[2019] AACR 4

**(VS v St Andrew's Healthcare
[2018] UKUT 250 (AAC))**

Judge Jacobs **HM/1261/2018**
23 July 2018

Mental health – capacity to bring proceedings – adequate reasons

On 23 October 2017 the appellant signed a form applying to the First-tier Tribunal, exercising its mental health jurisdiction, for discharge from his detention as an inpatient. When he completed the form, he was not represented and his responsible clinician subsequently wrote that although he did not have insight into his mental health difficulties, he had demonstrated on multiple occasions that he did not wish to remain an inpatient in the hospital and wanted to be discharged. The First-tier Tribunal appointed solicitors to represent the patient and they in turn raised concerns about his capacity. That issue came before the First-tier Tribunal which decided that the applicant's inability to retain that he was being held in a hospital was not ultimately fatal to a finding that he had capacity, as he was clearly able to retain the understanding that he was being held somewhere he did not want to be. The First-tier Tribunal dealt with the issue of capacity as a preliminary issue and decided that the patient had capacity when he made his application for a tribunal hearing. A different judge of the First-tier Tribunal granted permission to appeal to the Upper Tribunal on the basis that the First-tier Tribunal had not given adequate reasons on the capacity issue.

Held, dismissing the appeal, that:

1. The nature of the capacity required to bring proceedings before the First-tier Tribunal was less demanding than the capacity required to conduct them: *R(H) v Secretary of State for Health* [2006] 1AC 441 and *RD v Herefordshire Council* [2016] EWCOP 49

2. The correct test to determine if the patient had capacity to bring proceedings before the First-tier Tribunal was that the patient must understand that they are being detained against their wishes and that the First-tier Tribunal is a body that would be able to decide whether they should be released.

DECISION OF THE UPPER TRIBUNAL
(ADMINISTRATIVE APPEALS CHAMBER)

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 by name.

This decision is given under section 11 of the Tribunals, Courts and Enforcement Act 2007:

The decision of the First-tier Tribunal under reference MP/2017/28591, made following a hearing on 26 January 2018, did not involve the making of an error on a point of law.

REASONS FOR DECISION

A. The Upper Tribunal's caselaw on capacity and how this case fits in

1. The issue of a patient's capacity had been one of the themes in cases that have come before the Upper Tribunal over recent years. For convenience, these are the cases and the issues raised so far:

> *R (OK) v First-tier Tribunal and Cambian Fairview* [2017] UKUT 22 (AAC) dealt with the procedure to be followed in a case in which it was accepted (see [11]) that the patient did not have capacity to bring the proceedings.

> *YA v Central and North West London NHS Trust and Others* [2015] UKUT 37 (AAC) [2015] AACR 31 dealt with capacity to appoint a representative and with the relationship between capacity to appoint and the capacity to conduct proceedings.
>
> *AMA v Greater Manchester West Mental Health NHS Foundation Trust* [2015] UKUT 36 (AAC) [2015] AACR 30 dealt with capacity to conduct proceedings with particular reference to withdrawal.
>
> *PI v West London Mental Heath NHS Trust* [2017] UKUT 66 (AAC) dealt with capacity that fluctuated during proceedings.

2. The issue in this case is the nature of the capacity required by a patient to bring proceedings before the First-tier Tribunal in its mental health jurisdiction. I have decided that the test is this:

> The patient must understand that they are being detained against their wishes and that the First-tier Tribunal is a body that will be able to decide whether they should be released.

B. How the issue arises in this case

3. The patient signed a form applying to the First-tier Tribunal on 23 October 2017. When delivered, this initiated proceedings in that tribunal. Despite the language used by the responsible clinician and Tribunal Judge Fyall, the proceedings are not appellate.

