative since it explains why the patient's evidence was interposed.

8. At the outset of his evidence, the patient stated that "*I can hear lots of voices*" and was then asked by his legal representative to focus on him and to explain why he wanted to be discharged. The patient replied: "*I keep on walking up and down. My (outside?) keeper – I am British and*

innocent'. He was then asked if he knew why he was in hospital and replied "*I suffer from a mental disorder – paranoid schizophrenia*". He was then asked if he understood why he was there that day and replied *"To reduce my section down. Would help me a little bit. It would be a new method to use"*.

9. The judge's note then recorded the patient's legal representative asking the tribunal if it might review the patient's capacity to proceed so that he might act in the patient's best interests. The notes recorded that a remark from the tribunal that the evidence had started and the legal representative's response that this was not a tactical withdrawal as he had the patient's evidence that he was not sure why he was there. It might be that on another day he might wish to renew his application. The notes then recorded that the legal representative was told that the patient had had the capacity to make the application [to the tribunal] and it had been confirmed by the legal representative that day that the patient had the capacity to proceed. The notes stated that the tribunal told the legal representative that his application was not germane and that the hearing would proceed.

10. Thereafter the patient gave some short evidence to the effect that he would take his medication which was very helpful as it calmed him down and relaxed him. In reply to the question as to what he would do if he were not on section, he answered that he would be a fool not to take his medication as this would make him much worse and he would have to be sent back to hospital. In response to the next two questions about whether he would stay as an informal patient and if hospital had been good for him, he talked about the Queen and about family graves and said people in his family had died and *"they"* don't believe me. He was finally asked if the ward was good for him and his response was that it was and that he would leave and go to a hostel. The patient then left the hearing to return to the ward.

11. The judge's notes then recorded the preliminary issue which had arisen and the tribunal's decision that it was not necessary to review the patient's capacity and appoint the legal representative to act in the patient's best interests given what the legal representative and the RC had said prior to the start of the hearing.

12. The tribunal proceeded to hear the remainder of the evidence in the presence of the legal representative. I have not been told whether the patient's legal representative asked questions of all the witnesses. He then made submissions to the tribunal in favour of discharge. In the alternative he submitted that the tribunal consider making either a formal recommendation for a Community Treatment Order or adjourning the proceedings for more information about after-care to be available.

The Appeal Before the Upper Tribunal

13. The patient's solicitor applied to the tribunal for permission to appeal and on 1 July 2016 permission to appeal was granted by Tribunal Judge Postgate.

14. The Respondent has not participated in this appeal. In order that I might have assistance from more than one side with the legal issues in this case, I directed that the papers in this appeal should be sent to the Department of Health with an invitation to it to participate in the hearing. The Department of Health – and indeed the Ministry of Justice – subsequently declined my invitation.

15. I have had the benefit of written submission on behalf of the patient from Helen Curtis of counsel for which I am grateful. It has not been necessary for me to hold an oral hearing to determine the issues in this appeal.

16. In determining this appeal, I have had the benefit of all the material available to the First-tier Tribunal. I have also seen the notes of evidence relating to the issue of capacity recorded by the tribunal judge.

17. No question has been raised before me as to the patient's capacity to instruct a solicitor for the purpose of this appeal. Had that been in issue, I would have expected the patient's legal representatives to draw this to my attention.

18. Further, the information before me is that the patient remains detained under the Act. I have no information to the contrary.

The Tribunal's Decision

19. The reasons for the tribunal's decision comprised 47 paragraphs. One paragraph concerned itself directly with the issue of capacity. It was the first paragraph in a section of the Reasons headed "**Jurisdiction, Preliminary and Procedural Matters**" and reads as follows:
"*As a result of the PHE [the pre-hearing examination], the medical member had some concerns relating to [the patient's] capacity. His representative and [the RC] were asked to comment as a preliminary issue. They both considered that at the time of his application and as of this morning [the patient] was capacitous and had been able to give instructions. During the course of [the patient's] evidence his representative asked the Panel to review [the patient's] capacity to proceed so that he could act in his best interests. Given the RC's and the representative's opinion immediately before the commencement of the hearing and the representative's confirmation that he had already taken*

instructions when [the patient] was capacitous, the Panel was not persuaded this was necessary."

