IN THE UPPER TRIBUNAL **Upper Tribunal case No.** HMW/2359/2016

ADMINISTRATIVE APPEALS CHAMBER

Before: Mr E Mitchell, Judge of the Upper Tribunal

Venue: Cardiff Civil Justice Centre, 24 January 2018

Attendances: Ms Sutton, of counsel, for the Appellant Mr M, instructed by Confreys Solicitors.

Mr Walker, of counsel, for the Respondent ABM University Health Board, instructed by Blake Morgan LLP.

DECISION

This appeal succeeds. The decision of the Mental Health Review Tribunal for Wales, taken on 16 May 2016, to make a direction under rule 14(1) of the Mental Health Review Tribunal for Wales Rules 2008, involved an error on a point of law. However, the Tribunal's direction is not set aside. Instead, under section 12(2) of the Tribunals, Courts and Enforcement Act 2007, as applied by section 78A of the Mental Health Act 1983, the matter is remitted to the Tribunal for it to determine whether to set aside or vary its rule 14(1) direction, in accordance with the directions give at the end of the reasons for this decision.

PUBLICATION

Save for the cover sheet, this decision may be made public (rule 14(7) of the Tribunal Procedure (Upper Tribunal) Rules 2008 (SI No 2698)). That sheet is not formally part of the decision and identifies the patient's name, which must not be made public.

REASONS FOR DECISION

Introduction

1. This case concerns disclosure to a patient in mental health tribunal proceedings of information that he had been covertly medicated. This is an issue that has previously been considered by the Upper Tribunal but this case differs from the existing case law in that it involves a patient who lacked the mental capacity to appoint a representative. I decide that the Mental Health Review Tribunal for Wales' direction prohibiting disclosure of covert medication information involved an error on a point of law. Briefly, this was because the Tribunal did not consider the extent to which the patient, despite his impaired mental capacity, was nevertheless capable of participating in the proceedings. That issue should

have been addressed before the Tribunal decided whether, having regard to the interests of justice, it was proportionate to withhold covert medication information from the patient.

2. In these reasons:

- "1983 Act" means the Mental Health Act 1983;
- "the Rules" means the Mental Health Review Tribunal for Wales Rules 2008;
- "the Tribunal" means the Mental Health Review Tribunal for Wales

Background

Referral to the Mental Health Review Tribunal for Wales

3. The patient and Appellant in these proceedings, Mr M, was detained in hospital for treatment under section 3 of the 1983 Act, pursuant to an application made on 26 March 2015. The hospital managers to whom the application was addressed, the Respondent in these proceedings, referred Mr M's case to the Tribunal under section 68(2) of the 1983 Act. The hospital managers' case before the Tribunal was the statutory criteria for continued liability to detention for treatment were satisfied.

Questions of capacity

4. By letter of 30 December 2015, the Tribunal asked Mr M's responsible clinician whether he had mental capacity to appoint a legal representative. The clinician ticked a 'NO' box on the letter but, when this was returned to the Tribunal, was not accompanied by a mental capacity assessment. In due course, the Tribunal appointed a solicitor of Confreys Solicitors, as Mr M's legal representative. Mr Payne, solicitor of that firm, represented Mr M before the Tribunal.

5. According to Mr M's care and treatment plan, dated 4 January 2016, his local authority intended to apply to the Court of Protection for appointment as his deputy "as regards his finances". For this purpose, Mr M's responsible clinician "is to formalise his assessment of [Mr M's] mental capacity". According to a social circumstances report of 19 January 2016, the responsible clinician assessed Mr M as lacking the mental capacity to deal with his financial affairs.

6. A psychiatric report, dated 15 February 2016, written by Mr M's then responsible clinician stated that his capacity to consent to treatment was reviewed (on an unspecified date) and "during the assessment [Mr M] was grossly thought disordered. His conversation was peppered with delusional ideas and beliefs…Following assessment I concluded that he did not have capacity to consent or refuse treatment".

7. I observe that, while a number of clinicians have addressed Mr M's mental capacity in various decision-making contexts, the Tribunal appeal papers do not contain any document embodying a formal mental capacity assessment.

Mental Health background and covert medication history

8. Below:

- "care and treatment plan" refers to a plan dated 4 January 2016;
- "nursing report" refers to a report dated 11 February 2016. While this describes itself as an addendum report, it is the only nursing report within the Tribunal papers;
- "psychiatric report 1" refers to a report dated 6 January 2016, written by the responsible clinician at the Psychiatric Intensive Care Unit to which Mr M was admitted between 16 December 2015 and 25 January 2016;
- "psychiatric report 2" refers to a report dated 15 February 2016, written by the responsible clinician at the low secure unit to which Mr M was transferred on 25 January 2016
- "psychiatric report 3" refers to a document dated 2 March 2016, unsigned but said by the hospital managers to be written by the responsible clinician at the low secure unit;
- "social report" refers to a social circumstances report dated 19 January 2016.

9. From the Tribunal's papers, Mr M's mental health history may be summarised as follows:

- Having first been admitted to hospital in 1972, Mr M was subsequently discharged and re-admitted to hospital on a number of occasions;
- Psychiatric report 1 gave Mr M's diagnosis as "Treatment Resistant Schizophrenia" in one part of the report and "Paranoid Schizophrenia" in another. The social report described Mr M's diagnosis as "chronic paranoid schizophrenia within the setting of a personality disorder, with prominent aggressive and paranoid traits";
- According to the social report, Mr M's psychosis "never totally resolves" even when he is compliant with medication, and his aggressive behaviour "may sometimes occur as a result of his psychosis, and is sometimes the result of his personality";
- The care and treatment plan stated: Mr M could be verbally aggressive towards staff and patients; "when very irate he can also be physically aggressive and use furniture etc as weapons"; when Mr M thought he had special powers, or was responding to auditory hallucinations, he could assault without provocation; and alcohol made Mr M's behaviour more challenging;

- From January 2010 until March 2015, Mr M lived in a community placement. The papers suggest that, at this placement, Mr M was not subject to any of the compulsory provisions of the 1983 Act;
- According to the social report, Mr M's community placement broke down because of his "entrenched pattern of behaviour". Generally pleasant in the morning, after consuming alcohol bought from a local shop or pub in the afternoon, Mr M would be verbally aggressive and intimidate staff and other patients;
- On 6 March 2015, while at the community placement, Mr M requested admission to hospital. He became aggressive when not immediately admitted to hospital. Police attended and Mr M was taken to and admitted to a hospital, which I think was a general hospital. Due to an adverse blood test result, Clozaril (oral anti-psychotic medication, also referred to as Clozapine) was stopped and, as a result, he "became gradually more unwell and challenging in his behaviour" (social report);
- On 26 March 2015, an application was made for Mr M's compulsory admission to hospital for treatment under section 3 of the 1983 Act. He had assaulted a nurse and was only sporadically compliant with medication (social report);
- Following the hospital managers' acceptance of the section 3 application, Mr M was transferred to a locked rehabilitation unit. The intention had been to transfer him to a Psychiatric Intensive Care Unit (PICU) but initially no bed could be found (social report);
- The social report describes management challenges posed by Mr M at the unit but non-compliance with medication is not specifically described. Ultimately, unit staff decided they could no longer manage Mr M's care safely and he was transferred to a PICU on 16 December 2015;
- The PICU was "viewed as a 'holding placement' where [Mr M] can be safely nursed until a more appropriate placement can be identified". The multi-disciplinary team agreed that Mr M required nursing in a low secure environment but his wish to return to the community placement was unrealistic. He continued to have no insight into his condition nor to understand why he was detained (social report);
- At the PICU, Mr M was nursed in a low stimulant isolated environment "on 2:1 most of the day" (psychiatric report 1);
- Psychiatric report 1 described Mr M's physical health problems. He needed IV immunoglobin therapy once every 3 weeks and had a chest condition. Shortly before the report was written, Mr M's non-compliance with treatment for his physical health led to a deterioration in his condition health but he recovered after antibiotic therapy;

- On 25 January 2016, Mr M was transferred from the PICU to a different clinical setting, which I understand was a low secure ward (psychiatric report 1).