4. When he completed the form, the patient was not represented. His responsible clinician subsequently wrote about how the application came to be completed:

> Mr S… was asked on multiple occasions with the help of an interpreter about his view on inpatient treatment. Although he does not have insight into his mental health difficulties, he has demonstrated on multiple occasions that he does not wish to remain an inpatient in the hospital and wants to be discharged. This was evident in discussions with him with an interpreter on 6 October 2017, 5 October 2017 (when he was read his section 132 rights) and during discussions with a Lithuanian speaking health care assistant. Further, when explained that the treating team are of the opinion that he continues to remain an inpatient and when explained the possibility of appealing against the treatment and inpatient admission to the tribunal, he understood it as a possible avenue for his discharge. The application for the tribunal was filled out by him with the assistance of a Lithuanian speaking healthcare assistant who supported him on that day. This was preceded previously by discussions with a formal Lithuanian interpreter.
>
> The view of the treating team is that although he lacks capacity to fully understand the need for inpatient treatment, he was able to broadly demonstrate his understanding that an appeal to the tribunal may result in discharge. He has been consistently asking to be discharged and was able to comprehend this when informed about his section 132 rights and the appeal process. Therefore on the balance of probability, the treating team and I am of the opinion that he does retain capacity to appeal against his detention in view of requirements for a 'very limited' and 'not demanding' capacity.

5. The First-tier Tribunal appointed Noble Solicitors to represent the patient on 27 October 2017. Following a meeting with the patient, the solicitor had concerns about his capacity. She was concerned that:

- he told her that he wanted to be discharged to have a cigarette;
- he could not understand that he was being held in hospital; and

- he could not retain information about the purpose, procedure and powers of the tribunal.

The issue of the patient's capacity came before Judge Fyall on 13 December 2017. I have taken the statement of the solicitor's concerns from her reasons for deciding that the tribunal had jurisdiction as the application was valid as made by a patient with sufficient capacity. The judge had the letter from the responsible clinician. These are the relevant passage among the judge's reasons:

> 9. … when [the solicitor] met with him on 23rd November, Mr S… was still expressing to her that he wanted to be discharged because he was unhappy with the restrictions placed on him by being detained, on that day the limits on his freedom was to smoke.
>
> 10. … I do not think that Mr S…'s inability to retain that he is being held in a hospital is ultimately fatal to a finding that he has capacity, as he is able to clearly retain the understanding that he is being held <u>somewhere</u> he does not want to be, and he has 'repeatedly demonstrated' his unhappiness with that. …
>
> 11. I equally do not find that the processes and powers of the Tribunal are 'relevant information' as to whether a patient wants to appeal; what is relevant is that he wants to be discharged from the place where he is being kept against his wishes. The reality for a patient such as Mr S… is that the only way of achieving that against clinical advice will be via the Tribunal.

6. On 19 December 2017, the issue of the patient's capacity came before Tribunal Judge Foster who agreed with Judge Fyall. The application came before the tribunal for decision on 26 January 2018, with Tribunal Judge Pember presiding. The tribunal refused the application. It dealt with capacity as a preliminary matter saying that 'we were satisfied that the patient had capacity when the patient made his application for a Tribunal hearing. This was agreed by all parties.' The tribunal had seen Judge Fyall's reasons and I read what the tribunal said as agreeing with and adopting those reasons.

7. Tribunal Judge Bryer gave the patient permission to appeal to the Upper Tribunal, saying that the tribunal had heard further argument and 'it is not satisfactory to rely on an interlocutory decision of a Salaried Judge without some further analysis of the specific arguments.'

8. I gave directions for submissions and am grateful for the detailed arguments I have received, which have allowed me to decide the case without holding an oral hearing. St Andrew's Healthcare was represented by Stuart Wallace, a solicitor from its Legal Directorate. The patient was represented by Sophy Miles of counsel. I am grateful to both of them. I also wish to record my appreciation that St Andrew's took up the invitation in my directions:

> I appreciate that it is not usual for the hospital* to take an active part in appeal proceedings, but this case raises important practical issues of capacity and it would be helpful to the Upper Tribunal to have it argued out in full.

* I was there referring to hospitals generally and not to St Andrew's specifically.

