THE UPPER TRIBUNAL ORDERS that no one shall publish or reveal the name or address of the Appellant who is the subject of these proceedings or publish or reveal any information which would be likely to lead to the identification of her or any member of her family in connection with these proceedings. The decision itself may be made public, but not the cover sheet, which is not part of the decision and identifies the patient by name.

THE UPPER TRIBUNAL
(ADMINISTRATIVE APPEALS CHAMBER)

UPPER TRIBUNAL CASE NO: HM/0126/2020
[2020] UKUT 230 (AAC)

MC v CYGNET BEHAVIOURAL HEALTH LTD AND THE SECRETARY OF STATE FOR JUSTICE

Decided without a hearing

Representatives

Patient	Ian Harris of counsel, instructed by James McAulay of ABR Solicitors, both pro bono
Cygnet	Did not take part
Secretary of State	Fiona Paterson of counsel, instructed by the Government Legal Department

DECISION OF UPPER TRIBUNAL JUDGE JACOBS

On appeal from the First-tier Tribunal (Health, Education and Social Care Chamber)

Reference: MP/2019/21855
Decision date: 25 November 2019

As the decision of the First-tier Tribunal involved the making of an error in point of law, it is SET ASIDE under section 12(2)(a) and (b)(ii) of the Tribunals, Courts and Enforcement Act 2007 and the decision is RE-MADE.

The decision is: the patient (MC) is to be conditionally discharge at 14.00 on 10 August 2020, subject to these conditions:

a. MC will reside at supported accommodation or nursing home as agreed by her Responsible Clinician (the details of which should be notified to the Ministry of Justice at least 14 days prior to any move, where it is practicable to do so).

b. She will accept psychiatric and social supervision from her community Responsible Clinician and Social Supervisor.

c. She will comply with all aspects of the care package devised for her by her Responsible Clinician and/or any other professional responsible for her social and/or medical care, including (but not limited to) complying with prescribed medication, making herself available for assessment by the community mental health team and attending appointments.

d. MC, her Responsible Clinician and the Secretary of State have permission to apply to the First-tier Tribunal for a variation of conditions 1-3 above in the event of a material change in circumstances.

REASONS FOR DECISION

A. What this case is about

1. The patient in this case lacks capacity to make decisions about her accommodation, care or treatment. She has been subject to hospital and restriction orders under sections 37 and 41 of the Mental Health Act 1983 since 1993. She has now applied to be conditionally discharged. The evidence shows that she needs medical treatment but that there is no need for it to be delivered in a hospital. However, the only way that the treatment could be delivered effectively involves a deprivation of her liberty within the meaning of the Mental

Capacity Act 2005. The First-tier Tribunal has no power to impose a condition to that effect, but does it have power to co-ordinate its decision with the provision of an authorisation under the 2005 Act? I have decided that it does.

2. Every judge of the Upper Tribunal, the High Court and the Court of Appeal who has expressed a view has said this approach is permissible. The Supreme Court has declined to deal with the issue. No judge at any of those levels has said that it is not permissible. So what's the problem? In fact, there are three problems. All arise ultimately from the decision of the Supreme Court in *M v Secretary of State for Justice* [2019] AC 712.

3. The first problem is that there is a difference of view among the judges of the First-tier Tribunal. Ms Paterson has sent me a copy of a decision by a different panel of the First-tier Tribunal that took an approach that the tribunal in this case felt unable to take. Consistency is important in the interpretation and application of the 1983 Act and it is one of the roles of the Upper Tribunal to ensure this consistency. It will be achieved by this decision and I need say no more about this problem. I do, though, need to deal with the other problems.

4. The second problem underlies the difference of views. It is a disagreement whether the reasoning on the issue decided by *M* undermines the reasoning in previous cases on patients who lack capacity, and in particular the reasoning of Charles J in *Secretary of State for Justice v KC and C Partnership NHS Foundation Trust* [2015] UKUT 376 (AAC).

5. The third problem is whether a patient's Convention rights prevent the First-tier Tribunal from co-ordinating with the capacity decision-maker.

B. The case before the First-tier Tribunal

6. The patient was born in 1952. She has had resistant paranoid schizophrenia since the 1970s. She is subject to orders under section 37 and 41 of the 1983 Act, which were made in 1993 after she was convicted of arson. From June 2019, she has been living in a Nursing Home on extended leave under section 17(3). She applied to the First-tier Tribunal for a conditional discharge on 1 August 2019, with the support of her treating team.

7. The case came before the First-tier Tribunal on 30 October 2019, when the hearing was adjourned for a standard authorisation under the 2005 Act to be obtained from the local authority. The hearing was resumed on 25 November 2019, by which time the local authority had completed the standard authorisation assessments. Her solicitor invited the tribunal to defer the conditional discharge for a standard authorisation to be put in place. The conditions proposed were that the patient would: (a) reside at the Nursing Home; (b) comply with medication and make herself available for assessment; and (c) make herself available for appointments. The tribunal refused to discharge the patient.

> 35. The Tribunal was aware that Mental Capacity Act decision makers can deprive conditionally discharged patients of their liberty (as concluded by Mrs Justice Lieven in Birmingham City Council v SR and Lancashire City Council and JTA [2019] EWCOP 28). However, in the Tribunal's view based upon its analysis of KC, what is possible in another jurisdiction does not abrogate the Tribunal's statutory duty regarding the imposition of protective conditions upon a patient's conditional discharge.
>
> 36. If the Tribunal's understanding of the KC decision is correct, Mr Justice Charles was clear that it was the statutory duty of the Tribunal (or the Secretary of State) to impose conditions necessary for the patient's health and safety and/or for the protection of others and that that duty could not be delegated to a Mental Capacity Act decision maker. Consequently, Mr Justice Charles envisaged that the Tribunal would impose protective conditions and, if they created a deprivation of liberty, that that would be authorised for patients who lacked capacity by the Mental Capacity Act. That jurisdictional solution to achieving [the patient's] discharge is simply no longer available to the Tribunal because of the binding authority of the Supreme Court in MM which states that the Tribunal cannot lawfully impose such conditions.