10. The appeal papers contain many examples of the management challenges posed by Mr M across a range of clinical settings. While I do not refer to them, I have not overlooked them.

11. Since compliance with medication, and its covert administration, is a central issue in this appeal, I shall set out in some detail, in chronological order, what the Tribunal papers say about this. I note that Mr M's case was probably especially challenging because of the relationship between his mental health medication and his compliance with treatment for serious physical health conditions:

- The decision to stop Clozapine, as a result of adverse blood tests, caused Mr M to relapse. When the section 3 application was made shortly thereafter, on 26 March 2015, Mr M's compliance with medication was "sporadic" (psychiatric report 1);
- For the first 48 hours of Mr M's PICU admission (on 16 December 2015) he "was accepting of all prescribed medications" but, subsequently, "he frequently declines to accept medication" for a variety of reasons including that he only wanted medicine coloured brown and thought some medication was fattening and others would stop his heart (psychiatric report 1);
- At the PICU, Mr M refused immunoglobin replacement therapy which "places him at high risk of infection" but "he has no insight into the potential dangers of this". As a result, "the team [at the PICU] reverted to administering medication covertly" (social report);
- The care and treatment plan described Mr M's refusal to consent to treatment and health checks for his physical health problems but not for his mental health condition. The plan also made no mention of the involvement of a Second Opinion Appointed Doctor (SOAD). The plan stated that, in relation to Mr M's mental health, the plan was to monitor treatment "in an attempt to find a combination of medication that can stabilise his mental health";
- At 6 January 2016, Mr M's unpredictable and aggressive behaviour meant he had not received his required immunoglobin therapy nor a chest X-ray. His physical condition deteriorated but he recovered after antibiotic therapy (psychiatric report 1, which does not state whether antibiotics were administered covertly);
- Mr M's refusal of prescribed medication led the responsible clinician, on an unspecified date, to request a second opinion (i.e. SOAD) for covert medication to "prevent violence and allow regular rapid tranquilization" (psychiatric report 1);

- A SOAD visited Mr M on an unspecified date but he was verbally aggressive and refused to talk about his medication (psychiatric report 1);

- According to psychiatric report 1, covert medication began after "completion of policy and capacity assessment for consent to treatment" but Mr M "still unable to treat as he refuses his food and fluids after they are prepared….[Mr M] asks for drink but later declines to drink. [Mr M] needs a lot of persuasion for his depot [intra-muscular] injection". According to psychiatric report 3, covert administration of medication was preceded by a best interest meeting and a capacity assessment;

- According to psychiatric report 1, at the PICU the plan had been to re-start Clozapine. However, Mr M refused the medication and essential health-monitoring blood tests (the date/s of the refusals are not given nor is it explained why blood tests were necessary even though Mr M had refused Clozapine). Once the Clozapine plan was abandoned, Mr M "was treated with Lithium, Chlorpromazine and Clopixol depot IM [intra-muscular] weekly to prevent deterioration in mental health". Obviously, the depot medication could not have been administered covertly but the report does not state whether the orally-administered medications were administered covertly;

- Following the introduction of Chlorpromazine, Mr M indicated he would comply with treatment for his immunological disorder (psychiatric report 3);

- Upon admission to the low secure unit (on 25 January 2016) Mr M consented to physical observations and an ECG test and, for the first 48 hours, was generally compliant with medication (nursing report);

- "it was noted [at a multi-disciplinary meeting [at the low secure unit on 26 January 2016] that since his transfer from PICU [the previous day] he had been compliant with medication and ward boundaries…However, he has remained under covert administration of medicines policy" (psychiatric report 2);

- A risk log begins on 25 January 2016, the date on which Mr M was transferred to the low secure unit and so it must have been that unit's risk log. An entry for 26 January 2016 says "whilst reviewed in the MDT meeting, [Mr M] voiced delusional beliefs (?) [*question mark in the original*] that the Immunoglobin treatment is 'for werewolves' and 'stop me from turning into the beast'";

- On 27 January 2016, Mr M's prescribed medication was altered after an adverse ECG test. Diazepam, Chlopromazine and Haloperidol were stopped. Clonazepam and Promethazine were begun. Depot medication was unchanged. Following these changes, "there has been a marked and rapid deterioration in his mental state with the increase risk [*sic*] of violence and aggression and non-compliance with physical

health medication and monitoring" (nursing report). Psychiatric report 3 put Mr M's deterioration down to the withdrawal of Chlopromazine;

- After Mr M's first 48 hours at the low secure unit, he frequently "declines to accept" prescribed medication and "as a result the team reverted to administering mental health medication covertly (under the covert medication policy)". Mr M also "sporadically" declined medication for his physical condition (nursing report);
- A risk log entry for 29 January 2016 stated Mr M refused Levothyroxine (medication for physical illness) and Clonezapam. He thought they were fattening and he only wanted medication coloured brown. In response "covert medication management for psychiatric medication was initiated following the policy and completed paperwork". Psychiatric report 2, however, states that, following Mr M's 29 January 2016 refusal, "he was at times compliant";
- A risk log entry for 5 February 2016 stated Mr M no longer wanted to take medication or have injections. He said they would make him fat and give him a bad heart. It is not clear whether Mr M actually refused medication on this date;
- A risk log entry for 6 February 2016 stated that Mr M refused prescribed medication and no longer wanted depot injections. A 7 February 2016 entry stated that Mr M declined prescribed medication because 'it stops my heart';
- A multi-disciplinary team meeting on 9 February 2016 noted Mr M "was refusing observations and required the covert medication regime". Psychiatric report 2 describes the meeting's discussion about difficulties in identifying optimal anti-psychotic medication for Mr M:
    - "regarding efficacy it was noted that the situation was becoming increasingly acute and the risks of him remaining psychotic would be that he would refuse other medication for physical health including gammaglobulin with an increase in risk of life threatening infection";
    - "he had expressed prior to cessation of Chlorpromazine consent to re-start";
    - "he also had not responded to Olanzapine, Haloperidol or Depakote recently";
    - "in view of the rapid deterioration in mental state, the increasing risk of violence and aggression, a long history of violence and risk when unwell [there was a] need to re-instate Clozapine as soon as possible which would require his co-operation, [there was a need] to re-instate gamma globulin therapy as soon as possible to reduce the risk of infection …he would be re-started on Chlorpromazine 100 mgs on day one, 200 mgs on day [sic] and

300 mgs on day three and to continue covertly if required. It was agreed to continue his other medication";

- The nursing report (dated 11 February 2016, when Mr M was admitted to the low secure unit) stated that, while Mr M refused immune deficiency treatment at the PICU, he "has now agreed" to it. The report's recommendations included "for the covert medication policy to remain in situ".
- A risk log entry for 11 February 2016 stated "refused to take night time medication";
- Psychiatric report 2 stated that "since the re-instatement of Chlorpromazine [Mr M's] behaviour has been more settled. He remains psychotic but less aggressive and hostile. He is slightly sedated". Psychiatric report 3 stated "his Chlopromazine was reinstated being administered covertly";
- Psychiatric report 2 stated that Mr M had been "under a DNR [do not resuscitate] policy". The appropriateness of Mr M's DNR status is not an issue in these proceedings and it would therefore be wrong of me to express any view on it. Mr M had not been receiving gamma globulin treatment and "there was a risk of serious infection which could lead to a life threatening illness". The report also notes a number of options for administering immunoglobulin, including "subcutaneous";
- On 19 February 2016, the responsible clinician revoked Mr M's 'DNR' status because he "had a good quality of life prior to the cessation of Clozapine and if this could be re-instated he would probably be able to return to his previous function and life style" (psychiatric report 2);
- Psychiatric report 3 stated that Mr M's prospects of discharge would be improved by re-introducing Clozapine but this required either his consent or covert administration. Given the importance of Clozapine, it is not clear why, at the date of this report, it had not been administered covertly. It may be due to the complication mentioned in psychiatric report 2 that, if on Clozapine, Mr M would need to agree to regular blood tests to check for side-effects and blood cannot be extracted covertly;
- Psychiatric report 3 lists the risks if Mr M is not covertly medicated: increased violence and aggression; transfer to a higher security facility; increased use of restraint and seclusion; non-compliance with physical health treatment resulting in possible life-threatening illness; and inability to reinstate Clozapine with a likelihood of prolonged hospital admission and sustained poor mental health.