C. The principles and approach to capacity

9. The principles are found in the combined operation of the common law and the Mental Capacity Act 2005. The latter codified or confirmed the underlying common law principles (Lady Hale in *R (H) v Secretary of State for Health* [2006] 1 AC 441 at [26]) and approach

(*Dunhill v Burgin* [2014] 1 WLR 933 at [13]). So, although the Act does not deal with capacity to litigate, the courts have accepted the invitation in the Code of Practice that was made under section 42:

> 4.33 The Act's new definition of capacity is in line with the existing common law tests, and the Act does not replace them. When cases come before the court on the above issues, judges can adopt the new definition if they think it is appropriate. …

The First-tier Tribunal should now apply the principles and approach set out in the Act and its Code of Practice (*YA* at [30]). The common law cases can be used to exemplify the operation of the tests or provide more detail of their practical operation.

D. The Mental Capacity Act 2005

10. These are the relevant provisions of the Act.

> **1 The principles**
>
> (1) The following principles apply for the purposes of this Act.
>
> (2) A person must be assumed to have capacity unless it is established that he lacks capacity.
>
> (3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
>
> (4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
>
> (5) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
>
> (6) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.
>
> **2 People who lack capacity**
>
> (1) For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.
>
> (2) It does not matter whether the impairment or disturbance is permanent or temporary.
>
> (3) A lack of capacity cannot be established merely by reference to–
>
> (a) a person's age or appearance, or
>
> (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.
>
> (4) In proceedings under this Act or any other enactment, any question whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities.
>
> (5) No power which a person ("D") may exercise under this Act–
>
> (a) in relation to a person who lacks capacity, or

(b) where D reasonably thinks that a person lacks capacity,

is exercisable in relation to a person under 16.

(6) Subsection (5) is subject to section 18(3).

3 Inability to make decisions

(1) For the purposes of section 2, a person is unable to make a decision for himself if he is unable–

(a) to understand the information relevant to the decision,

(b) to retain that information,

(c) to use or weigh that information as part of the process of making the decision, or

(d) to communicate his decision (whether by talking, using sign language or any other means).

(2) A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).

(3) The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.

(4) The information relevant to a decision includes information about the reasonably foreseeable consequences of–

(a) deciding one way or another, or

(b) failing to make the decision.

E. Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 (SI No 2699)

11. Rule 11 deals with the appointment of representatives in a mental health case:

11 Representatives

(7) In a mental health case, if the patient has not appointed a representative, the Tribunal may appoint a legal representative for the patient where—

(a) the patient has stated that they do not wish to conduct their own case or that they wish to be represented; or

(b) the patient lacks the capacity to appoint a representative but the Tribunal believes that it is in the patient's best interests for the patient to be represented.

(8) In a mental health case a party may not appoint as a representative, or be represented or assisted at a hearing by—

(a) a person liable to be detained or subject to guardianship or after-care under supervision, or who is a community patient, under the Mental Health Act 1983; or

(b) a person receiving treatment for mental disorder at the same hospital as the patient.

12. Rule 17 deals with withdrawal:

17 Withdrawal

(1) Subject to paragraphs (2) and (3), a party may give notice of the withdrawal of its case, or any part of it—

(a) at any time before a hearing to consider the disposal of the proceedings (or, if the Tribunal disposes of the proceedings without a hearing, before that disposal), by sending or delivering to the Tribunal a written notice of withdrawal; or

(b) orally at a hearing.

(2) Notice of withdrawal will not take effect unless the Tribunal consents to the withdrawal except—

(a) in proceedings concerning the suitability of a person to work with children or vulnerable adults; or

(b) in proceedings started by a reference under section 67 or 71(1) of the Mental Health Act 1983.

…….

F. Analysis of capacity

13. The tribunal's rules of procedure do not prescribe the nature of the capacity required by a patient at any stage of the proceedings. That is because the enabling powers in the Tribunals, Courts and Enforcement Act 2007 do not authorise rules 'to alter the substantive law as to the test of mental capacity applicable in relation to the pursuit or defence of legal proceedings' (Chadwick LJ in *Masterman-Lister v Brutton & Co* [2003] 1 WLR 1511 at [64]). This does not prevent the rules forming part of the context in which the issue specific question of capacity arises.

