[2018] AACR 11

**(JMcG v Devon Partnership NHS Trust
[2017] UKUT 348 (AAC))**

Judge Knowles QC **HM/869/2017**
23 August 2017

Mental Health – detention under Mental Health Act – section 72(3) – whether tribunal had power to defer the discharge of a detained patient beyond the date of the order authorising detention

The appellant, a prisoner, was transferred to hospital for treatment after he became psychotic and paranoid. His condition eventually improved after he was transferred to a hospital closer to his home and had received anti-psychotic medication. On 9 December 2016, he applied to the First-tier Tribunal (F-tT) for discharge from detention. The appellant recognised that immediate discharge would be inappropriate and the tribunal was invited to defer discharge to allow the care team sufficient time in which to arrange for appropriate accommodation. The F-tT refused the application having found that such deferment would be for a short period as the appellant's section was due to expire in early February 2017. The appellant appealed to the Upper Tribunal (UT) on the basis that the F-tT had erred in its belief that, pursuant to section 72(3) Mental Health Act 1983, it could not defer the discharge of a detained patient beyond the date of the order authorising detention and had failed to give adequate reasons for its decision overall.

Held, allowing the appeal, that:

1. a tribunal when exercising its power pursuant to section 72(3) to direct a discharge on a future specified date, cannot specify a future date for discharge after that on which the authority for the patient's detention expires (paragraph 32);

2. once the tribunal had made a direction pursuant to section 72(3) liability to be detained, either pursuant to sections 2 or 3 or indeed to a Community Treatment Order, came to an end on the date specified for discharge. A date set beyond the date of the order authorising detention would be as invalid as the continuation of the Community Treatment Order in *MP v Mersey Care NHS Trust* [2011] UKUT 107 (AAC) since the necessary underpinning of the order authorising detention would be lacking (paragraph 34);

3. there was no basis to intervene with the F-tT's decision as it had carried out its fact-finding role rationally and its written reasons accorded with the UT's guidance in *MS v North East London Foundation Trust* [2013] UKUT 92 (AAC) - the F-tT had (a) stated what facts it had found; (b) explained how and why it made them; and (c) showed how it applied the law to those facts (paragraphs 41 to 46).

DECISION OF THE UPPER TRIBUNAL
ADMINISTRATIVE APPEALS CHAMBER

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

The decision of the First-tier Tribunal (Mental Health) on 19 January 2017 did NOT involve the making of an error on a point of law.

The appeal is dismissed.

REASONS FOR DECISION

The Issue in this Appeal

1. The principal issue in this appeal is whether the First-tier Tribunal (Mental Health) ("the tribunal") erred in law in its belief that, pursuant to section 72(3) of the Mental Health Act 1983 ("the Act"), it could not defer the discharge of a detained patient beyond the date of the order authorising detention.

2. The appellant patient ("the patient") criticised the tribunal for (a) refusing to defer his discharge until a date after the authority for his detention had expired and (b) failing to give adequate reasons for its decision overall.

3. I have concluded that the tribunal did not err in law with respect to the effect of section 72(3) since its reasons did not assert that a deferred discharge could not exceed the date of the order authorising detention. Though strictly obiter, I have concluded that a deferred discharge cannot exceed the date of the order authorising detention and explain why I have reached that view below.

4. I also concluded that the tribunal's reasoning in this case was adequate.

Relevant Factual Background

5. I have had the benefit of reading the notes of evidence prepared by the tribunal judge and also an attendance note of what occurred at the hearing prepared by the patient's representative.

6. The patient, aged 43 years, had an extensive history of offending behaviour with 39 convictions from 100 offences. He was 28 when he went to prison for the first time. He had had some limited contact with mental health services as a teenager and as a young man but had never been detained under the Act. In August 2015 the patient was convicted of attempted burglary of a dwelling, burglary of a dwelling and theft and was sentenced to two years imprisonment.