20. The other paragraph which touched on the issue of capacity was that in which the tribunal summarised the pre-hearing examination. It reads as follows:
"*At the PHE [pre-hearing examination] [the patient] said voices are bothering him "a very lot" and he mainly attributed this to his brother bobby, who he referred to as the rapper "LLCoolJ" and whom he said had raped him when he was small and at a later stage. The voices also involve children and the Queen. [The patient] said he sleeps well and dreams, thinks and designs in his head. He also said he had diabetes and breast cancer. He then gave difficult to follow account of his situation, but denied his thinking was muddled and said it is very clear and he has a good memory. He also described being sexually assaulted last year. He would like to leave hospital and go to a hostel in Ladbroke Grove although he was concerned he would be robbed there. He also said he had no intention of harming himself. Throughout the interview [the patient] was distractible, thought disordered and his thinking was hard to follow with clear interpenetration of themes. He appeared to be hallucinating and sometimes changed his voice or spoke in what appeared to be the voices he heard. He was reasonably well kempt, polite and tried hard to co-operate, but his mood was somewhat flat and brittle and he required management and reassurance that he could leave if required. He had some insight and acknowledged he has schizophrenia*."

21. The tribunal noted that the hospital records indicated that the patient had been more unsettled recently, particularly in the last two weeks. He had been hallucinating, disorganised, screaming, laughing, abusive and uncooperative [Statement of Reasons, paragraph 7]. The tribunal also recorded a summary of the patient's evidence where it stated that the patient acknowledged he had schizophrenia; that the week had been very difficult for him as he had freaked out; and that his medication was very helpful as it calmed him down and relaxed him. He said, if discharged, he would be a fool not to take his medication as he would become much worse and have to be sent back to hospital. He acknowledged the ward was very good for him but, if he could, he would leave and go to a hostel. The tribunal noted that the patient was unable to respond appropriately to any further questions and left the hearing [Statement of Reasons, paragraph 23].

22. No issue is taken on appeal with the reasons given for the substantive decision that the patient should not be discharged from section.

<u>The Grounds of Appeal</u>

23. I summarise the two grounds of appeal.

24. First, it was submitted that the tribunal erred in law by refusing to review the patient's capacity during the hearing and in particular after he left the hearing. The tribunal's refusal occurred in circumstances where the patient's legal representative, who had received instructions when the patient had capacity, had asked for his client's capacity to be reviewed. If the request had been granted, the process would have determined whether the patient had capacity. If the patient had capacity, the legal representative could have confirmed his instructions. If the patient did not have capacity, then the continuation of the appointment of his legal representative could have been considered in conjunction with how best to achieve the patient's full participation in the tribunal hearing.

25. The request for a review of capacity was made in the known context of the patient's fluctuating capacity in the day preceding the tribunal hearing. It was submitted that the consequences of the tribunal's refusal was to implicitly deny the patient's entitlement to have a legal representative appointed. It was also said to prejudice the patient's position as the legal representative was deprived of the opportunity of acting in the patient's best interests in accordance with rule 11(7)(b) of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 ["the Rules"]. It was argued that so acting might have prompted the representative to apply to withdraw the patient's application pursuant to rule 17(1)(b) of the Rules.

26. Second it was submitted that the tribunal had failed to give adequate reasons for its refusal to review the patient's capacity during the hearing. Its decision made no reference to factors other than the opinions of the patient's RC and the representative when the patient did have capacity.

The Relevant Legal Framework

27. The tribunal has the power under rule 11(7)(b) of the Rules to appoint a legal representative for the patient where the patient lacks the capacity to appoint a representative and the tribunal believes it is in the patient's best interests for the patient to be represented. Rule 11(7) reads as follows:
(7) In a mental health case, if the patient has not appointed a representative, the Tribunal may appoint a legal representative for the patient where –
(a) the patient has stated that they do not wish to conduct their own case or that they wish to be represented; or
(b) the patient lacks the capacity to appoint a representative but the Tribunal believes that it is in the patient's best interests for the patient to be represented.