14. The tribunal's rules of procedure do not make any specific provision about bringing proceedings by a mental patient. The only provision is rule 11. By its terms, that rule refers only to the appointment of a representative. But, as Charles J explained in *YA v Central and North West London NHS Trust and Others* [2015] UKUT 37 (AAC) [2015] AACR 31 at [58] to [60], in practice the distinction between the capacity required to appoint a representative and that required to conduct proceedings 'narrows' and can be 'theoretical rather than real.'

15. The capacity required to conduct proceedings can be a demanding threshold. Charles J was reflecting the caselaw on capacity to conduct civil proceedings when he said in *YA*:

58. … So factors that the patient will have to be able to sufficiently understand, retain, use and weigh will be likely to include the following:

i) the detention, and so the reasons for it, can be challenged in proceedings before the tribunal who, on that challenge, will consider whether the detention in justified by the provisions of the MHA,

ii) in doing that, the tribunal will investigate and invite and consider questions and argument on the issues, the medical and other evidence and the legal issues,

iii) the tribunal can discharge the section and so bring the detention to an end,

iv) representation would be free,

v) discussion can take place with the patient and the representative before and so without the pressure of a hearing,

vi) having regard to that discussion a representative would be able to question witnesses and argue the case on the facts and the law, and thereby assist in ensuring that the tribunal took all relevant factual and legal issues into account,

vii) he or she may not be able to do this so well because of their personal involvement and the nature and complication of some of the issues (e.g. when they are finely balanced or depend on the likelihood of the patient's compliance with assessment or treatment or relate to what is the least restrictive available way of best achieving the proposed assessment or treatment),

viii) having regard to the issues of fact and law his or her ability to conduct the proceedings without help, and so

ix) the impact of these factors on the choice to be made.

16. The specific issue that arises in this case, and the issue in respect of which the patient's capacity had to be judged, was the ability to bring proceedings before the First-tier Tribunal. I consider that the capacity required to bring proceedings is less demanding that the capacity required to conduct them. It is appropriate for there to be a minimal control over access to the tribunal and its powers to review a patient's detention. It is not necessary to resort to Article 5 of the European Convention on Human Rights to justify this approach. It has ample support in the centuries-old concern of the common law to protect the liberty of the subject.

17. If the position were otherwise, it would produce a surprising result. If the same test of capacity were applied to bringing proceedings as applies to conducting proceedings, any decision by the First-tier Tribunal to appoint a representative under rule 11(7) for a patient whose capacity was not fluctuating would have the inevitable result that the proceedings had not been properly brought. Given that the existence of an application is the foundation of the tribunal's jurisdiction, that case would then have to be struck out.

18. There are two statements that both support my analysis and indicate the necessary capacity required. The first is that of Lady Hale in *R (H)*:

> 4. How can a patient who is so severely mentally disordered that she cannot apply to a court or tribunal challenge her detention in hospital? The problem very rarely arises but it may do so more often in future. Most of the patients who are admitted under the formal procedures in the Mental Health Act 1983 do have *the very limited capacity required to make an application to a mental health review tribunal* or have someone else who can help them to make it. The exceptions may be patients with severe learning disability or severe dementia. It is now unusual for people with those disabilities to be formally admitted to hospital under the 1983 Act. Indeed, these days few patients with severe learning disability are admitted to hospital at all.

The italics in that passage are mine. The other statement is by Baker J in *RD v Herefordshire Council* [2016] EWCOP 49, where he said at [86(1)(a)] that the capacity to bring proceedings in the Court of Protection 'simply requires P to understand that the court has the power to decide that he/she should not be subject to his/her current care arrangements. It is a lower threshold than the capacity to conduct proceedings.'