7. On 9 December 2015 the patient presented as acutely psychotic with paranoid beliefs. The onset of these symptoms may have been precipitated by the patient's ingestion of "spice", a psycho-active substance. The patient quickly became very ill and prison staff arranged for him to be transferred to hospital where a brain scan and other investigations were carried out. However his mental state continued to deteriorate on his return to prison. He began smearing faeces on his body; refused to wear clothes; and was observed responding to auditory hallucinations. On 20 January 2016 the patient was assessed to be floridly psychotic and was transferred to a medium secure facility at a psychiatric hospital.

8. The patient's paranoia continued and by May 2016 he had suicidal thoughts accompanied by significant levels of anxiety and depression. He was transferred to the current hospital on 24 October 2016 as it was closer to his home. After being placed on depot anti-psychotic medication, the patient's mental state gradually improved.

9. The patient applied to the tribunal on 9 December 2016 for discharge from detention pursuant to a notional section 37 order. At the tribunal hearing on 19 January 2017, the patient gave oral evidence which the tribunal described as impressive. The tribunal's Reasons recorded that the patient recognised that it would be inappropriate for him to be discharged immediately into what would amount to little more than bed and breakfast accommodation.

He felt he would benefit from staying in hospital for some three months whilst his leave in the community was built up and suitable accommodation was found for him.

10. According to the patient's representative's notes, the tribunal invited the patient's representative to take instructions as to whether the patient wished to apply for an adjournment in order to allow for more concrete and robust discharge plans to be available for consideration by the tribunal. The patient however confirmed that he sought a deferred discharge to allow a package of support to be put in place prior to discharge. The tribunal was invited to defer discharge for as long as it saw fit in order to allow the care team to put in place appropriate accommodation. The representative's notes recorded that the tribunal judge said he did not feel he could grant deferred discharge for any longer than a period of three weeks as this was "the date of the renewal".

The Tribunal's Reasons

11. The tribunal noted the Responsible Clinician's view that this was a complex case. He acknowledged that the events in December 2015 could be explained by a drug induced psychosis. However, on balance, he felt that the proper diagnosis was that of an unusual atypical psychosis exacerbated by drug misuse. The tribunal accepted that latter diagnosis because, had the patient been suffering from drug-induced psychosis, his presentation might have been expected to improve much more quickly than in fact it did.

12. The tribunal noted that the Responsible Clinician did not contend that the degree of the patient's mental disorder made it appropriate for him to be liable to be detained. Instead the argument focussed on the nature of the disorder. The tribunal noted the complexity of the diagnosis and the severity of the patient's symptoms when his mental disorder first presented itself. It concluded that the mental disorder was of a nature which made it appropriate for the patient to be detained and "that a gradual introduction into the community with proper support once discharged is a consequence of its nature".

13. The tribunal went on to find that the risk to the patient if he were to be precipitously discharged was significant because it was likely that he would revert to illicit substance misuse unless he was significantly supported in the community. The tribunal also concluded that the public would be at risk if the patient's mental health were to deteriorate given his previous assaults on staff and his violent behaviour when unwell.

14. Having paid tribute to the patient's insight, the tribunal recorded that it was extremely important for future successful pathway planning that attempts were begun to find suitable accommodation for the patient. It also found that a gradual extension of leave was important so that the patient could familiarise himself with the proposed place of discharge. The tribunal noted that a timescale of three months for all these steps to take place was recommended by those working with the patient.

15. The tribunal recorded in paragraph 3 that the patient's case was for deferred discharge

> "whilst appropriate social arrangements have been put in place. In effect given that his section was due to expire in early February 2017. Such deferment would be for a short period. It would not be long enough to wean him from Diazepam and nor would it be enough time to give the best opportunity of finding appropriate discharge accommodation nor to reintroduce him to the community by way of controlled leave."

The Appeal to the Upper Tribunal

16. The patient's representative applied to the tribunal for permission to appeal and on 9 February 2017 permission to appeal was refused by Tribunal Judge Fisher. I granted permission to appeal on 6 April 2017.

17. The respondent has not participated in this appeal.

18. I have had the benefit of written submissions from the patient's representative for which I am grateful. It has not been necessary for me to hold an oral hearing to determine the issues in this appeal.

19. 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 prepared by the tribunal judge and also the attendance note prepared by the patient's representative.