28. The hearing which considers the patient's detention must be conducted fairly and justly in accordance with rule 2(2)(c) of the Rules which requires the tribunal to deal with a case fairly and justly by:
"ensuring, so far as practicable, that the parties are able to participate fully in the proceedings."

29. YA v Central and North West London NHS Trust and Others [2015] UKUT 0037 (AAC) ["YA"] concerned the appointment and duties of a legal representative appointed by the tribunal under rule 11(7) of the Rules. In his Overview at the start of that decision, Charles J emphasised that, in practice, appointments pursuant to rule 11(7) appeared to work well and that it was important not to create complications and problems into what was intended to be a user friendly investigative system by reference to over-analysis or the introduction of a too rigid approach [Overview, paragraph 2]. He went on to state in paragraphs 7 and 8 of the Overview that:
"(7) An assessment of a person's capacity to appoint a representative must involve an assessment of their capacity to decide whether or not to appoint one, and it is this choice that identifies the specific decision that is the subject of the capacity assessment set as the trigger to the power conferred by Rule 11(7)(b). To have the capacity to make that choice the decision maker has to be to sufficiently understand, retain, use and weigh the reasons for and against the rival decisions and thus their advantages, disadvantages and consequences. So to have capacity to appoint a representative a patient needs to have more than only an understanding that they can make an application to a mental health review tribunal or have someone else make it for them, and thus the limited capacity referred to in R(H) v SSH [2006] 1 AC 441.
(8) Although there is a substantial overlap between them a person's capacity (a) to appoint a representative and (b) to conduct proceedings himself are not mutually exclusive concepts. But, in this context, the differences between them are theoretical rather than real because a relevant factor to be taken into account in deciding whether or not to appoint a representative is the capacity of the patient to conduct the proceedings and an inability by the patient to appreciate that he or she lacks the capacity to conduct the proceedings effectively determines that he or she does not have the capacity to make that choice. A distinction between these two issues of capacity would found an argument that Rule 11 does not provide a procedure that complies with Article 5(4)."

30. For patients who do not have the capacity to provide instructions on all relevant matters relating to the conduct of proceedings, Charles J acknowledged the position was more complicated than for those who did have capacity. The best interests test in Rule 11(7)(b) and the general requirement to act in the best interests of a person who lacks relevant capacity mean that the legal representative is not only appointed in the patient's interests but must also seek to promote them (having regard to the relevant issues of fact and law that are relevant in the proceedings) [Overview, paragraphs 13-14]. He noted that the main problems which

were likely to arise were when (a) the legal representative's views on what was in the patient's best interests and those of the patient diverged in respect of issues where facts that the patient does not have capacity to give instructions on were relevant; (b) the patient wanted the legal representative to advance an unarguable point and/or (c) the patient maintained that he did not want to be represented. In those circumstances Charles J noted that case law emanating from the Court of Appeal and the European Court of Human Rights emphasised that the withdrawal of representation or the advancing of unreasoned or hopeless argument would not promote either the patient's best interests or an effective and practical review of a deprivation of liberty [Overview, paragraph 15]. Those factors, amongst others, strongly favoured the continuing appointment of the legal representative [Overview, paragraph 16].

31. In paragraph 58 of his decision Charles J listed the factors that the patient would have to be able to sufficiently understand, retain, use and weigh when deciding whether or not to appoint a representative. Those same factors are also relevant when a tribunal has to decide whether to appoint a solicitor to represent the patient. In making that determination, the tribunal will have regard to the best interest test and should also have regard to the principles and approach set out in the Mental Capacity Act 2005 and the associated statutory guidance in the Mental Capacity Act Code of Practice.

32. In paragraph 105 of YA, Charles J stated that the issue of capacity should be considered and kept under review by all involved including the responsible clinician, the hospital managers, a tribunal appointed representative, any representative who has been or has purportedly been appointed by the patient and the tribunal itself. That statement is to be found under the heading, **"What procedure should be adopted where the First-tier Tribunal identifies a case in which there is an issue relating to the patient's capacity to appoint a representative: whether and if so when the Tribunal should direct of its own motion a capacity assessment; if so, who should be responsible for conducting that assessment, and how should it be funded"**.