Observations on the evidence

12. At this point, I make certain observations on the documentary evidence in the Tribunal bundle:

(a) while a number of mental capacity assessments were carried out for different purposes, the appeal papers contained no document embodying a structured mental capacity assessment;

(b) the managers' covert medication policy was not included in the bundle;

(c) the 'best interests' decision that preceded the decision to commence covert medication was not explained;

(d) there was no documentary evidence about the SOAD's involvement in the institution of covert medication, including the certificate the SOAD must have given to authorise covert medication;

(e) the risk log stated that, on 29 January 2016, "covert medication management for psychiatric medication was initiated following the policy and completed paperwork". However, psychiatric report 1 stated that, at 6 January 2016, covert medication had already begun. This might be explained by the terms of the managers' covert medication policy, e.g. if it provides for completion of 'paperwork' on each occasion of covert medication. But, if that was the case, it would have left a covert medication paper trail;

(f) it seems that Mr M was at times compliant with oral medication. If there was an explanation for Mr M's intermittent compliance, it is not found in the Tribunal bundle;

(g) Mr M's care and treatment plan did not mention covert medication. It is dated 4 January 2016, that is two days before psychiatric report 1, which makes it clear that, by that date, covert administration of medication had begun. I suppose it is possible that the managers' covert medication policy was applied, a best interests decision taken and a SOAD visit arranged over the course of two days. But, if so, I think it is odd that the care and treatment plan was not updated to reflect the commencement of covert medication;

(h) In June 2017, the hospital managers' solicitors informed the Upper Tribunal that Mr M had not been covertly medicated since February 2016 (they argued that this rendered Mr M's appeal to the Upper Tribunal academic). I can identify no indication that the Tribunal, sitting on 16 May 2016, was informed that Mr M had not been covertly medicated for some three months. The Tribunal should have been informed. As it was, psychiatric report 3, written in March 2016, suggested that, if covert administration of medication was imperilled, a range of dire consequences would follow. If the Tribunal sitting in May 2016 knew that Mr M had not been covertly medicated for three months, I have to wonder if it would still have directed non-disclosure. At the very least, the Tribunal was likely to have asked the hospital managers to

explain if their case was that disclosure of historical covert medication would impede Mr M's ongoing overt administration of medication.

Proceedings before the First-tier Tribunal

Initial consideration of non-disclosure

13. The hospital managers' Mental Health Act Administrator informed the Tribunal, by letter of 15 February 2016, that the author of the nursing report "has raised an objection to the patient seeing the contents of her report". I have some concerns about this request for information to be withheld from Mr M:

(a) I cannot think of a legitimate objection to Mr M seeing those parts of the report that were not concerned with covert medication;

(b) the application failed to comply with rule 17(2) of the Rules (see below) because it was not accompanied by a disclosable copy of the nursing report;

(c) the managers gave no reasons for their application for non-disclosure. It is difficult to understand why because the Tribunal informed the mangers by letter of 30 December 2015 that, if they considered that any information should not be disclosed, they needed to give reasons. Simply stating that the author objected was not a reason.

14. Strangely, the Mental Health Administrator also informed the Tribunal that the authors of the social circumstances report and psychiatric reports 1 and 2 did not object to their disclosure. Moreover, psychiatric report 1 ended with the words "I am happy to share my report with [Mr M] if he wants to read it". This was odd because (a) these reports referred to covert medication and, of course, if one such report was disclosed, withholding the nursing report would seem pointless; and (b) the absence of an objection to disclosure is difficult to reconcile with the hospital managers' evidence that, if Mr M knew he had been covertly medicated, serious consequences would follow.

The adjourned hearing

15. The Tribunal adjourned a hearing on 23 February 2016 at which only Mr M was represented. It seems to me that the Tribunal's reasons for adjourning were not entirely accurate:

(a) the Tribunal said Mr M "usually" refuses all medication but, as the background set out above shows, depot injections, at least, were not refused and there were periods during which Mr M appears to have been compliant (although I recognise this may have been a consequence of certain medication having been administered covertly);

(b) the Tribunal said that the hospital mangers did not apply for permission to withhold "this aspect of the treatment". But an application, albeit a very broad one, was made in respect of the nursing report;

(c) the Tribunal said that the responsible clinician thought that, if Mr M knew he had been covertly medicated, he would probably refuse all medication. I have not been able to identify such an opinion in the papers before the Tribunal on 23 February 2016 (psychiatric report 3 had yet to be produced) and the responsible clinician did not attend the adjourned hearing to give evidence.

16. Those observations are not intended as a criticism of the Tribunal's decision to adjourn the hearing. I make them because cases of this type may be highly fact-sensitive so that careful scrutiny of the evidence is particularly important.

17. Mr M's solicitor, Mr Payne, argued that he would be unable to take meaningful instructions if Mr M was unable to see all of the evidence relied on by the hospital managers. The solicitor also argued that, the closer a patient is to having mental capacity to 'conduct proceedings', the greater is the weight that should be given to the patient's wishes and feelings.

18. The Tribunal directed a hearing to consider whether evidence about Mr M's covert medication should be disclosed to him. Skeleton arguments were directed from both parties and the managers were directed to provide details of Mr M's covert medication in a 'not for disclosure' form. Psychiatric report 3 was produced in response to the Tribunal's directions.

The arguments before the Tribunal

19. Mr Payne appeared for Mr M at the hearing on 16 May 2016 and Professor Richard Jones, of Blake Morgan Solicitors, appeared for the hospital managers. No one else attended.

20. Professor Jones accepted that the general rule in favour of full disclosure placed a burden on the hospital managers to justify non-disclosure. He also accepted that non-disclosure would interfere with Mr M's right to respect for his private life under Article 8(1) of the European Convention on Human Rights but also drew attention to Munby LJ's decision in *Re B (Disclosure to Parties)* [2001] 2 F.L.R. 1017 in which he held that although a party "has an absolute right under Article 6 to a fair trial, and although his absolute right to a fair trial cannot be watered down by reference to Article 8, he does *not* necessarily have an absolute and unqualified right to see all the documents in the case".

21. Professor Jones argued that the 'serious harm' limb of the rule 17(1) test was met given the "very significant consequences of the patient not consenting to accept medication for both his physical and mental health disorders", as described in psychiatric report 3. He

accepted this was not determinative but submitted that the Upper Tribunal's decision in *RM v St Andrew's Healthcare* [2010] UKUT 119 (AAC) required the Tribunal, in having regard to the "interests of justice", to determine whether non-disclosure would exclude Mr M completely from knowing the real process being followed, allow him to participate in a pretence and severely hamper his legal team in participating effectively in that process. However, there were factual differences between *RM* and Mr M's case. The patient in RM was largely symptom-free and had the mental capacity to consent to treatment.

22. In conclusion, Professor Jones argued that the balance was tilted firmly in favour of non-disclosure given Mr M's extreme behaviour when not taking anti-psychotic medication, the risk of death were he non-compliant with treatment for his physical ill-health and non-administration of medication would "inevitably result" in a prolonged period of detention in hospital. While it was accepted that non-disclosure would prejudice Mr M's legal interests, his legal adviser would still be able to take his instructions on the 'themes' to which the covert medication information spoke.