8. The tribunal would have preferred to discharge the patient conditionally if it felt the law allowed it to do so, as is evident from the final paragraph of the written reasons:

> 51. It was with regret that the Tribunal was unable to reconcile case law and its statutory duty to impose conditions to give effect to the conditional discharge sought …, an outcome which was unanimously supported by her clinical team. …

C. The legislation

9. These are the relevant provisions of the 1983 Act:

> **72 Powers of tribunals**
>
> (1) Where application is made to the appropriate tribunal by or in respect of a patient who is liable to be detained under this Act or is a community patient, the tribunal may in any case direct that the patient be discharged, and—
>
> …
>
> (b) the tribunal shall direct the discharge of a patient liable to be detained otherwise than under section 2 above if it is not satisfied—
>
> (i) that he is then suffering from mental disorder or 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

(ii) 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

(iia) that appropriate medical treatment is available for him; …

73 Power to discharge restricted patients

(1) Where an application to the appropriate tribunal is made by a restricted patient who is subject to a restriction order, or where the case of such a patient is referred to the appropriate tribunal, the tribunal shall direct the absolute discharge of the patient if—

(a) the tribunal is not satisfied as to the matters mentioned in paragraph (b)(i), (ii) or (iia) of section 72(1) above; and

(b) the tribunal is satisfied that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment.

(2) Where in the case of any such patient as is mentioned in subsection (1) above—

(a) paragraph (a) of that subsection applies; but

(b) paragraph (b) of that subsection does not apply,

the tribunal shall direct the conditional discharge of the patient.

(3) Where a patient is absolutely discharged under this section he shall thereupon cease to be liable to be detained by virtue of the relevant hospital order, and the restriction order shall cease to have effect accordingly.

(4) Where a patient is conditionally discharged under this section—

(a) he may be recalled by the Secretary of State under subsection (3) of section 42 above as if he had been conditionally discharged under subsection (2) of that section; and

(b) the patient shall comply with such conditions (if any) as may be imposed at the time of discharge by the tribunal or at any subsequent time by the Secretary of State.

(5) The Secretary of State may from time to time vary any condition imposed (whether by the tribunal or by him) under subsection (4) above.

(6) Where a restriction order in respect of a patient ceases to have effect after he has been conditionally discharged under this section the patient shall, unless previously recalled, be deemed to be absolutely discharged on the date when the order ceases to have effect and shall cease to be liable to be detained by virtue of the relevant hospital order.

(7) A tribunal may defer a direction for the conditional discharge of a patient until such arrangements as appear to the tribunal to be necessary

> for that purpose have been made to its satisfaction; and where by virtue of any such deferment no direction has been given on an application or reference before the time when the patient's case comes before the tribunal on a subsequent application or reference, the previous application or reference shall be treated as one on which no direction under this section can be given.
>
> (8) This section is without prejudice to section 42 above.

D. The issue in principle

10. Before coming to the authorities, it is worthwhile looking at the issue as a matter of principle. There are two regimes, governed by the 1983 Act and the 2005 Act. They deal with different things, but they are related. The mental health regime is concerned with detention on the basis of a mental disorder, a need to protect the patient or the public, and the availability of treatment in hospital. The mental capacity regime is concerned with the best interests of a person who lacks capacity to make decisions. Those are separate matters but they can interrelate. The mental health regime will involve a deprivation of liberty, and the mental capacity regime may do so.

11. The difficulty arises at the point of transition as a patient moves from the mental health regime to the mental capacity regime. Suppose that a patient has a mental disorder that requires treatment for their benefit and the protection of others which could be given without the need to detain the patient under the mental health regime but only if the patient was not free to leave the place where they were living without being accompanied and supervised. The First-tier Tribunal has power to discharge a patient conditionally, but has no power to impose a condition that would involve a deprivation of liberty. The mental health regime requires the tribunal to take account of the possibility of treatment and protection being provided outside that regime, but how is that to be organised in a way that is compatible with the limited powers of the different decision-makers operating the two regimes? That is what underlies this case.

E. DN v Northumberland, Tyne & Wear NHS Foundation Trust [2011] UKUT 327 (AAC), [2012] AACR 19

12. In this case, the patient was detained pursuant to section 3 of the 1983 Act. He lacked capacity to make decisions relating to his residence and alcohol consumption. His representative argued that he should be discharged but only when a deprivation of liberty authorisation was in place. The tribunal decided not to discharge the patient and took no account of the representative's argument. I set the tribunal's decision aside. In essence, my reasoning was this. (a) A patient could only be detained under the 1983 Act if that was the least restrictive option available. (b) If the provision that was appropriate for the patient could be achieved under the 2005 Act, detention under the 1983 Act was

no longer permissible. (c) An authorisation could be given in advance to take effect at the moment of discharge.

F. B v Secretary of State for Justice [2012] 1 WLR 2043

13. In this case, the patient was subject to hospital and restriction orders. The First-tier Tribunal ordered that the patient be conditionally discharged to live in the community on specified conditions. It found that those conditions would not amount to detention or to the deprivation of his liberty. On appeal, the Upper Tribunal decided that: (a) the conditions would amount to a deprivation of his liberty; and (b) the First-tier Tribunal had power to discharge him to live somewhere other than a hospital if it was in his best interests to do so.