33. Finally, the Law Society's Guidance on Representation Before Mental Health Tribunals issued in May 2016 makes clear to legal representatives that "*if you think your client lacks capacity to instruct you, then you cannot act for this client unless either you are instructed by a properly authorised third party, such as a court appointed deputy or the donee [**my insertion as the use of the word "done" in the original text is clearly a spelling error**] of a power of property and affairs power of attorney, [**or – my insertion**] the relevant tribunal has appointed you to act under the First-tier Tribunal Rules, Tribunal (Wales) Rules or the Upper Tribunal Rules.*"

Some Preliminary Observations

34. I respectfully agree with Charles J that the issue of a patient's capacity to appoint a representative, to give instructions and to participate in proceedings before the tribunal should be kept under review by all of those involved, not least the tribunal itself [paragraph 105 of YA]. The passage in YA is of more general application than the heading under which it appears would suggest. It is a statement of the obvious (a) that a person's capacity may fluctuate over time and (b) that fluctuation is something which is not uncommon in patients with a mental disorder detained under the Act. Ongoing review by the tribunal of the patient's capacity to instruct a representative, to give instructions and to participate in tribunal proceedings may be thought to give effect not only to a detained patient's best interests but also to the procedural safeguards required by Article 5 of the European Convention on Human Rights.

35. I also venture to suggest that, alongside the problems identified by Charles J in paragraph 15 of the Overview in YA, can be added the problem of a patient who has capacity to appoint a representative, to give instructions and to participate in the proceedings but who then either loses capacity in respect of some or all of those matters or whose capacity in respect of those matters fluctuates. It seems desirable that, in those circumstances and as envisaged in paragraph 16 of the Overview in YA, there should be continuity of representation with the previously patient-appointed legal representative acting in accordance with the guidance set out in that paragraph.

36. The tribunal's power to appoint a representative pursuant to rule 11(7)(b) is triggered "*if the patient has not appointed a representative*". That is consistent with the reasoning of Charles J in paragraph 27 of AMA v Greater Manchester West Mental Health NHS Foundation Trust [2015] AACR 30. That paragraph states as follows:
"*So, as appears from Rule 11, an appointment by the F-tT under Rule 11(7) is limited to the appointment of a* ***legal representative*** *(as defined by Rule 1(3)). It should also be noted that the power to do so only exists when the patient has not appointed a representative (who need not be a legal representative) and either*
i) the patient has said that he does not want to conduct the case himself or wants to be represented,
ii) the patient does not have capacity to appoint a representative."

37. This wording does not sit easily with the tribunal's duty of ongoing review described above since it appears to exclude appointment by the tribunal when capacity is presently lacking but where, in the past, a patient had capacity and exercised it so as to appoint a representative. That narrow reading of the words in rule 11(7) strikes me as being inconsistent with the overall purpose of rule 11(7) which operates as a mechanism to ensure that the tribunal has regard to the interests of detained patients,

including those who lack capacity, so that they may be afforded legal representation to give effect to their Article 5 and 6 rights under the European Convention. My reading of the role of the First-tier Tribunal in that regard accords with what is set out by Charles J about the role of the tribunal in paragraph 35 of AMA.

38. However, in practice, the difficulty with the wording of rule 11(7) may be more apparent than real as discussed below.

Discussion and Analysis

(a) The Tribunal's Reasons

39. The patient submitted that the tribunal's decision not to review the issue of capacity once the hearing had begun was an error of law for which inadequate reasons were given.

40. The notes made by the tribunal judge record that the application was made at a very early stage of the patient's evidence and in circumstances where the answers given by the patient did not appear to raise serious concerns about a lack of capacity to either appoint or instruct a legal representative or participate in the proceedings. However I remind myself that I do not have the benefit of having seen the patient's demeanour either during the earlier part of the hearing or in response to questions. I note that he was said to have become upset whilst the RC gave his evidence. That had prompted the tribunal to bring forward his evidence during the hearing. I also note some unexpected, if not strange, responses to some questions posed by his legal representative after the application was made. Finally I remind myself of the manner in which the patient presented to the Medical Member the previous day and of the concerns expressed on that same day by the RC and the Medical Member that the patient lacked the capacity to instruct a solicitor and to participate in the tribunal hearing.