23. Mr Payne, for Mr M, conceded that the 'significant harm' limb of the rule 17 test was met since the evidence indicated that, if informed of his covert medication, Mr M was likely to refuse treatment. As a result, the issue was whether it was proportionate, having regard to the interests of justice, to withhold the covert medication information from Mr M.

24. Mr Payne argued the issues in Mr M's case were essentially the same as those in *RM* and the result should be the same. He also referred to the Law Society's January 2015 publication *Representation before Mental Health Tribunals*, which states "the closer the patient is to having capacity, the greater the weight you must give to their wishes in seeking to formulate and advance submissions on their behalf", as well as a solicitor's general obligation under the Solicitors Code of Conduct to disclose to a client relevant information within the solicitor's knowledge.

25. Mr Payne conceded there might be cases in which failing to disclose covert medication information would not, in practice, affect a patient's rights under Articles 5 or 6 of the European Convention on Human Rights. For example, a patient with advanced dementia who could understand or retain information for a very short period of time would arguably be unable to express any meaningful wishes. However, Mr M did not fall into that category. Despite Mr M having been assessed to lack mental capacity, the evidence showed that he had frequently expressed wishes and feelings about medication. Mr M remained entitled to know the evidence against him particularly where, as here, it was of central relevance to the issues that fell to be resolved on his referral.

26. Mr Payne further argued that failing to disclose the information would interfere with Mr M's rights under Article 8(1) of the European Convention on Human Rights. *Re B*, relied on

by the hospital managers, in fact resulted in an order for disclosure. In that case, the substantial prejudice to the father's ability to participate in proceedings, flowing from a failure to disclose information, outweighed the risks to the mother arising from disclosure. Moreover, Munby LJ said that, even if the mother had established a risk of significant harm to herself or her children, the right to a fair trial would still have tipped the balance in *RB's* favour. Such a risk would still not have supplied the "compelling" or "strictly necessary" grounds for withholding the information.

27. The overriding objective of the Rules – dealing with cases fairly, justly, efficiently and expeditiously - should also be taken into account, argued Mr Payne, in deciding whether non-disclosure would be proportionate. Mr M's instructions on the theme of covert medication could not realistically be obtained while the information was withheld from him. Mr M had expressed views on medication and it was not possible to take meaningful instructions from him without disclosing that he had been covertly medicated.

The First-tier Tribunal's decision

28. The Tribunal granted the hospital managers' request and directed that information relating to Mr M's covert administration of medication was not to be disclosed to him. The Tribunal's findings and conclusions included the following:

- The Tribunal agreed with the parties that the 'serious harm' limb of the Rule 17 test was satisfied. The "overwhelming medical evidence" showed that, if Mr M knew he was being covertly medicated, he would be likely to refuse to accept medication for his mental illness and his physical condition. His life would be in danger and the risk of unprovoked violence to others would increase;
- The issue was whether it would be proportionate, having regard to the interests of justice, to withhold covert medication information;
- Fairness called for a strong presumption in favour of disclosure in the absence of compelling reasons for withholding information;
- Mr Payne conceded that the Upper Tribunal's decision in *RM* was not binding although the Tribunal endorsed and "adopted the careful and measured balancing exercise…in *RM*". However, Mr M's case could be distinguished since he lacked the mental capacity either to represent himself, instruct a representative or consent to treatment;
- Mr M's lack of mental capacity was relied on in finding that any disadvantage or prejudice flowing from withholding the information "is outweighed by the amelioration of the risks that would arise to Mr M and others if that information were disclosed to

him". It was therefore proportionate to direct that covert medication information was not to be disclosed to Mr M;

- The Tribunal accepted that Mr Payne would be put in a difficult position by the Tribunal's decision but those difficulties would be reduced if, before the final hearing, the managers presented their information in a way that distinguished between the disclosable and non-disclosable evidence.

Legal Framework

Mental Health Review Tribunal for Wales Rules 2008

29. The overriding objective of the Rules is "to enable the Tribunal to deal with cases fairly, justly, efficiently and expeditiously" (rule 3(1)). Dealing with a case in those ways includes "ensuring, so far as practicable, that the parties are able to participate fully in the proceedings" (rule 3(2)(b)). The Tribunal must "seek to give effect to the overriding objective" when it exercises any power under the Rules or interprets any rule.

30. Rule 10(2) confers power on the Tribunal to make an order prohibiting the disclosure of "specified documents or information relating to the proceedings". Rule 10(3) permits this power to be exercised "in order to take action under rule 17".

31. As a general rule, the Tribunal must send a copy of any document received from a party to every other party (rule 15(1)). The patient is always a party (see the definition of "party" in rule 2(1)). However, rule 15(1) is subject to rule 17.

32. Upon receipt of a reference in respect of a patient, rule 15(2) requires the Tribunal to request that the hospital managers supply the documents and information required by rule 15(5). That rule requires the hospital managers to send a statement to the Tribunal which contains:

(a) the information specified in Part A of the Schedule to the Rules, in so far as within the knowledge of the managers, which includes the application to which the proceedings relate (paragraph 4 of Part A). Mr M's 2015 application, however, is not within the Tribunal bundle;

(b) the report specified in paragraph 1 of Part B of the Schedule that is "an up-to-date clinical report, prepared for the Tribunal, including the relevant clinical history and a full report on the patient's medical condition";

(c) the other reports specified in Part B of the Schedule, in so far as it is reasonably practicable to provide them. These include an up-to-date social circumstances report (paragraph 2 of Part B), the views of the hospital managers on the patient's suitability for discharge (paragraph 3) and "any other information or observations" which the managers wish to provide (paragraph 5).

33. The Tribunal's general case management powers in rule 5 permit it to direct a party to provide documents, information or submissions (see rule 5(2)(c)). Rule 18(1) provides that the Tribunal may give directions as to the issues on which it requires evidence, the nature of the evidence required and the manner in which evidence is to be provided. And rule 19(1)(b) permits the Tribunal by order to require any person to produce any documents in that person's possession or control which relate to any issue in the proceedings.

34. Rule 17, which is at the heart of this appeal, is entitled "Withholding documents or information likely to cause harm". Rule 17(1) positively requires the Tribunal to give a direction prohibiting the disclosure of a document or information to a person if satisfied of two matters:

(a) such disclosure "would be likely to cause that person or some other person serious harm"; and

(b) having regard to the interests of justice it is proportionate to give such a direction.

35. While there may well be some overlap in the considerations relevant to these two matters, it should be noted that they are independent tests that are not to be merged. It follows that satisfaction of the 'likely to cause serious harm' test does not necessarily compel the conclusion that the proportionality test is met.

36. Rule 17(1) differs from the counterpart provision in rule 14(2) of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) 2008 in that rule 14(2) confers power to direct non-disclosure if the two conditions are met, rather than a duty.

37. Rule 17(2) provides the mechanism by which a party may invite the Tribunal to make a rule 17(1) direction. If a party considers a rule 17(1) direction should be given it must:

(a) "exclude that part of the relevant document or that information from any document that will be provided to the second party"; and

(b) provide the excluded part of a document, or information, to the Tribunal; and

(c) give the party's reasons for exclusion "in order that the Tribunal may decide whether the document or information should be disclosed to the second party or should be the subject of a direction under paragraph (1)".

38. Rule 17(4) permits the Tribunal to give a direction for disclosure of rule 17(1) information to a party's representative if satisfied:

(a) disclosure to the representative would be in the interests of the party; and

(b) the representative would not be likely to disclose the documents or information to any person without the Tribunal's consent nor use them otherwise than in connection with the proceedings.

39. Rule 25(4)(c) permits the Tribunal to give a direction excluding from a hearing, or part of a hearing, any person whom the Tribunal considers should be excluded in order to give effect to a rule 17 direction.