14. The Court of Appeal allowed the Secretary of State's appeal. It is important to understand the limited basis on which it dealt with the case. It decided that detention was only authorised in a hospital and that the tribunal had no power to discharge him to live anywhere else if that involved a deprivation of liberty, even if that was in his best interests.

15. It is easy to read the decision as saying that a First-tier Tribunal has no power to order a conditional discharge if this would involve a deprivation of liberty. That is, though, not what the Court decided. It was only concerned with what the First-tier Tribunal could do. It did not consider how the patient's best interests might be given effect under the 2005 Act and how that might work in conjunction with the tribunal's statutory powers. The closest the Court came was to comment on the Secretary of State's powers and the tribunal's power to make a non-statutory recommendation:

> 66. I am of course mindful that I am differing from the very careful and comprehensive judgment of the Upper Tribunal. The Upper Tribunal was very concerned with the position of RB and with his best interests. But, as I see it, the difficulties of interpretation cannot be overcome in the way that the Upper Tribunal sought to resolve them. In those circumstances, differing from the Upper Tribunal, I conclude a tribunal cannot rely on the patient's best interests as a ground for ordering conditional discharge on terms that involve a deprivation of liberty. This is more particularly so if the detention would not be for the purpose of any treatment. However, the position is to some degree mitigated by the fact that the Secretary of State has powers of transfer in an appropriate case. The Secretary of State could well be at risk of judicial review if he does not make an appropriate decision to exercise his powers of transfer. A tribunal may be able to express some helpful non-statutory recommendation for a transfer in an appropriate case.

16. My reading of this case is that it is concerned, and only concerned, with what the First-tier Tribunal could do under its powers in the 1983 Act. It did not deal with the other ways in which it might be possible to operate the 1983 and

2005 Acts in a co-ordinated fashion to ensure that a patient can be discharged under the 1983 Act on the basis that the 2005 Act procedures have been appropriately exercised in the patient's best interests. That is the conclusion that Charles J came to in *KC*. I agree with it and that disposes of this case as an obstacle to the co-ordinated operation of the mental capacity and mental health regimes.

G. Secretary of State for Justice v KC and C Partnership NHS Foundation Trust [2015] UKUT 376 (AAC)

17. This is the decision of Charles J that the First-tier Tribunal mentioned in this case. It was decided before *M* and was not the subject of an appeal to the Court of Appeal. This is how the judge dealt with the issue of a patient who lacked capacity:

> **The process under the MCA to render a deprivation of his liberty lawful if the conditionally discharged restricted patient lacks capacity to consent to the regime of his care and its effect. The eligibility of such a patient to be deprived of liberty by the MCA**
>
> 94. I have already set out the approach taken under the MCA and its DOLS.
>
> 95. The difficulties in applying those provisions is demonstrated by the point that initially the Secretary of State and KC, by the Official Solicitor, argued that a restricted patient who was conditionally discharged was not ineligible and so could be deprived on his liberty by the MCA on different bases.
>
> 96. The Secretary of State based his argument on Case B and KC based his on Case E (see paragraph 2 of Schedule 1A of the MCA). KC, by the Official Solicitor, now accepts that the relevant case is Case B (and that Case E applies and only applies to a restricted patient when there is an absolute discharge).
>
> 97. Ineligibility under paragraph 2 of Schedule 1A is determined:
>
> (1) by applying criteria identifying the status of the relevant person, and then
>
> (2) by applying the paragraphs applicable to a person with that status to him.
>
> The person is ineligible if he falls within one of the status descriptions and the paragraphs corresponding to it provide that he is ineligible.
>
> 98. I agree with what has become common ground that on a conditional discharge KC would be within the status of P described in Case B as he would remain subject to a hospital order (see paragraphs 8(1) and (4)).

99. The next step is to apply paragraphs 3 and 4.

100. Paragraph 3 also applies to Cases C and D (when P is subject respectively to the community treatment and guardianship regimes). It provides that: P is ineligible if the authorised course of action is not in accordance with a requirement which the relevant treatment regime imposes, which includes any requirement as to where he is to reside (see paragraphs 3(2) and (3)).

101. Given the approach under the MCA it is unsurprising that paragraph 13 defines 'authorised course of action' as any course of action amounting to a deprivation of liberty which the order under section 16(2)(a) authorises. Paragraph 14 relates to the DOLS and has an equivalent definition. Paragraph 15(2)(a) provides that the Court of Protection is to proceed on the basis that the proposed provision that brings into existence the relevant course of action amounting to a deprivation of liberty is included in the court order.

102. Writing in the definition of authorised course of action paragraph 3(2) reads: - P is ineligible if any course of action amounting to a deprivation of liberty is not in accordance with a requirement that the relevant regime imposes.

103. So if any course of action amounting to a deprivation of liberty contained in the relevant care plan (and thus in or referred to in the court order or the standard authorisation) is not in accordance with a requirement imposed by the MHA the conditionally discharged patient is ineligible.

104. At the first hearing the Secretary of State argued that paragraph 3(2) should be read as meaning that the terms of the proposed care and treatment amounting to a deprivation of liberty must not conflict with a condition of discharge (or a condition of leave of absence or a condition of a community treatment order or a requirement of guardianship).

105. I accept that this is within the natural and purposive reading of paragraph 3(2). But it also occurred to me when writing this decision that it was arguable that paragraph 3 should be read as meaning that if the matters that give rise to the deprivation of liberty outside hospital are not 'imposed' by a requirement under the MHA (and so here a condition of discharge) a conditionally discharged restricted patient is ineligible to be deprived of liberty. In part this is because in my view a natural meaning of the language that something 'X' is 'not in accordance' with a requirement imposed by a regime is not that X does not conflict with that regime or anything imposed by it. Rather it is that X must be so imposed.