41. I conclude that, leaving aside the timing of the application made by the legal representative and having regard to all the circumstances, the application for review of the patient's capacity required a considered response from the tribunal. I also accept the submission made on behalf of the patient that a short pause in the proceedings was desirable in order to:
a) establish whether the patient lacked capacity which may have meant him being seen on the ward;
b) ascertain the patient's wishes about the continuation of the hearing; and
c) ascertain whether the patient's legal representative remained instructed.
That pause should perhaps have occurred at the conclusion of the patient's evidence rather than during its course when the application

seems to have been made. Having established the matters set out above, the tribunal might then have come to more well-founded conclusions about the patient's capacity to appoint or instruct a legal representative and to participate in the proceedings.

42. In any event, the tribunal's reasons for refusing the application were, in the circumstances of this case, inadequate. The reasons given were that the tribunal did not consider it necessary to review the patient's capacity given the RC's and the legal representative's opinions on that issue. However poor the timing and content of the legal representative's application, I find that the tribunal was itself under an obligation to consider all the circumstances when coming to a conclusion about this important issue. Making every allowance for brevity of reasoning about an application made during the course of a hearing, the tribunal's reasons fail to persuade me that it did so. I thus find that it was in error of law.

(b) The Significance of the Tribunal's Error

43. However, it does not automatically follow that this error was material or that it justifies setting aside the tribunal's decision. The question which needs to be asked is what the significance of the tribunal's failure was. Given the flaw both in the way the hearing was conducted and in the reasoning of the tribunal, did either have the actual effect of bringing about a hearing so unfair that the patient was materially disadvantaged?

44. I have decided that the answer to that question is no for the following reasons.

45. The patient's own legal representative continued to participate in the hearing after the patient had left and returned to the ward. If he had had any doubts about his instructions given his own assessment of his client's capacity, I ask myself why an application for a short pause was apparently not made by him at the conclusion of the patient's evidence so that he could see his client. He could then have checked his instructions and the patient's willingness to participate in the proceedings and acted in accordance with what he then discovered. After all, the Law Society's guidance on the issue was clear – if the legal representative thought his client lacked the capacity to instruct him, he should not continue to act.

46. Following a short pause, a number of different options might then have presented themselves. If he continued to have concerns about the patient's capacity, the legal representative could have renewed his application for a review of his client's capacity. It might not have been unreasonable for a legal representative in the circumstances of this case to consider that he could no longer act for the patient and to have explained that difficulty to the tribunal. That might well have prompted the tribunal to review the patient's capacity with a greater degree of urgency

than was previously apparent. If a review had then established a lack of capacity or indeed fluctuating capacity, the tribunal might well have made an appointment pursuant to Rule 11(7)(b) so that the patient could have continuation of representation dedicated to his best interests. That appointment could have been made on the basis that the appointment of the legal representative by the patient had been terminated by the loss of capacity thereby satisfying the terms of rule 11(7).

47. However, during a short break, the legal representative might conversely have established that the patient did have capacity to instruct him and was content for the proceedings to conclude in his absence. It might also have allowed him to take instructions about whether he should apply to withdraw the proceedings in accordance with rule 17(1)(b).

48. The apparent absence of either an application for a short break or indeed any evidence that such a pause took place leads me to the conclusion that the legal representative was content to act for the patient on the basis of his earlier instructions and was moreover content to act in his client's absence. The tribunal's reasons recorded the submissions made by the legal representative in paragraphs 29-31 of its Statement of Reasons. Those submissions were, in my view, helpful and said everything that might realistically have been argued in favour of discharge from detention. Submissions were also made requesting the tribunal recommend a Community Treatment Order and requesting an adjournment to seek further information about after-care. It is thus difficult to see how, in those circumstances, the patient's participation in the proceedings was significantly compromised or that the manner in which the hearing was conducted after the refusal of a capacity review was unfair to the patient.