40. The Mental Health Act 1983 Code of Practice for Wales does not really take matters any further. Paragraph 12.20 states:

> "12.20 If the author of a report prepared for the Tribunal knows of information they do not think the patient should see, they should follow the Tribunal's procedures for the submission of such information. Generally it is expected the professional submitting a report will have discussed the contents with the patient. Ultimately it is for the Tribunal to decide what should be disclosed to the patient."

41. Turning, now, to legal representation, rule 13(1) permits any party to appoint a representative, whether legally qualified or not. Rule 13(5) permits the Tribunal in certain cases to appoint a legal representative for a patient who has not appointed a representative. One such case is where "the patient lacks the capacity to appoint a representative but the Tribunal believes that it is in the patient's best interests to be represented" (rule 13(5)(b)(ii)).

Mental Health Act 1983

42. On a reference to the Tribunal, sections 72(2) & (4) of the 1983 Act require it to direct the discharge of a patient liable to detention for treatment under section 3 of the 1983 Act if not satisfied as to any of the following:

(a) that the patient is then suffering from mental disorder; or

(b) that the patient is then suffering from mental disorder of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or

(c) that it is necessary for the health of safety of the patient or for the protection of other persons that he should receive such treatment; or

(d) that appropriate medical treatment is available for the patient. Section 3(4) provides that "in this Act, references to appropriate medical treatment, in relation to a person suffering from mental disorder, are references to medical treatment which is appropriate in his case, taking into account the nature and degree of the mental disorder and all other circumstances of his case".

43. Unless the issue is simply whether the patient is suffering from mental disorder, all the discharge criteria call for some qualitative analysis by reference to a patient's medical treatment. It must therefore be difficult to dispute that a patient, without knowing what his medical treatment is, is unlikely himself to be able to mount a meaningful challenge to his detention.

44. Part 4 of the 1983 Act regulates the treatment of a patient liable to be detained under section 3. Within Part 4, section 58, entitled "Treatment requiring consent or a second opinion", applies to treatment that includes "administration of medicine to a patient by any means…at any time during a period for which he is liable to be detained…if three months or more have elapsed since the first occasion in that period when medicine was administered to him by any means for his mental disorder".

45. Where a patient has not consented to such treatment, then, subject to the urgent cases referred to in section 62, section 58(3)(b) prohibits the treatment unless an appointed registered medical practitioner, not being the responsible clinician, has certified in writing that either (i) the patient is not capable of understanding the nature, purpose and likely effects of that treatment but that it is appropriate for the treatment to be given, or (ii) where a capable patient has not consented it is appropriate for the treatment to be given.

46. The appointed medical practitioner referred to above has come to be known as a SOAD – Second Opinion Appointed Doctor.

47. For section 58 purposes, it is appropriate for treatment to be given to a patient "if it is appropriate in his case, taking into account the nature and degree of the mental disorder from which he is suffering and all other circumstances of his case" (section 64(3)).

48. The Welsh Code of Practice provides:

> "24.34 In every case sufficient information must be given to ensure the patient understands in broad terms the nature, likely effects and risks of that treatment including the likelihood of its success and any alternatives to it. A record should be kept of information given to patients.
>
> …24.36 Patients should be invited and encouraged to ask questions, and professionals should answer fully, frankly and truthfully, particularly if the patient asks about the risks. There may sometimes be compelling and exceptional reasons, in the patient's interests, for not disclosing certain information. Any decision not to disclose information must be justifiable and recorded with reasons and regularly reviewed."

49. A section 58(3)(b) certificate:

(a) may not be given before the SOAD has consulted two other persons professionally concerned with the patient's medical treatment, one of whom shall be a nurse but the other shall be neither a nurse nor registered medical practitioner (section 58(4));

(b) is to be given in such form as may be prescribed by regulations (section 64(2)). Regulation 40 of the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment (Wales) Regulations 2008 requires the certificate to be in Form CO3, which is set out in the Schedule to the Regulations:

> "I…have consulted [full name of nurse], a nurse and [full name and profession] who have been professionally concerned with the medical treatment of [full name and address of patient].
>
> I certify that the patient…is not capable of understanding the nature, purpose and likely effects of…the following treatment [give description of treatment or plan of treatment; indicate clearly if the certificate is to apply to any or all of the treatment for a specified period] but that it is appropriate for the treatment to be given.
>
> My reasons are as below/I will provide a statement of reasons separately <delete as appropriate> [Set out reasons; when giving reasons please indicate if, in your opinion disclosure of the reasons to the patient would be likely to cause serious harm to the physical or mental health of the patient or to that of any other person.]
>
> Signed [signature]
>
> Date [date]."

Mental Capacity Act 2005

50. Section 28(1) of the 2005 Act provides:

> "(1) Nothing in this Act authorises anyone—
>
> (a) to give a patient medical treatment for mental disorder, or
>
> (b) to consent to a patient's being given medical treatment for mental disorder,
>
> if, at the time when it is proposed to treat the patient, his treatment is regulated by Part 4 of the Mental Health Act."

51. Since Mr M's treatment was regulated by Part 4 of the 1983 Act, section 28(1) prevented anyone from relying on the 2005 Act in order to give Mr M medical treatment for mental disorder.

RM v St Andrew's Healthcare

52. Since this decision of the Upper Tribunal was at the forefront of both parties' submissions, I shall describe it here. It concerned the application of rule 14(2) of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care) Rules 2008 but that is not material for present purposes since the provisions of rule 14(2) are very similar to those of rule 17(1) of the Rules.

53. The facts in RM differed from Mr M's in two potentially material respects.

54. Firstly, the patient had been informed, during earlier tribunal proceedings, that he had been covertly medicated, the consequences of which were described as follows:

> "he then refused medication and became suspicious of food and drink. His epileptic control worsened, his psychotic illness was exacerbated, his mental state deteriorated, he refused to engage in rehabilitiation and he became physically aggressive and unco-operative…he was at increased risk of sudden, unexpected death".

55. Subsequently, the patient was again medicated covertly which "improved his epileptic control and reduced his psychotic symptoms".

56. Secondly, it seems that the patient had capacity to appoint a legal representative. Certainly, the decision does not state that he lacked capacity in that respect nor that he lacked capacity to conduct proceedings.

57. The First-tier Tribunal ordered that information about the patient's covert medication should be withheld from him. The Tribunal concluded non-disclosure was proportionate because the patient's solicitor "can take his instructions on the themes with which the material is concerned".

58. On my reading, Upper Tribunal Judge Jacobs' general rulings on the law included:

(a) the 'serious harm' limb of the rule 14 test requires a finding of fact – would disclosure be likely to cause serious harm to the patient or another person – and "the medical evidence is relevant" in making any such finding;

(b) the House of Lords' decision in *Secretary of State for the Home Department v AF (No. 3)* [2009] 3 WLR 74 identified the test to be applied – "does it [non-disclosure] allow the patient to make an effective challenge to the decision to continue to detain him";

(c) RM's legal team's views on the difficulty in obtaining instructions from him was "not decisive, but it is important" especially when conducting the 'individualised balancing act' envisaged by Baroness Hale in *AF*;

(d) a direction prohibiting disclosure of covert medication information has the effect of preventing a patient ever being told the real reasons for his detention.