106. I therefore invited further submissions on this issue.

107. A solution could be that 'imposed' means effectively imposed or required as a result of the MHA decision maker's role in defining the protective conditions and so terms that must be included in the choices open to the Court of Protection (and the DOLS decision makers). Rather than imposed and included in the s. 73(4) statutory duty. But I am persuaded by the common ground before me on the further hearing that the Secretary of State's argument is correct and applies to the protective conditions that the MHA decision maker so defines and accordingly this possible alternative argument is irrelevant or circular.

108. The Secretary of State's argument accords with:

(1) paragraph 13.56 of the Mental Health Act Code of Practice, and

(2) the Explanatory Notes to the Mental Health Act 2007, which indicate that the mischief at which paragraph 3 is aimed is the potential for inconsistency between requirements imposed under the MHA and authorisations under the MCA (not a concern that the deprivation of liberty should be imposed under the MHA). The relevant parts state with my emphasis:

> A person must also meet the eligibility requirement, which relates to cases where a person is, or might be made, subject to the 1983 Act. Grounds for ineligibility are set out in new Schedule 1A to the MCA (inserted by Schedule 8). In summary, a person is ineligible if they are already subject to the 1983 Act in one of the following circumstances:
>
> - they are actually detained in hospital under the main powers of detention in the 1983 Act (or treated as such).
> - they are on leave of absence from detention or subject to guardianship, SCT or conditional discharge and in connection with that are subject to a measure (such as a requirement to live in a particular place) <u>which would be inconsistent with the authorisation if granted. This means that a person who is subject to the 1983 Act but who is not in hospital could be subject to an authorisation under these new provisions. This might be necessary for example if a person subject to guardianship who normally lived at home needed respite care in a care home.</u>
> - they are on leave of absence from detention, or subject to SCT or conditional discharge and the authorisation, if given, would be for deprivation of liberty in a hospital for the purposes of treatment for mental disorder. This means that a authorisation cannot be used as an alternative to the procedures for recall in the 1983 Act.

Such Explanatory Notes are admissible as an aid to construction to cast light on the objective setting or contextual scene of the statute, and the

mischief at which it is aimed (see Lord Steyn in Westminster City Council v NASS [2002] UKHL 38 at paragraph 5).

109. The Secretary of State's argument also fits more easily with guardianship and community treatment. As to these:

(1) there is no express power under guardianship to impose any particular care and treatment regime although in my view before requiring a person to live at a particular place the guardian must consider and be satisfied that the care plan is appropriate, and

(2) in respect of community treatment orders, the power to set conditions is drafted open-endedly, but the authority to detain is suspended (s.17D(2)(a)) and the Government stated during the course of the legislation through Parliament that it would not be appropriate 'for the responsible clinician and the AMHP to impose conditions on a CTO which are so restrictive in nature that they would effectively amount to a deprivation of liberty for the purposes of Article 5 of the Convention' (Joint Committee on Human Rights, Fourth Report, Annex C).

110. Also and importantly, the conclusion argued for by the Secretary of State prevents lacunas arising in respect of care or treatment not linked to a patient's mental disorder which cannot have been the intention of Parliament when enacting the relevant amendments to the MCA. This is reinforced by the point that the amendments to the MCA relating to deprivation of liberty were introduced under the Mental Health Act 2007 to fill the 'Bournewood Gap' by enacting a complete code in respect of deprivation of liberty for persons lacking mental capacity.

111. The potential for such a lacuna arises because conditions imposed and decisions made under the MHA must be consistent with its purposes and so with the reception, care and treatment of patients with disorders. Thus, any condition of discharge (and any condition imposed on leave of absence or under guardianship or a community treatment order) must be linked to the underlying mental disorder which engages the MHA. It follows that there is no power under the MHA to require a patient to undergo treatment or to accept care which is not linked to a mental disorder. This is relevant both to physical conditions or illnesses and to learning disabilities which are not associated with abnormally aggressive or seriously irresponsible conduct (pursuant to section 2(2B) such learning disabilities are not a 'mental disorder' for the purpose of, inter alia, sections 3 (detention for treatment), 7 (guardianship), 17A (community treatment), 37 (hospital order) and 72(1)(b) and (c) and (4) (discharge)).

112. So, if paragraph 3 was construed as requiring the terms of any care plan amounting to a deprivation of liberty to be imposed under the MHA, care and treatment in respect of physical conditions or illnesses and most

learning disabilities, where they amount to a deprivation of liberty, could not be authorised under the MCA in respect of any conditionally discharged patient (or any patient on leave of absence or under guardianship or a community treatment order). The following examples illustrate the problems that would arise:

(1) if the conditionally discharged patient had schizophrenia and a learning disability and (a) the schizophrenia is controlled by conditions requiring attendance at hospital for medication, and no other conditions are necessary to address the schizophrenia which is in remission, but (b) the learning disability (which is not a 'mental disorder' for the purpose of sections 3 and 37 of the MHA) means that the patient requires a package of community care and support involving constant supervision and control, to which he does not object but to which he cannot consent because he lacks the relevant capacity, the care package could not be authorised under the MCA because it could not be imposed by the MHA, and

(2) if the conditionally discharged patient suffered from gangrene, required an amputation in his best interests and objected to the operation so that it could only be carried out by depriving him of his liberty, the necessary treatment could not be authorised under the MCA because it could not be imposed under the MHA.