49. It was submitted that the tribunal's refusal to review capacity was to implicitly deny the patient's entitlement to have a representative appointed and also prejudiced the patient's position because the representative was deprived of the opportunity to act in patient's best interest and possibly withdraw the application to the tribunal in accordance with rule 17(1)(b). That submission, in my view, is misconceived because it presupposes that the outcome of the review would have been a conclusion that the patient lacked capacity.

50. Further, Charles J in YA gave guidance as to how a legal representative should act where the patient does not have the capacity to instruct him or her on all relevant matters relating to the conduct of the proceedings. Paragraph 101 sets out how the representative should conduct themselves and reads as follows:
"i) should so far as is practicable do what a competent legal representative would do for a patient who has capacity to instruct him to represent him in the proceedings and thus for example (a) read the available material and seek such other relevant material as is likely to be or should be available, (b) discuss the proceedings with the patient and

in so doing take all practicable steps to explain to the patient the issues, the nature of the proceedings, the possible results and what the legal representative proposes to do,
ii) seek to ascertain the views, wishes, and feelings, beliefs and values of the patient,
iii) identify where and the extent to which there is disagreement between the patient and the legal representative,
iv) form a view on whether the patient has the capacity to give instructions on all the relevant factors to the decisions which found the disagreement(s),
v) if the legal representative considers that the patient has capacity on all those factors and so to instruct the representative on the areas of disagreement the legal representative must follow those instructions or seek a discharge of his appointment,
vi) if the legal representative considers that the patient does not have or may not have capacity on all those issues, and the disagreements or other problems do not cause him to seek a discharge of his appointment, the legal representative should inform the patient and the tribunal that he intends to act as the patient's appointed representative in the following way:
a) he will provide the tribunal with an account of the patient's views, wishes, feelings, beliefs and values (including the fact of any wish that the legal representative should act in a different way to the way in which he proposes to act, or should be discharged),
b) he will invite the tribunal to hear evidence from the patient and/or to allow the patient to address the tribunal (issues on competence to give evidence are in my view unlikely to arise but if they did they should be addressed before the tribunal),
c) he will draw the tribunal's attention to such matters and advance such arguments as he properly can in support of the patient's expressed views, wishes, feelings, beliefs and values, and
d) he will not advance any other arguments."

What is set out in YA is a process of **engagement with the tribunal** by a legal representative for a patient who lacks the capacity to instruct in relation to the proceedings. That is reinforced by paragraph 103 in YA where it is said that, if the legal representative concludes the patient does not have the capacity to instruct him on all relevant matters, *"he should advance all arguable points to test the bases for the detention"*. Though withdrawal under rule 17(1)(b) – if consented to by the tribunal – may allow the patient to make another application in future for discharge to the tribunal earlier than is provided by section 66 of the Act, withdrawal where a patient lacks capacity to instruct would deprive the patient via his legal representative of the opportunity contemplated by YA to test the basis for his or her detention **at that point in time**. In my view it is particularly important that the detention of a person who lacks capacity to instruct in relation to the proceedings is challenged without delay.

51. My analysis is not intended to be critical of the patient's legal representative who, in the circumstances, found himself in a very difficult position. In my view he did all that could have been expected of him consistent with his instructions whether those came from a patient who he believed to have capacity or whether those came from a patient who, at the time of the hearing, he believed did not have the capacity to instruct him.

(c) The Outcome of this Appeal

52. Given my conclusion as to the significance of the tribunal's error of reasoning, I have decided that this error does not require a remedy. Section 12(2)(a) of the Tribunals, Courts and Enforcement Act 2007 provides that, if the Upper Tribunal finds that the First-tier Tribunal's decision involved the making of an error of law, it may but need not set aside that decision.

53. I thus find that, although the decision of the First-tier Tribunal dated 1 June 2016 involved the making of an error of law, I do not set it aside.

Gwynneth Knowles QC
Judge of the Upper Tribunal
8 February 2017.

[signed on the original as dated]