59. Judge Jacobs went on to decide that, in RM's case, it would not, having regard to the interests of justice, be proportionate to withhold from the patient information about his covert medication. On my reading, the judge's findings on this aspect of the case included:

(a) without disclosure to the patient, the "real proceedings" would have to be conducted "out of the patient's sight and knowledge" and, if he were unsuccessful, would never know the real reason why;

(b) it was not good enough that RM's legal team were aware of the information and could present a case "as best they can". Inevitably, they would have to approach the issue obliquely with RM and that difficulty in obtaining his instructions would be exacerbated by the likelihood that the lawyers would err on the side of caution;

(c) "32… The effect of the order in this case would be a series of further non-disclosure orders. In total, they would exclude the claimant completely from knowing of the real process that was being followed and allow him to participate only in a pretence of a process. They would severely hamper his legal team in participating effectively in that process. *AF (No 3)* shows the importance of process, even over the 'correctness' of the ultimate outcome";

(d) "33. ..the judge was not entitled in the circumstances of the case, judged by the standards of fairness set by *AF(No 3)*, to direct non-disclosure. Disclosure will, on the evidence, have some immediate adverse consequences for the claimant's condition. However, they have been overcome in the past. It seems that the patient is not able to link his past experiences with his present freedom from symptoms. Those short-term consequences, while involving risk, do not justify the legal consequences that would follow from non-disclosure";

(e) a non-disclosure direction would impair RM's prospects of future discharge:

> "30. Without knowledge of his covert medication, the patient will continue to believe that his symptoms do not justify his continued detention. He will not mentally be able to accept the need to engage with treatment. At the best, his chances of taking steps towards his ultimate release will be hampered by lack of knowledge of the real reasons for his detention";

(f) while disclosure would have some adverse consequences, that did not justify the legal consequences that would follow from non-disclosure:

> "Disclosure will, on the evidence, have some immediate adverse consequences for the claimant's condition. However, they have been overcome in the past. It seems that the patient is not able to link his past experiences with his present freedom from symptoms. Those short-term consequences, while involving risk, do not justify the legal consequences that would follow from non-disclosure."

60. It should be noted that there were two aspects to the *RM* decision. Firstly, Judge Jacobs' rulings on points of law. Secondly, Judge Jacobs' application of those rulings to the facts of RM's case although I acknowledge that, in applying those rulings, the judge made findings that may be apposite in other covert medication cases.

Proceedings before the Upper Tribunal

61. The President of the Tribunal, in response to Mr M's solicitors' detailed application for permission to appeal to the Upper Tribunal, granted permission and, in so doing, stated it would be useful to have guidance from the Upper Tribunal guidance on requests to withhold covert medication information from patients lacking mental capacity. On my reading, the President did not limit the grounds on which permission to appeal was granted.

62. Proceedings before the Upper Tribunal made slow progress largely because it took the Legal Aid Agency more than a year to determine Mr M's solicitor's application for legal aid. While Mr M had not been covertly medicated since February 2016, the solicitors still had to wait far too long. It is also right that I commend Confreys Solicitors for the way in which they acted as Mr M's representative during this period. In fact, this is not the only case I have dealt with recently in which that firm have continued diligently to represent a patient in Upper Tribunal proceedings in the face of legal aid difficulties.

63. I must also take some responsibility for the delay in deciding this appeal following the hearing. It has taken me longer than I anticipated to complete these reasons, for which I apologise.

The arguments – introductory matters

64. Both parties were ably represented by counsel at the hearing before myself. I am grateful to both counsel for their assistance. I also record my gratitude to both parties' solicitors for

their co-operation with each other and the Upper Tribunal throughout the proceedings, in exactly the spirit required in mental health cases.

65. Initially, the hospital managers argued the Upper Tribunal might not have jurisdiction to hear this appeal, or at least determine certain grounds of appeal, since the President of the Tribunal, in granting permission to appeal, did not identify any arguable error on a point of law in the Tribunal's non-disclosure decision. The President, it was argued, simply granted permission so that the Upper Tribunal could give guidance on the issues that arose in Mr M's case. At the hearing, however, this point was not seriously pressed by Mr Walker, correctly in my view. Even if there was some doubt as to the grounds on which the President of the Tribunal granted permission to appeal, subsequent Upper Tribunal case management directions made it clear that the Upper Tribunal was not simply engaging in a proposed guidance-giving exercise and the grounds of appeal were those put to the President of the Tribunal.

66. The hospital managers' solicitors argued in pre-hearing written submissions that, since Mr M had not been covertly medicated since February 2016, this appeal is purely academic and it would serve no useful purpose to review the Tribunal's decision. I do not agree. Even though Mr M has not been covertly medicated for some time, there must be a realistic prospect of future applications or references in respect of Mr M raising the same issue as arose in this case whether directly, because covert medication has re-commenced, or because evidence of historical covert medication is considered relevant on any such application or reference. Further, I agree with the point made by Ms Sutton at the hearing that the Tribunal may find a decision of the Upper Tribunal about covert medication disclosure disputes, involving patients without the capacity to appoint a representative, of general assistance.

67. At the hearing, Mr Walker requested that the identity of the hospital managers be anonymised in any published version of this decision.

Ground 1 – whether undue weight given to Mr M's lack of capacity

68. Ms Sutton argues the Tribunal, in substance, relied solely on Mr M's lack of capacity to appoint a legal representative and consent to treatment. This involved a misdirection in law:

- rule 17 itself does not distinguish between patients who lack capacity and those who do not;

- there is clear authority that capacity does not carry significant weight in determining whether to administer treatment without consent (*R(B) v S (Responsible Medical Officer*)

[2006] EWCA Civ 28. It was therefore illogical to treat it as a critical factor or give it significant weight in questions of non-disclosure;

- applied more generally, the Tribunal's reasoning placed patients lacking capacity at a categorical disadvantage, which cannot be right and could lead to injustice or inequality. *M v N* [2015] EWCOP 76 draws attention to "the obligation to be alert to direct or indirect discrimination against those who lack capacity";

- if capacity is relevant in the application of Rule 17, the overriding objective of the Rules required the Tribunal to consider how the hospital managers / responsible clinician came to decide that covert medication was in Mr M's best interests. That would not involve reviewing a clinical decision but would rather involve the Tribunal satisfying itself that the correct approach had been taken. The Tribunal should also have taken into account that, despite lacking capacity to consent to treatment, Mr M had expressed views about medication.

69. Ms Sutton further argues that, even if capacity was of significance, the Tribunal failed adequately to explain why. Its reasons did not demonstrate the required careful and measured balancing exercise (see *AF*). Moreover, evidence about the assessment of Mr M's capacity was largely absent from the documentary evidence as were details of a decision that covert medication was in Mr M's best interests.

70. Ms Sutton also submits the Tribunal failed to recognise that there is a spectrum of incapacity, some patients being closer to the capacity threshold for a particular decision than others. If the Tribunal did recognise this point it did not have the evidential material properly to give effect to it when applying Rule 17(4). Since the Tribunal papers contained no formal capacity assessments, it would not have been possible to gauge how close or far Mr M was from having the capacity to appoint a legal representative.

71. At the hearing, I raised the absence from the appeal papers of the certificate that the SOAD must have given when authorising Mr M's covert medication for mental disorder. Counsel agreed it was not supplied to the Tribunal. With my permission, Ms Sutton further argued that its absence amounted to an error on a point of law in the Tribunal's decision. Not only would the SOAD certificate have confirmed that the correct legal process was followed in administering medication covertly, it was likely to have been an important piece of evidence about the nature and extent of Mr M's impaired capacity to consent to treatment and the likely consequences of not administering medication covertly.

72. I put to Mr Walker, for the hospital managers, that the Tribunal's decision might be considered tantamount to saying something like 'this patient lacks capacity so he doesn't really need to know how his case is presented'. Mr Walker said his argument did not go that

far. He did not argue that a lack of capacity should be determinative but it is a potentially relevant factor on which this Tribunal was entitled to rely and, to the extent that it did rely on it, did so justifiably and rationally.

Ground 2 – whether the Tribunal failed to follow RM v St Andrew's Healthcare

73. Ms Sutton argues the Tribunal failed to follow *RM* and, in seeking to distinguish it, gave inadequate reasons for finding 'important differences' between the *RM* and Mr M's case. If the apparent capacity of the patient in *RM* was the 'important difference', it was an inadequate reason for distinguishing. Before the Tribunal, Mr M's solicitor did not in fact concede that *RM* was not binding on it; he accepted that it did not need to be followed if it could be distinguished which is a different matter. I observe that, given the obvious skill with which Mr Payne represented Mr M before the Tribunal, this argument is not without support. The fact was, argues Ms Sutton, *RM* could not be distinguished on the basis of a materially different factual matrix

74. Mr Walker accepts the general rule in favour of full disclosure required the hospital managers to demonstrate to the Tribunal that non-disclosure was appropriate. While the Tribunal's reasons for distinguishing *RM* might have been better expressed, the issue was whether the Tribunal's approach was in conflict with the decision in *RM*. Mr Walker submitted it was not, so far as legal principles were concerned, and, to the extent that the approaches differed, this was explained by Mr M's accepted lack of mental capacity.