The Grounds of Appeal

20. I summarise the two grounds of appeal.

21. First, it was submitted that the tribunal misinterpreted the law relating to deferred discharge pursuant to section 72(3) of the Act because the tribunal erroneously believed that it could not defer discharge beyond the date of the order authorising the patient's detention. It was asserted that such an interpretation of section 72(3) fettered the tribunal's discretion and prejudiced those patients making an application for discharge near to the expiry of their detention. It was also suggested, in accordance with the decision in *MP v Mersey Care NHS Trust* [2011] UKUT 107 (AAC), that a period of six weeks' deferral would not be objectionable. This would mean, it was said, that the tribunal's interpretation of section 72(3) would impact any patient applying for a tribunal six weeks prior to the date their section required renewal.

22. Second, it was submitted that the tribunal failed to provide adequate reasons for concluding that the statutory criteria for detention were satisfied in this case. Thus, it failed to explain why it did not rely on the Responsible Clinician's diagnosis of an unspecified non-organic psychosis and failed to explain adequately its conclusions as to the nature of the patient's disorder. This was an important issue given that this was the first time the patient had experienced a psychotic episode. Further criticism was made of the tribunal's analysis of risk. Its linking of risk of relapse to the consumption of illicit substances was said not to be borne out by the evidence before it. Finally, the tribunal was criticised for not addressing the arguments made by the patient's legal representative that, on the balance of probability, the responsible authority had not demonstrated that the statutory criteria were made out.

The Relevant Legal Framework

23. Section 72 empowers tribunals to discharge patients from hospital, guardianship or community treatment orders and directs tribunals to discharge such patients if specified criteria are satisfied. Section 72(3) applies to those detained in hospital or those subject to community treatment orders and reads as follows:

> "72(3) A tribunal may under subsection (1) above direct the discharge of a patient on a future date specified in the direction; and where a tribunal does not direct the discharge of a patient under that subsection the tribunal may –
>
> (a) with a view to facilitating his discharge on a future date, recommend that he be granted leave of absence or transferred to another hospital or into guardianship; and
>
> (b) further consider his case in the event of any such recommendation not being complied with."

24. A patient who is subject to a deferred discharge continues to be "liable to be detained" (see section 72(1) for this phrase) and the Responsible Clinician thus retains the power to grant leave of absence during the period of deferment. It should be noted that section 72(3) does not apply to patients who are the subject of restriction orders as the reference to subsection (1) refers back to the power to discharge unrestricted patients which is set out in section 72(1).

25. There is no previously decided case law which directly addresses the first ground of appeal, namely whether a tribunal has the power to defer discharge beyond the date of the order authorising the patient's detention. The powers of the tribunal to defer discharge is not a topic addressed in any detail in the Code of Practice, Mental Health Act 1983 (revised version published in January 2015).

Discussion and Analysis

(a) Deferred Discharge

26. When granting permission to appeal in this case, I said that I was not entirely persuaded that the tribunal erred in its interpretation of section 72(3). I noted that there was no case authority on whether discharge pursuant to that section could be deferred beyond the date of the order authorising a patient's detention and that clarification on this issue might be helpful to mental health practitioners. There was thus good reason to give permission to appeal though any observations I may make on this issue may, strictly speaking, be obiter given what I say in paragraph 35 below.

27. The power to defer discharge arises in circumstances where the tribunal has reached a conclusion that the grounds for detention are not made out but that, nevertheless, a discharge should not be immediate. As Upper Tribunal Judge Jacobs said in [17] of *CNWL NHS Foundation Trust v H-JH* [2012] UKUT 210 (AAC):

> "It is well-established that a tribunal has to decide whether the statutory conditions remain satisfied at the time of the hearing. In other words, it has to be satisfied that the patient is entitled to be discharged at that time. This applies whether the discharge is immediate or deferred. Deferral is a means of managing the discharge. [I note the last word in the preceding sentence in Upper Tribunal Judge Jacobs' decision is "deferral" but it is clear that what he meant was "discharge" and so I have substituted that word instead]. A tribunal is not entitled to use the deferral to test whether a patient is ready for discharge.…"

I emphasise that, in order to use its powers to defer discharge, the tribunal must have been satisfied that the patient's continued detention was no longer justified pursuant to section 72(1). Deferral to test whether a patient is ready for discharge is thus wholly illogical. In accordance with the clear wording of section 72(3), discharge of the order authorising detention takes effect on the "future date specified in the direction" made by the tribunal.