113. *Conclusions.* A restricted patient who is conditionally discharged is not ineligible to be deprived of his liberty by the MCA and so if the implementation of the conditions selected by the MHA decision maker would result in a deprivation of liberty it can be authorised under the MCA by the Court of Protection or under the DOLS (provided of course that the relevant tests and assessments are satisfied).

The timing of an authorisation of a deprivation of liberty under the MCA

114. A standard authorisation under the DOLS can provide for it to come into force at a time after the time at which it is given (see paragraph 63 of Schedule A1 to the MCA). Also, in my view the Court of Protection can approve a care plan and authorise any deprivation of liberty it would create from a date in the future (i.e. when it comes into effect).

H. M v Secretary of State for Justice [2017] 1 WLR 4681 and [2019] AC 712

18. M was subject to hospital and restriction orders. He applied to the First-tier Tribunal for a conditional discharge. He required a care package that would amount to an objective deprivation of his liberty, but he had capacity to make decisions about this and was willing to accept the deprivation. Accordingly, the

tribunal refused his application. The Upper Tribunal allowed his appeal and remitted the case for a rehearing, but the Secretary of State appealed against that decision to the Court of Appeal.

19. The Court, including the President of the Court of Protection and the Senior President of Tribunals, decided that M's consent could not confer jurisdiction on the tribunal to authorise detention otherwise than in a hospital; that was a power that the tribunal did not have under the 1983 Act. The Court did, though, mention in passing how it might be possible to achieve the outcome that M wanted:

> 32. A FtT and the MHRTW [Mental Health Review Tribunal for Wales] are inferior tribunals. Unlike the UT, they are not a superior court of record (see section 3(5) Tribunals Courts Enforcement Act 2007 [TCEA]) nor do they possess the powers, rights, privileges and authority of the High Court granted to the UT by section 25(1)(a) TCEA. The FtT and the MHRTW cannot make binding declarations or exercise the judicial review jurisdiction of the High Court or the UT. Neither the FtT/MHRTW nor the UT is able to exercise the jurisdiction of the Court of Protection, although this should not be taken to suggest that a judge authorised in a tribunal jurisdiction cannot also sit in the Court of Protection and vice versa so that in an appropriate circumstance the judge might exercise both jurisdictions concurrently or separately on the facts of a particular case.

20. The Supreme Court dismissed M's appeal and decided that the First-tier Tribunal had no power to impose such a condition, even with the patient's consent. The Court declined to deal with other possibilities:

> 27. Whether the Court of Protection could authorise a future deprivation, once the FtT has granted a conditional discharge, and whether the FtT could defer its decision for this purpose, are not issues which it would be appropriate for this court to decide at this stage in these proceedings. Assuming that both are possible, and therefore that there might be an incompatibility with article 14, read either with article 5 or with article 8, it would make no difference to the outcome of this case. The outcome of this case depends upon whether it is possible to read the words 'discharge … subject to conditions' in section 42(2) (dealing with the Secretary of State's powers) and 'conditional discharge' in section 73(2) (dealing with the FtT's powers) as including the power to impose conditions which amount to a deprivation of liberty within the meaning of article 5.

The Court did not reject the Court of Appeal's suggestion. It simply declined to deal with it and indicated that there might be an issue with the patient's Convention rights, which it also did not discuss.

I. Birmingham City Council v SR and Lancashire County Council v JTA [2019] EWCOP 28

21. This is the decision of Lieven J that the First-tier Tribunal mentioned in this case. It was decided after *M*. Both cases involved restricted patients who lacked capacity in respect of decisions about their care packages, where they lived, and their liberty or otherwise. In SR, the patient's case was before the First-tier Tribunal, which had adjourned to await authorisation. In JTA, the First-tier Tribunal had previously conditionally discharged the patient on a condition that amounted to a deprivation of his liberty. The tribunal had no power to impose that condition, but the issue was resolved by an authorisation given by the Court of Protection. The judge was concerned with an application to continue the authorisation.

22. After summarising the reasoning of the Supreme Court in *M*, Lieven J went on:

> 25. The Secretary of State's response to the decision in *M* has been set out in a Guidance document produced by the Mental Health Casework Section; '*Discharge conditions that amount to a deprivation of liberty'*. This is guidance not law, but it sets out the Secretary of State's proposed solution to the problem posed by the Supreme Court's decision. The Guidance distinguishes between patients with capacity, whom the Secretary of State proposes could be considered for long term leave of absence under s.17(3) and patients lacking capacity. Both the individuals in the current case have been assessed not to have capacity, and therefore I do not deal further with the position of patients with capacity.
>
> 26. In respect of patients lacking capacity the Guidance then breaks that category down into two parts. Firstly, those patients whose best interests require them to be subject to a care plan to help them perform daily living activities or self-care and where the support would amount to a deprivation of liberty. Secondly, those whose care plan required a deprivation of liberty primarily in order to protect the public.
>
> 27. For the first category the Guidance suggests at para 4.1 that if the care plan requires a DoL authorisation under the MCA, the FTT can issue a deferred conditional discharge, and the necessary arrangements made to put in a place a DoL authorisation before the patient is discharged.
>
> 28. For the second category, the Guidance suggests at para 4.2 that a conditional discharge would not be appropriate and s.17(3) leave would be open to consideration.
>
> 29. The issue as to whether a patient can be detained because s/he poses a risk to the public, and it is said to be in his/her best interests to be detained for that reason, was considered by Moor J in *Y County Council v ZZ* [2013]

COPLR 463. Moor J recognised that the purposes of the restrictions on P's liberty was to address, prevent and control P's sexual urges and he said at [49];