75. Mr Walker submitted there was no domestic case law on the meaning of the term "would be likely to cause…serious harm", as used in rule 17(4), but whatever its precise scope, Mr M's solicitor had been right to concede that the serious harm limb of the test was met.

Ground 3 – whether the Tribunal gave undue weight to Mr M's best medical interests

76. Ms Sutton argues the Tribunal's focus on capacity effectively transformed the disclosure issue into a best interests decision. Mr Walker disagrees. The Tribunal did not purport to give its own ruling on whether covert medication was in Mr M's best interests.

Ground 4 – whether non-disclosure would deny Mr M a fair hearing

77. Ms Sutton argues the Tribunal failed adequately to explain how Mr M's solicitor would be able to take instructions on the 'general themes' of the evidence. Quite apart from the Tribunal's failure to identify these general themes, *RM* required the Tribunal to recognise the importance and particular significance to be attached to Mr Payne's views on the difficulties he would face, were the covert medication information withheld, in properly representing Mr M. The Tribunal did not do this; its treatment of Mr Payne's views read like an afterthought.

78. Mr Walker accepts that *RM* required the Tribunal, in considering whether the proportionality limb of the test was met, to determine whether non-disclosure would prevent Mr M from knowing the real process being followed, result in him participating in a pretence and severely hamper his legal team in participating effectively in the process. However, there were factual differences between *RM* and Mr M. The patient in RM was largely symptom-free and had the mental capacity to consent to treatment.

79. While Mr Walker accepted non-disclosure could reasonably be considered likely to have an adverse effect on Mr M's legal interests, his solicitor would still be able to take his instructions on the 'themes' with which the withheld information was concerned. And, before the Tribunal, Mr M's solicitor did not articulate any specific prejudice that would be caused to Mr M by non-disclosure.

Ground 5 – whether the Tribunal's made a decision that could properly be considered proportionate, having regard to the interests of justice

80. Ms Sutton argues the Tribunal failed adequately to explain why it was proportionate simply to disclose 'general information' to Mr M when this would, as the Tribunal failed to recognise, prevent him from effectively challenging his detention. The Tribunal also failed to factor in the possibility that, even if Mr M reacted adversely to knowledge that he had been covertly medicated, the health risks relied on by the hospital managers might be ameliorated by forcible administration of medication, although this would doubtless be a difficult and unpleasant experience. I am not a doctor and so have no specialist knowledge but am uncertain how oral medication (Mr M did not refuse depot medication) might be forcibly administered.

81. To the extent that violence against staff or other patients was taken into account by the Tribunal, Ms Sutton argues violence and unpredictable behaviour is a sad fact of life in many hospitals. Specialised units have been designed to minimise the risks of injury and, for the same reason, staff are highly trained professionals

82. Mr Walker accepts failing to disclose to Mr M that he was covertly medicated would interfere with his right to respect for his private and family life under Article 8(1) of the European Convention on Human Rights, and raises an issue as to whether Mr M would receive the fair trial required by Article 6(1) of the Convention. However, he relied on Munby LJ's decision in *Re B (Disclosure to Parties)* [2001] 2 F.L.R. 1017. Munby LJ addressed the relationship between the right to a fair trial under Article 6 and Article 8 rights and held that although a party "has an absolute right under Article 6 to a fair trial, and although his absolute right to a fair trial cannot be watered down by reference to Article 8, he does *not* necessarily have an absolute and unqualified right to see all the documents in the case".

83. Mr Walker concedes that Baroness Hale's observation in *Secretary of State for the Home Department v AF* [2009] UKHL 28 that "these days, a Mental Health Review Tribunal would be unlikely to uphold a non-disclosure claim on the general ground that disclosure would be damaging to the doctor patient relationship" might not, on the face of it, support his arguments under this ground. However, Baroness Hale went on to stress the importance of an "an individualised balancing act" in which potential harm is balanced against the fairness of proceedings. In any event, *AF* concerned legal challenges to control orders and the Upper Tribunal should take care in applying the decision to the very different context of Mr M's case.

84. Mr Walker further submits that the interests of justice are not determinative. The Rules only require the tribunal to have "regard" to the interests of justice. The Upper Tribunal's decision in *RM* could be criticised for treating the interests of justice as a decisive consideration. The question ought to be whether it would be proportionate to disclose the matter, in other words whether infringing the patient's right to the full disclosure of information about his treatment is a proportionate means of achieving the legitimate aim of protecting the patient and/or others from serious harm. In Mr M's case, the balance was tilted firmly in favour of non-disclosure given the likely consequences of disclosure namely the risk of Mr M's death and the inevitability of a prolonged period of detention in hospital due to an exacerbation of his violently aggressive behaviour. In those circumstances, the Tribunal's decision was plainly justifiable.

85. More generally, Ms Sutton argues, as a matter on which the Upper Tribunal's guidance would be useful, that if a medical consensus that covert medication is in a patient's best interests is lacking, a Tribunal should consider whether to adjourn so that an application may be made to the Court of Protection for a welfare order under section 16 of the Mental Capacity Act 2005 authorising covert medication (if considered by the Court of Protection to be in the patient's best interests). Mr Walker cautioned against giving any general guidance given the fact-specific nature of cases of this type.

Conclusions

The case presented to the Tribunal

86. At the outset, I should observe that two aspects of the case, as put to the Tribunal, may have weakened or undermined its analysis when applying rule 17(4).

87. The first is the concession that the 'serious harm' limb of the rule 17(4) was satisfied. I do not suggest that the concession was wrong in fact – it is not my role to adjudicate on that. My point is that some types of 'serious harm' are more severe than others. To take a dramatic

example, a likelihood of certain death is a more significant form of serious harm than a likelihood of a drastic but temporary deterioration in a patient's mental health. The nature of the likely serious harm must be relevant once the Tribunal goes on to decide whether, having regard to the interests of justice, non-disclosure would be proportionate. In cases such as this, if the parties agree the serious harm limb of the test is satisfied then, in my view, the Tribunal should be informed of the basis of that agreement, i.e. the nature of the serious harm which the parties agree would be caused by disclosure. I appreciate that, in this case, the Tribunal appears to have made findings of fact about the serious harm likely to be caused by disclosure but these were not the subject of argument. I cannot help but wonder whether, had the point been argued, the fact that Mr M had not been covertly medicated for some three months would have been unearthed, if not at the hearing then subsequently.

88. The second point is that it seems to me highly likely that the Tribunal, sitting in May 2016, was not informed that Mr M had not been covertly medicated for some three months. Had it been, I am sure it would have mentioned it in the reasons for its decision. Given the pressing need for covert medication, described in psychiatric report 3, the absence of covert medication for this period was a relevant feature of Mr M's case that should have been brought to the Tribunal's attention. The Tribunal should have been told why Mr M had not been covertly medicated during this period and whether, as a result, any of the adverse consequences of ceasing covert medication – said to be the likely result of revealing to Mr M that he had been covertly medicated – had come to pass.

Observations on the evidence before the Tribunal

89. The Tribunal has power to require production of documents or information in addition to that required by the Rules to be supplied in every case. In my view, the SOAD certificate should have been supplied by the hospital managers and, when it was not, should have been required by the Tribunal. The scope of the authority covertly to medicate Mr M would have been limited by the terms of the SOAD certificate. The certificate would, in all likelihood, also have contained relevant information about Mr M's mental capacity and the consequences of not administering medication covertly. All of these matters were relevant to the issues before the Tribunal.