28. Given that the tribunal has determined that the patient's continued detention is no longer justified under the Act, it thus follows that deferring discharge is a permissible course of action in (a) a limited number of situations and (b) for a limited period of time. *R (on the Application of H) v Ashworth Hospital Authority; R (on the Application of Ashworth Hospital Authority) v MHRT* [2002] EWCA Civ 923 illustrates one of the circumstances in which a deferred discharge was thought inappropriate. In that case, a tribunal had decided to discharge the patient with immediate effect. The patient had an extensive history of violent behaviour and criminal offending coupled with a diagnosis of paranoid schizophrenia. Those circumstances together with his limited response to treatment remained of concern to the hospital. Further, the patient had no real access to support in the community and he had no accommodation available to him. The tribunal had not been provided with an effective after-care plan, the Court of Appeal observing that "it was obvious that suitable after-care should be available" at [67]. It should be noted that both the Court of Appeal and the High Court were concerned that it had been unreasonable for the tribunal not to have adjourned in order to obtain further information which would have enabled the tribunal to consider whether the criteria for detention were made out or not. Lord Justice Dyson stated at [68]:

> "…H was a patient in respect of whom it was essential that the Tribunal considered the availability of suitable after-care services when deciding whether to order his immediate discharge from hospital. If the Tribunal had any doubt as to whether such services would be available, they should have adjourned to obtain any necessary information. I regard the alternative of a deferral […] as less satisfactory … if the tribunal is in doubt as to whether suitable after-care arrangements will be available, it is difficult to see how they can specify a particular date for discharge. In cases of doubt, the safer course is to adjourn...."

29. The above authority reinforces the need for care on the part of tribunals when deciding if a deferred discharge is appropriate. It moreover accords with my view that deferred discharge is permissible in a limited number of situations which almost but not always centre on the arrangements for a patient's after-care. It will be a matter for the good sense of tribunals to discern whether there is both sufficient and certain information about after-care such that a particular date for discharge can be specified.

30. Further, deferred discharge is permissible for a limited period of time consistent with the tribunal's decision that the grounds for detention are no longer made out. It would be unwise to prescribe precisely the length of any deferral as this will vary from patient to patient. In the case of *CNWL NHS Foundation Trust v H-JH* (see above), Upper Tribunal Judge Jacobs upheld the decision of a tribunal to defer the discharge of a patient subject to a Community Treatment Order for a period of three months. In *MP v Mersey Care NHS Trust* (see above), the tribunal deferred discharge for a period of six weeks to enable a patient's structured after-care plan to be implemented within his supported accommodation.

31. The commentary to the Mental Health Act Manual by Richard Jones (nineteenth edition) submits that, with respect to the date specified in the direction given pursuant to

section 72(3), Larry Gostin and Phil Fennell were correct in arguing that a tribunal could not specify a date for discharge after that on which the authority for a patient's detention expired (see page 428 of the nineteenth edition of Jones). Gostin and Fennell's argument is set out in the second edition of Mental Health: Tribunal Procedure [1992] at page 91. I set out the relevant passage in full as follows:

> "The Act does not explicitly limit the period for which an order for discharge may be delayed, but it is presumed that the delay would have to be a reasonable one and related to a valid objective such as the availability of aftercare. A tribunal could not specify a date for discharge after that on which the authority for the patient's detention expires. This follows from the fact that the tribunal derives its authority from the provisions in the Act relating to discharge. Its concern is to ensure that the patient's freedoms are not unnecessarily curtailed. It is not empowered by law, either expressly or by implication, to extend a person's detention beyond that which is specified in the Act. Clearly the provisions for delayed discharge do not override those provisions in the Act relating to the expiry of the authority for detention. The representative should use his endeavours to ensure that the earliest date is set for discharge so that the patient is in hospital for no longer than is necessary."