19. I put the capacity that a patient must have in order to make a valid application to the First-tier Tribunal in its mental health jurisdiction like this. The patient must understand that

they are being detained against their wishes and that the First-tier Tribunal is a body that will be able to decide whether they should be released. The more detailed and demanding requirements for capacity to conduct proceedings are not in point at the stage of making an application. A patient who lacks that understanding 'because of an impairment of, or a disturbance in the functioning of, the mind or brain', to quote section 2(1), does not have the capacity required (*PC and NC v City of York Council* [2013] EWCA Civ 478 at [58] and [59]).

20. I have considered whether the patient needs to understand that it is possible to withdraw a case before the First-tier Tribunal but that the tribunal's consent is required if this is to be done. I have decided that this is not a necessary element in the patient's understanding. I have come to this conclusion because taking account of withdrawal would add to the complexity of the issues that the patient would have to understand, as it would raise questions of the circumstances in which withdrawal might be sought and, if sought, approved or refused. That would inevitably lead into the patient's particular circumstances and how withdrawal and consent might apply to them. All that would take the test a long way from the simple and clear cut approach that I have set out, rendering it inappropriate for the initial jurisdictional filter in a mental health case.

G. The tribunal did not go wrong on capacity

21. The ground on which Judge Bryer gave permission to appeal was essentially that the First-tier Tribunal had not given adequate reasons on the capacity issue. I do not agree. Leaving aside the use of the word 'appeal', I can find no fault with Judge Fyall's reasoning. Given the explanation from the responsible clinician of how the application came to be made and the background to it, the judge could not properly have come to any other conclusion, notwithstanding the solicitor's concerns. What the tribunal did in January 2018 was essentially to adopt what Judge Fyall had said. Given the evidence and the thoroughness of that judge's reasoning, that was acceptable and, in legal terms, adequate. The solicitor's concerns were matters that related to the different and more demanding test for capacity to conduct proceedings. The tribunal accepted that the patient did not satisfy that test, which is why it had appointed the solicitor to act for him.

H. The issue of withdrawal

22. So far, I have dealt with the issue as one of jurisdiction to make an application. The tribunal also considered separately whether to give consent to the withdrawal of the case. It decided not to do so:

> [The solicitor] made an application to withdraw as she felt it unlikely that the patient would succeed in his application and representing his best interests she felt this was an appropriate way forward. The panel listened carefully to her application and rejected it as the patient had made an application for a hearing when he had capacity and had not specifically given instruction to his solicitor to withdraw.

Judge Bryer did not give permission to appeal on this ground, but I will deal with it as this issue was part of the grounds of appeal and Ms Miles has presented a detailed argument on it. Mr Wallace has not commented on it.

23. I can summarise the argument that the solicitor put to the tribunal at the hearing from what she wrote in the grounds of appeal:

- It was in the patient's best interests to have his application made later in the period allowed for an application under the statutory timetable.

- The patient told the solicitor through an interpreter that what he wanted was to move wards.
- He was unable to understand that this was outside the power of the tribunal.
- He did not know that the tribunal was a tribunal or that he had made an application or what the tribunal was about.

She asked for a decision 'whether a solicitor appointed under rule 11(7)(b) can make a request to withdraw an application to the tribunal if the representative feels that it would be in the best interests of the patient to do so where the patient has fluctuating capacity or does not understand or recall an application to the tribunal being submitted.'

24. I can deal with the request for a ruling on the issue identified by the solicitor. The answer to that question is: yes. But that does not mean that the tribunal must give its consent. All it means is that a solicitor is entitled to ask.

25. For the record, I do not accept that this is a case of fluctuating capacity. The clear and carefully worded letter from the responsible clinician shows that the patient had limited capacity varying from issue to issue, not fluctuating capacity. The letter shows consistency of understanding over time. The solicitor may have come to a different conclusion, but she is not a consultant psychiatrist and does not say that she based her conclusion on medical advice. Although I am sure that she has experience in making a judgment about likely capacity, the answers she received from her client had to be interpreted and understood in the context of his presentation as a whole with the benefit of medical understanding.