> *'I have come to the clear conclusion, for all the reasons given by the various doctors, that it is lawful as in Mr ZZ's best interests to deprive him of his liberty in accordance with the local authority care plan, pursuant to schedule A1 of the Mental Capacity Act 2005. I make that declaration. In doing so, I am following the advice of the expert professionals who know Mr ZZ so well. Indeed, the Official Solicitor accepts, on his behalf, that I should do so. I make it clear to Mr ZZ that I have no doubt that the restrictions upon him are in his best interests. They are designed to keep him out of mischief, to keep him safe and healthy, to keep others safe, to prevent the sort of situation where the relative of a child wanted to do him serious harm, which I have no doubt was very frightening for him, and they are there to prevent him from getting into serious trouble with the police.'*

31. The same patient with substantially the same restrictions was considered again by Peter Jackson J in *Re (N) (Deprivation of Liberty)* [2016] EWCOP 47, and he adopted the same approach.

31. As is set out above, the Supreme Court did not deal with the powers of the Court of Protection under the MCA to deprive an individual who had been (or was contemplated to be) conditionally discharged under the MHA.

32. Under the MCA the CoP has the power to make decisions in a patient (P)'s best interests in respect of welfare decisions, which can include decisions as to where they live and decisions that deprive P of his/her liberty. The CoP only has this power if the individual lacks the capacity to make the said decision themselves. In the present case both the individuals have been assessed as lacking capacity, but it can immediately be seen that if they did have capacity then the legal position would be entirely different.

33. There are categories of case under Schedule 1A of the MCA of 'Persons ineligible to be deprived of liberty by this Act'. Parts of this Schedule are more than a little opaque, but the position seems to be as follows. Case A covers patients who are detained in hospital under the MHA. Case B is patients subject to the hospital treatment regime under the MHA but not detained under the MHA. Case C is those subject to the community treatment regime under the MHA.

34. As Baroness Hale said at [26] in *M*,

> *'A deprivation of liberty whose purpose consists wholly or mainly in medical treatment in hospital cannot be authorised, but a deprivation*

> *of liberty for other purposes can be authorised, provided that it is not inconsistent with the requirements of the MHA regime'.'*

35. It seems SR and JTA fall within Case B because they remain subject to the 'hospital treatment regime' as defined in Para 8 of Schedule 1A, namely a hospital order under s.37, but they are not detained. Case B then refers to paragraphs 3 and 4. Paragraph 3(2) states; '*P is ineligible if the authorised course of action is not in accordance with a requirement which the relevant regime imposes.'* The relevant regime is that under the MHA.

36. Case D is those subject to the guardianship regime under the MHA. Case E covers the situation where P objects to being a mental health patient.

37. It therefore follows that in these cases both individuals fall, or potentially fall, within Case B, as being subject to the hospital treatment regime under the MHA but either not detained (in the case of JTA) or will not be detained at the date the order under the MCA comes into effect (SR). For individuals who fall within Case B they are ineligible if paragraphs 3 or 4 apply. Paragraph 3 (2) states;

> *'P is ineligible if the authorised course of action is not in accordance with a requirement which the relevant regime imposes'*

38. It therefore covers the situation where there is a conflict or inconsistency between the authorised course of action under the MCA (i.e. the care plan including the deprivation of liberty) and any requirement under the MHA. Happily, there is no such conflict here.

Conclusions

39. In both cases the patients have been assessed not to have capacity in respect of decisions about their care packages, where they live, and their liberty or otherwise. I accept those assessments and therefore conclude that both patients do not have capacity in the relevant respects.

40. Equally, I have no doubt, and there is no dispute or any potential for a dispute, that it is in both patients' best interests that they should be cared for and accommodated in the community settings proposed. In reaching this conclusion I take fully into account their wishes and feelings, which in both cases are that they are allowed to live in the proposed placements.

41. In the case of SR, it might be argued that the purpose of the deprivation of liberty and some of the other elements of the care package is the protection of the public, rather than the care of SR. However, for the reasons given by Moor J in *ZZ* I think that is a false dichotomy. It is strongly in SR's best interests not to commit a further offence, or to place himself at risk of recall under the MHA, if the Secretary of State were to conclude that the risk of other offences was too great. In those

circumstances the provisions of the care plan in terms of supervision and ultimately deprivation of liberty is, as Moor J put it, '*to keep him out of mischief*' and thereby assist in keeping him out of psychiatric hospital. This is strongly in his best interests, as well as being important for reasons of public protection.

42. It is for this reason that I am not convinced that the division the Secretary of State makes in the Guidance between patients whose care plan is in the patients' best interests, and those where the deprivation of liberty is primarily for the purpose of managing risk to the public, is one that stands up to close scrutiny. However, on the facts of this case I have found that both patients would fall into the first category in any event.

43. The final point is whether there is anything in the Supreme Court decision in *M* or the MCA itself in the light of *M*, which would prevent the Court of Protection authorising a deprivation of liberty here. In my view there would not be any such difficulty. *M* is concerned with the powers under the MHA to deprive a conditionally discharged patient of his/her liberty. The Supreme Court made clear that they were not considering the powers under the MCA to authorise a deprivation of liberty, see [27] of the judgment.

44. The caselaw establishes that the Court of Protection may make declarations and orders concerning best interests, including deprivation of liberty, in advance of any discharge under the MHA, see *DN v Northumberland, Tyne & Wear NHS Foundation Trust* [2011] UKUT 327 (AAC). In a case such as SR it is appropriate that this should happen, so that the FTT and the Secretary of State can be confident that SR will be deprived of his liberty to a proportionate degree when he is discharged into the community.