32. For the reasons set out in the above passage from Gostin and Fennell's book, I find that a tribunal, when exercising its power pursuant to section 72(3) to direct discharge on a future specified date, cannot specify a future date for discharge after that on which the authority for the patient's detention expires. I am fortified in that view by *MP v Mersey Care NHS Trust* [2011] UKUT 107 (AAC) ("*MP*").

33. In *MP*, the tribunal deferred discharge for a period of six weeks to enable a patient's after-care plan to be fully implemented in the community. The specified date for discharge was 6 April 2010. On 31 March 2010 the patient was made subject to a Community Treatment Order pursuant to section 17A of the Act. Though the appeal before the Upper Tribunal did not directly consider the point, it was common ground that a deferred discharge brought to an end a Community Treatment Order made before the deferred discharge date. As the tribunal's decision stood, the Community Treatment Order dated 31 March 2010 came to an end on 6 April 2010 at [32-33]. The Upper Tribunal observed at [14] that:

> "The underlying difficulty in this case arises out of the position in law that if a tribunal discharges a patient, but defers the discharge to a future date, that decision brings to an end any Community Treatment Order on the date that the patient is discharged from liability to be detained (section 17C). Both Mr Pezzani and Ms Rowbotham agree that this represents the correct position in law."

34. The decision in MP makes clear that, once the tribunal has made a direction pursuant to section 72(3), liability to be detained either pursuant to sections 2 or 3 or indeed pursuant to a Community Treatment Order comes to an end on the date specified for discharge. A date set beyond the date of the order authorising detention in this case would be as invalid as the continuation of the Community Treatment Order in MP beyond 6 April 2010 since the necessary underpinning of the order authorising detention would be lacking in both situations.

35. The tribunal in paragraph 3 of its decision set out the case made by the patient's representative for a deferred discharge. It noted that the section was due to expire in early February 2017 and rejected the representative's submission. The tribunal's decision did not

state unequivocally that, in law, a deferred discharge could not exceed the date on which the order authorising detention fell for renewal/expired though, according to the representative's notes, the tribunal judge believed this to be the case. Read as a whole, paragraph 3 explained why the tribunal rejected the application for a deferred discharge rather than simply stating that this was unlawful.

36. The representative's notes of the hearing recorded that the tribunal asked whether the representative wished to take instructions about making an application for the tribunal to adjourn in order to allow for a care plan to be put in place. The representative's notes stated that the tribunal judge appeared to be suggesting that such an adjournment would allow more time for the plan to be put in place and for the patient to be weaned off Diazepam and be given additional support. The patient's representative made it clear that no such application would be made. It is suggested in the patient's submission that the tribunal was willing to use its case management powers to consider adjourning the hearing past the date the section required renewal.

37. I am not persuaded that these submissions have force. Enquiry by the tribunal about the option of an adjournment to obtain further information did not mean the tribunal thought such a step was necessary. It also did not mean that such an application would have met with success if it had been made. If the tribunal was considering an adjournment beyond the date of the order authorising detention, there was nothing to prevent it taking that course since this would not have the same legal effect as a discharge pursuant to section 72(3). Of course, during the period of any adjournment, the Responsible Clinician could have used his/her powers to discharge the patient from liability to be detained in which case the adjournment and indeed the application to the tribunal would have been rendered academic. The reverse would have been the case if the patient continued to be detained. Neither scenario would have prejudiced the patient in my view.

38. The patient's submission also suggested that, if a deferred discharge had the meaning contended for by Gostin and Fennell, this would prejudice patients whose aftercare arrangements would only be in place following the date their section was due to expire. They would be forced to withdraw their application for a deferred discharge and wait for a new section to be in place or they would be forced to proceed with an application which was bound to be unsuccessful. It was submitted that this would amount to a de facto interference with their rights pursuant to Article 5(4) of the European Convention on Human Rights.