90. Also absent from the Tribunal bundle was any formal assessment of Mr M's mental capacity. In my view, in cases such as Mr M's, that is covert medication disclosure disputes involving a patient said without capacity to appoint a legal representative, such assessments as have been carried out should be provided to the Tribunal. The reason why should be apparent from the rest of these reasons.

Findings on the law

91. Rather than dealing with each ground of appeal in turn, I shall set out my findings on the matters in dispute in what appears to me to be a logical order. I do so because many of the relevant considerations overlap the grounds of appeal.

Whether the Tribunal erred by failing to follow RM

92. I shall first deal with the relevance of the Upper Tribunal's decision in *RM v St Andrew's Healthcare*. I again note that, in *RM*, Upper Tribunal Judge Jacobs did two things. First, he made rulings about the relevant law. Second, he applied that law in deciding for himself whether information about a patient's covert medication ought to be disclosed. I note that, in this case, neither party asks me to re-decide the disclosure issue in the event that the appeal succeeds.

93. In my view, *RM* must have concerned a patient who was capable of making an effective challenge to his detention. Had *RM* been incapable of appointing a representative, or was considered incapable of conducting proceedings, Judge Jacobs' decision would have said so. Therefore, in the light of the detention criteria, failing to disclose to the patient that he had been covertly medicated was bound to have the adverse consequences described by Judge Jacobs. Mr M's case was different in that the Tribunal had already found that he lacked the mental capacity to appoint a legal representative. To some extent, therefore, Mr M's mental condition impaired his ability himself effectively to challenge his detention.

94. I add that I do not agree that Judge Jacobs' decision places too great an emphasis on the interests of justice. It is true that rule 17(4) merely requires the Tribunal to "have regard" to the interests of justice but that formulation is explained by the fact that failing to disclose relevant evidence to a patient could never be said to be in the interests of justice. In a case involving a patient who has capacity to appoint a legal representative, I can well understand why the failure to disclose information about covert medication may be considered so great a rupture in the fairness of proceedings that it could not be proportionate to withhold the information. As I pointed out above, assuming a patient does in fact have a mental disorder, the statutory detention criteria all require some qualitative analysis of a patient's medical treatment. Medical treatment will nearly always be a central issue in proceedings before a mental health tribunal

Capacity

95. The fact that a patient lacks the mental capacity to appoint a legal representative does not mean the patient has no relevant wishes and feelings about his detention nor that any wishes and feelings fall out of account. Further, the Upper Tribunal's decision in *YA v Central and North West London NHS Trust* [2015] UKUT 37 (AAC) acknowledges that a patient,

despite lacking mental capacity to appoint a representative, might nevertheless have capacity to give instructions on some relevant issues. *YA* also recognises that, in theory, a patient who lacks capacity to appoint a representative my nevertheless have capacity to conduct proceedings although I note that, in *YA*, Charles J considered that, in practice, it was difficult to envisage cases in which a patient who lacked capacity to appoint a representative nevertheless had the capacity to conduct proceedings.

96. Throughout, the Tribunal in Mr M's case remained under an obligation to ensure, so far as practicable, that Mr M was able to participate fully in the proceedings (rule 3(2) of the Rules). That obligation was concordant with the Law Society's expectations of Mr M's solicitor as set out in its 2015 guidance and to which Mr Payne referred in his arguments to the Tribunal. The Tribunal's participative duty did not disappear upon the appointment of a legal representative for Mr M on the ground that he lacked capacity to appoint a representative. For this reason, the Tribunal was required to turn its mind to the extent to which Mr M was capable of participating in the proceedings. Only then could it properly answer the key question, that is whether the obstacles placed in the way of Mr M's participation in the proceedings by non-disclosure of information about covert medication, including the difficulties this would cause for his solicitor, were such that, having regard to the interests of justice, it would nevertheless be proportionate to withhold the information from Mr M.

97. In conclusion, I decide that the Tribunal's decision involved an error on a point of law. In deciding whether it would be proportionate to withhold covert medication information from Mr M the Tribunal failed to take into account its ongoing obligation to ensure, so far as practicable, that Mr M was able to participate in the proceedings.

98. It is, of course, important not to introduce unnecessary complexity into mental health tribunal proceedings. I do not suggest that a patient's lack of capacity needs to be calibrated. In fact, the precise issue is the extent to which a patient's mental condition allows him or her to participate in the proceedings rather than some determination of 'residual' capacity. However, it is necessary, in a case like Mr M's, to seek submissions from the parties as to the patient's ability to participate in the proceedings. A Tribunal may also decide it is necessary for this purpose to require the detaining authority to supply it with any formal mental capacity assessments that have been carried out.

99. I arrive at the above conclusions without recourse to the Human Rights Act 1998 and the rights under the European Convention on Human Rights given further effect by that Act. I do note that, in *Mikhaylenko v Ukraine*, application no. 49069/11, 30 May 2013, the European Court of Human Rights decided "it is for the State to decide how the procedural rights of a

person who has been deprived of legal capacity should be ensured at domestic level". However, I have decided this appeal simply by construing the procedural rights afforded at a domestic level, under the Rules.

Other points

100. To the extent that the arguments advanced have not been dealt with already, I decide:

(a) I decline to attempt to define 'serious harm'. This is a question of fact to be determined by a mental health tribunal, a task for which it is well-equipped by the inclusion of medical members on tribunal panels;

(b) I do not agree that Mr Payne, who represented Mr M before the Tribunal, ought to have articulated the specific prejudice to Mr M's interests flowing from withholding from Mr M information about his covert medication, and it was now too late for Mr M's solicitors to seek to do so. It was obvious what the prejudice would be. It would have significantly reduced Mr Payne's practical ability to engage in any meaningful discussion with Mr M about matters such as whether his mental order was severe enough (of a 'nature or degree') to justify keeping him in hospital for medical treatment or whether appropriate medical treatment was available for him;

(c) The Court of Protection's jurisdiction does not extend to medical treatment for mental disorder that is regulated by Part 4 of the 1983 Act. There is no scope for me or anyone else to give guidance which assumes the Court of Protection possesses a jurisdiction which it does not have;

(d) I am not certain that the Tribunal was asked to consider, as part of its proportionality analysis, the possibility that Mr M could forcibly be administered the medication that had been administered covertly. In any event, I simply do not know whether oral medication can be administered forcibly or, if it can, whether to do so is accepted medical practice. It would be wrong of me to express any opinion on a point such as this which clearly falls outside my area of expertise;

(e) I see no justification for anonymising the hospital managers in the publication version of these reasons. It has not been explained to me how this might adversely affect the legitimate interests of Mr M, other patients or anybody else.

Disposal of the appeal

101. Both parties submit that, if Mr M's appeal is allowed, this matter should be remitted to the Tribunal in order for it to re-determine whether the covert medication information supplied to the Tribunal should be withheld from Mr M. While the underlying reference itself must have been decided some time ago, I take the course suggested by the parties. I am not in a position to determine whether a rule 14(1) direction is still required. I do not, for example, know whether Mr M's responsible clinician thinks disclosure would now give rise to serious harm by affecting his continued compliance with medication.

102. It follows that, while this appeal succeeds, I do not set aside the Tribunal's rule 14(1) direction nor do I set aside the similar direction I made for the purpose of these proceedings. Once the Tribunal has reconsidered its rule 14(1) direction, it is open to Mr M's solicitors to apply to the Upper Tribunal for a set aside or variation of the direction made for the purpose of these proceedings.

Directions

(1) This matter is remitted to the Mental Health Review Tribunal for Wales in order for it to determine whether to set aside or vary its May 16 2016 rule 14(1) direction.

(2) The need for any further case management directions is to be considered, in the first instance, by the President of the Mental Health Review Tribunal for Wales.

(Signed on the Original)

E Mitchell

Judge of the Upper Tribunal

27 March 2018