45. Equally, there is nothing in Schedule 1A of the MCA, which would prevent the Court of Protection from authorising the deprivation of liberty of a conditionally discharged patient, whether or not that discharge had been deferred.

46. I am loathing to speculate about arguments that might be made. However, to a degree there is some suggestion in the FTT's reasoning in SR that he might be ineligible under Schedule 1A because a conditional discharge under the MHA cannot be made in the light of *M* and therefore to deprive him of his liberty under the MCA would be inconsistent with the MHA, that argument does not appear to me to be correct. The inconsistency required under Cases B and C would be between the power that has been exercised under the MHA and any a deprivation of liberty under the MCA. There is no inconsistency between the two orders, it is merely that under

the MHA, as interpreted in *M*, there is no power to deprive the patient of his/her liberty. That does not prevent the MCA powers being used.

47. I should end by making clear, that there are of course different issues if the patient has capacity in respect of the care plan and any proposed deprivation of liberty. That is not these cases and therefore I make no comment upon that situation.

J. M does not affect or undermine the essence of the reasoning in KC

23. This is the second problem that arises in this case. It is the question whether something in the Supreme Court's reasoning on the issue it decided might affect the proper analysis of the issue I have to decide.

24. The Court expressly did not deal with the issue of a patient who lacked capacity to consent to a deprivation of liberty. The terms of paragraph 27 also show that it did not consider that its reasoning might have an impact on such a patient. Otherwise, paragraph 27 of its judgment would not have been worded as it was. But it left open the issue open for later cases to decide.

25. *KC* was a case under the 1983 Act, but Charles J had to consider the relationship between that Act and the 2005 Act. He was well placed to do so as the President of the Administrative Appeals Chamber and Vice President of the Court of Protection. I am satisfied that the Supreme Court's reasoning on the issue it decided did not undermine Charles J's reasoning in *KC*. The Court's reasoning related to the First-tier Tribunal's powers if a patient with the capacity to do so was willing to consent to a deprivation of his liberty on discharge. That is not the issue in this case. It may be that Charles J thought that the First-tier Tribunal was not limited to the terms of its jurisdiction as set out in the 1983 Act. We know from his decisions that he considered the tribunal did have additional powers in order to avoid a violation of the patient's Convention rights. It is also one reading of paragraph 113 of his judgment in *KC* that the First-tier Tribunal could impose conditions that would result in a deprivation of liberty. But that was not essential to his reasoning, which was concerned with achieving a coherent interpretation of the 1983 and 2005 legislation in a way that was appropriate across the range of circumstances in which it might apply and did not leave gaps. His reasoning is persuasive.

26. *SR* and *JTA* was a case under the 2005 Act and Lieven J sits as a judge of the Court of Protection. It was not her role to decide whether the 1983 Act had been applied correctly, but she was aware of how the issues she had to decided related to the 1983 Act. She had to decide how the 2005 Act could be operated in a way that co-ordinated with the decisions taken under the 1983 Act. She confirmed that it would be possible to give an authorisation in advance or while a conditional discharge was deferred. Her reasoning is clear, cogent and persuasive.

27. I stand by what I said in *DN*:

> 10. I regard the least restriction principle and its numerous applications in the Code as inherent both in the stringent conditions that must be satisfied for continuing detention pursuant to the MHA and in Mr N's Convention rights under the Human Rights Act 1998 to liberty and respect for home and family life pursuant to Articles 5 and 8.

28. Those factors combine to provide the imperative for the First-tier Tribunal to apply the 1983 Act in a way that allows a patient to be discharged if there are means by which the patient's case can be appropriately dealt with under other legislation. The 2005 Act is such legislation. If a patient's case is to be dealt with correctly under the 1983 Act and fairly and justly under the tribunal's rules of procedure, the tribunal is under a duty to find a way that allows both Acts to be applied in a co-ordinated manner.

29. How can the necessary mental capacity arrangements be made? If the mental capacity issue has already been dealt with by an advance authorisation, the tribunal may be able to proceed to a conditional discharge without more ado. If it has not, there are two possibilities that have been discussed in the cases. It may be that there are other and better approaches, but if there are I cannot think of them. I certainly do not intend to limit the First-tier Tribunal to these approaches if there is a more appropriate option.

The different hats approach

30. If appropriate, the same judge could sit in the Court of Protection and in the First-tier Tribunal to ensure that all decisions could be made that would allow the patient to be conditionally discharged on appropriate conditions and with the benefit of a deprivation of liberty authorisation. This was the suggestion of the Court of Appeal in *M*. The Supreme Court did not deal with this possibility, but nor did it come within the possibilities that the Court expressly said it would not deal with. It was simply silent on the point.

31. The First-tier Tribunal and Upper Tribunal have been flexible in the way that they exercise their jurisdictions. The two tribunals sat together with the same panel to hear an appeal to the First-tier Tribunal and judicial review proceedings in the Upper Tribunal in *Reed Employment plc v the Commissioners for Her Majesty's Revenue and Customs* [2010] UKFFT 596 (TC). And the same panel of the Upper Tribunal heard an appeal together with a judicial review transferred from the High Court in *Fish Legal and Emily Shirley v Information Commissioner, United Utilities plc, Yorkshire Water Services Ltd, Southern Water Services Ltd and the Secretary of State for the Environment, Food and Rural Affairs* [2015] UKUT 52 (AAC), [2015] AACR 53 at [12]–[13]. The Lands Chamber of the Upper Tribunal has also approved in principle the practice of the same judge sitting in the county court at the same time as presiding as a member

of a panel of the Property Chamber of the First-tier Tribunal in *Avon Ground Rents Ltd v Child* [2018] UKUT 204 (LC) at [84]. All of those cases are consistent with the suggestion by the Court of Appeal in *M* that the same judge could sit at the same time in the First-tier Tribunal and the Court of Protection in order to exercise both jurisdictions concurrently or separately.