39. I reject this submission. Where aftercare arrangements would only be in place following the date a patient's section was due to expire, the proper course for the representative would be to apply for an adjournment if there was uncertainty about whether and when such arrangements would be in place. During the period of any adjournment I have already pointed out that a patient could be discharged from liability to be detained by the Responsible Clinician. If no discharge took place, the matter would revert back to the tribunal for judicial consideration at the conclusion of the adjournment. I cannot see that this amounts to a de facto interference with Article 5(4) rights – the patient's argument really amounts to the submission that any and every application should be at large before the tribunal no matter how poorly founded.

40. It thus follows that I dismiss this ground of appeal.

(b) Adequacy of Reasoning

41. Written reasons should (a) state what facts the tribunal found; (b) explain how and why the tribunal made them; and (c) show how the tribunal applied the law to those facts at [15] of *MS v North East London Foundation Trust* [2013] UKUT 092 (AAC)). I agree with that guidance given by Upper Tribunal Judge Jacobs. If a tribunal's reasons accord with this guidance and the tribunal carried out its fact-finding role rationally, there is no basis for the Upper Tribunal to interfere with its decision.

42. The patient's representative submitted that the tribunal failed to provide adequate reasons for concluding that the statutory criteria for detention were satisfied. Specifically, the tribunal failed to explain why it relied on the Responsible Clinician's diagnosis of an unspecified non-organic psychosis. I reject this submission. The notes of evidence produced by the tribunal judge and by the patient's representative demonstrated that there was an evidential foundation for the tribunal's conclusion on this issue. The tribunal explained clearly why it accepted that the patient was suffering from an atypical psychosis exacerbated by drug misuse. That conclusion was open to it on the evidence – nothing more was required.

43. Criticism is also levelled at the tribunal's conclusions about the nature of the patient's mental disorder. This was said to be especially important because it was the first time the patient had experienced a psychotic episode. I likewise reject this submission. Though brief, the tribunal's reasons explained why it concluded that the nature of the patient's mental disorder made it appropriate for him to be detained. It referred to the complexity of the diagnosis, the severity of the symptoms when first detained, and the need for a gradual introduction into the community with proper support. Those matters seem to me to involve consideration of chronicity, prognosis and response to treatment though the tribunal did not use these terms explicitly in its decision.

44. The tribunal's analysis of risk was also criticised, especially as its linking of risk of relapse to the consumption of illicit substances was said not to be borne out by the evidence before it. I disagree. The tribunal judge's note of the evidence at page 37 of the bundle recorded the Responsible Clinician's evidence that if the patient were discharged, he would be likely to turn to illicit substances because of anxiety/mood instability and this might cause his psychotic symptoms to re-appear. Though the patient was said to have a long history of addiction, the Responsible Clinician was concerned about an accidental overdose as well. The representative's notes are different and recorded the Responsible Clinician as saying that there was no clear link between the patient's psychosis and using heroin, the patient's illicit drug use being prompted by anxiety. I prefer the tribunal judge's notes which recorded the use of illicit substances [not specified] as a possible precipitant of psychotic illness – this risk analysis was founded on what actually happened to the patient, namely the consumption of "spice" which prompted the admission to hospital. In my view, the tribunal had a clear evidential foundation for its conclusion that it was likely the patient would revert to illicit substances given the history and that this factor made the risk to the patient significant.

45. I note that the patient did not challenge the tribunal's conclusion that he would pose a risk to others if his mental state were to deteriorate.

46. Finally the patient's representative complained that the tribunal did not address the argument made on the patient's behalf that the statutory criteria were not made out. I consider this criticism to be unfair. The tribunal recorded in paragraph 3 of its decision that the patient's case was for discharge with discharge being deferred for a period to allow

appropriate after-care to be put in place. It was thus implicit that the statutory criteria for detention were being challenged. The tribunal did not need to say more than it did to accurately summarise the patient's case. It went on to address the statutory criteria in the remainder of its decision.

47. I thus find this ground of appeal not made out.

(c) The Outcome of this Appeal

48. Given my conclusions about both grounds of appeal, it follows that the tribunal's decision did not involve the making of error on a point of law. The appeal is dismissed.