26. The fact that the patient wanted to move wards is susceptible to the same interpretation that Judge Fyall gave to his complaint that he was not allowed to smoke: that is simply how his dissatisfaction with his detention manifested itself at the time.

27. That fact that he does not understand what a tribunal is does not take the case anywhere, either on capacity grounds or on withdrawal grounds. Understanding the nature of a tribunal is only required to the extent that it represents a way to obtain a release from detention.

28. It seems to me that all the application came to was this. There were doubts about whether the patient really had capacity to make his application, it had been made prematurely, and it would be counter productive in limiting the time when he could next apply. It would be better for him, given how unlikely he was to obtain a discharge, to have his application heard later. Viewed in that way, the tribunal was entitled to reject it and it is understandable why it regarded capacity and withdrawal as linked.

29. I have no doubt that that the solicitor's judgment on her client's best interests was made in good faith and was fully justified by the circumstances as known to her and understood by her. But the issue for the tribunal was different. The tribunal was asked to exercise a power conferred by rule 17. In deciding whether to consent, the tribunal had to act judicially. That means that it had to make a judgment in the individual circumstances of the case. A tribunal's consent to withdrawal is not a rubber stamp to be applied for the asking. It has to take account of the interests of the patient, but that cannot alone be decisive. If it were, the tribunal proceedings would become a filter to test the strength of a patient's case for discharge, with withdrawal allowing the patient to abort the proceedings and preserve their position in the statutory timetable for applications. Tribunals are rightly alert to that possibility. It would abuse the process of the tribunal and affect the efficient operation of the tribunal. But that does not mean that those are the only circumstances in which the tribunal should refuse to consent. It is not possible or appropriate to give a definitive description of the circumstances

in which a decision one way or the other should be made, or even to describe exhaustively the factors that the tribunal should take into account.

30. Looking at the essence of the application, as I have analysed it, the tribunal was presented with a clash between the desire of the patient to come before a tribunal and the solicitor's assessment of what was in his best interests. The evidence showed that the patient had given a clear indication of a desire to be released and shown an understanding that the tribunal was a way to achieve that. The tribunal had to bring that desire into the balance with the solicitor's best interests assessment in the context of the judicial exercise of its power to give or withhold consent under rule 17. The tribunal was entitled, as part of the overall judgment that had to be made, to give effect to the patient's own wish for the tribunal to decide. That is what it did and what its short reasons express. Frankly, given the nature of the case and the responsible clinician's evidence, it was optimistic to expect the tribunal to do other than it did.

I. Disposal – strike out and withdrawal

31. The history of this case shows how jurisdiction, strike out and withdrawal can become entangled.

32. As I explained in *OK*, the correct procedure when a tribunal lacks jurisdiction is to comply with its duty to strike out the proceedings under rule 8(3). How would the Upper Tribunal react if the First-tier Tribunal were to deal with a case over which it had no jurisdiction by consenting to the patient's application to withdraw?

33. The issue of a tribunal using a different form of disposal from rule 8 was considered by the three-judge panel in *LS and RS v Commissioners for Her Majesty's Revenue and Customs* [2017] UKUT 257 (AAC) [2018] AACR 2:

> 52. If the First-tier Tribunal lacks jurisdiction to hear an appeal, the proper disposal before that tribunal is to strike out the proceedings. It is unlikely that the Upper Tribunal would give permission to appeal if the tribunal took a different course, such as refusing to admit the appeal, dismissing it or recording that it has lapsed. But the strike out procedure contains an important safeguard in that the claimant has a chance to make representations, which the duty of fairness would require the tribunal to respect if it did take another course. That is not a mere formality; it may save a tribunal from using its powers inappropriately or without first ensuring that the conditions for a strike out are met.

In other words, provided that the proceedings were conducted fairly, the Upper Tribunal is unlikely to regard the use of withdrawal rather than strike out as a material error of law.