The ducks in a row approach

32. If it not possible or appropriate for some reason to follow the same hat approach, it would be a proper use of the tribunal's powers to adjourn, to make a provisional decision or to defer discharge in order to allow the necessary authorisation to be arranged. I discussed these possibilities in *DC v Nottinghamshire Healthcare NHS Trust and the Secretary of State for Justice* [2012] UKUT 92 (AAC). The choice may come to little more than a matter of preference for the tribunal. It may, though, depend on how sure the tribunal is that the mental capacity decision will be put in place and how confident it is of the terms of any such decision (the terms of the care package, for example).

K. This approach does not involve a violation of a patient's Convention rights

33. This is the third problem that arises in this case. It is the question whether the Charles/Lieven outcome is a violation of the Convention right under Article 14 of the European Convention on Human Rights, read together with Article 5 or Article 8. Lieven J did not deal with this, but in *KC* Charles J dealt with Articles 5(4) and 14:

> **Article 5(4) and Article 14**
>
> 115. Article 5(4) requires the availability of proceedings to challenge the lawfulness of the detention.
>
> 116. Paragraph 58 of the judgment of Arden LJ in the RB case [*B* in the Court of Appeal] indicates that if she had concluded that s. 73 of the MHA gave the FTT power to direct a conditional discharge on conditions that resulted in a deprivation of liberty at the relevant placement she would not have found a breach of Article 5(4). But as (a) she does not analyse this issue, (b) there may be contrary indications in paragraphs 63 to 65 of her judgment and (c) my analysis introduces new points it would not be appropriate for me to found my conclusion on the indication in paragraph 58 of her judgment.
>
> 117. The MCA contains such provisions in respect of orders of the court and authorisations under the DOLS including the need for reviews. But on my analysis the Court of Protection and the DOLS decision makers could not change the protective conditions decided on by the FTT or the Secretary of State. Rather the continued authorisation of the deprivation of liberty

would be considered by reference to the choices available that include such protective conditions and the application of a best interests test. As already mentioned the Court of Protection or the DOLS decision maker could refuse to authorise any such placement and if that happened the provider would be likely to refuse to continue to provide it.

118. If that was to happen the Secretary of State could vary the conditions or recall the restricted patient or, subject to timing the restricted patient would have the right to make an application to the FTT under s. 75 of the MHA. If the restricted patient could not make such an application because of a timing point (or some other reason) or another effective application to the FTT I do not share Arden LJ's doubt (see paragraph 28 of her judgment) that judicial review of a decision of the Secretary of State would not be available.

119. Problems relating to the existence of two statutory schemes and decision makers can arise in other circumstances (see for example the discussion in KD v A Borough Council, the Department of Health and Others [2015] UKUT 251 (AAC) in particular at paragraphs 44 to 54). Whereas here they involve public authorities exercising statutory powers and duties they are approached pragmatically and cooperatively. And, for example, the duties of the Secretary of State under the MHA would require him to address material changes in circumstances (including the non-availability of a placement or changes of view on protective conditions) and a high court judge sitting in both the Court of Protection and the Administrative Court could resolve a judicial review challenge to a decision of the Secretary of State on such issues.

120. Further, in my view the language of s. 73 permits a FTT to write into the conditions it imposes an ability to apply to it for a variation or discharge of protective (or other) conditions on the basis of a material change in circumstances (a) if a variation or discharge is refused by the Secretary of State or the FTT agree to consider the application, and (b) if the FTT is invited to consider such an application by the Court of Protection (or a DOLS decision maker). Such a provision would be in line with the approach in R(H) v SSHD [2003] QB 320 and [2004] 2 AC 253 to the problem of a material change in circumstances after deferral of a direction until arrangements have been made. It seems to me that generally it would be sensible for the FTT to do this to provide a further alternative route of challenge to a continuing deprivation of liberty.

121. In my view, a combination of the proceedings available under the MHA (and if not available under it by way of judicial review) and the MCA give a conditionally discharged restricted patient an effective and speedy process to challenge in a court the creation and continuation of any deprivation of his liberty that satisfies Article 5(4).

> 122. For the same reasons I consider that there is no breach of Article 14.
>
> 123. Further, in my view the ratio of the RB case in the Court of Appeal on what Arden LJ described as the justification issue does not preclude me from reaching this view.

34. Ms Paterson for the Secretary of State dealt with the Convention rights argument succinctly. After setting out her argument, which was essentially the approach to co-ordination that I have just explained, she wrote:

> The above is, in fact, compliant with Article 14 (see [27] of MM in which Lady Hale held that it was arguably in breach of Article 14 in combination with either Article 5 or 8 (see [33 above]), by virtue of Guidance. The provision for capacious patients to be provided with leave under s17(3) so that they maybe transferred from hospital to another placement means that there is no discrimination in favour of incapacious restricted patients.

I accept that argument and I also agree with Charles J's analysis in *KC*. I can see no violation of the patient's rights in providing a procedural route that works within the limited mental health jurisdiction of the First-tier Tribunal and is in the patient's best interests. Quite the reverse.

L. Disposal

35. I informed the parties of the basis on which I would allow this appeal and asked them to agree the terms on which I could re-make the decision. I am grateful to them for their co-operative approach to arranging the necessary assessments, obtaining the standard authorisation, and agreeing the appropriate conditions. I have incorporated their agreed terms into my decision.

Signed on original
on 16 July 2020

Edward Jacobs
Upper Tribunal Judge