IN THE UPPER TRIBUNAL

Appeal No. *UA-2023-000128-HM*

ADMINISTRATIVE APPEALS CHAMBER **[2024] UKUT 190 (AAC)**

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

Between:

OO

Appellant

- v –

Central and North West London NHS Foundation Trust

First Respondent

and

Secretary of State for Justice

Second Respondent

Before: Upper Tribunal Judge Church

Decided following a remote oral hearing on 29 January 2024

Representation:

Appellant:	Mr Roger Pezzani of counsel, instructed by Omiros Nicholas and Georgina Thomas of Messrs Guile Nicholas, Solicitors
First Respondent:	Weightmans LLP (written submissions only)
Second Respondent:	Ms Angie Munley of the Mental Health Casework Section of The Ministry of Justice (written submissions only)

DECISION

This decision may be made public (rule 14(7) of the Tribunal Procedure (Upper Tribunal) Rules 2008 (SI No 2698)).

The decision of the Upper Tribunal is to allow the appeal.
The decision of the First-tier Tribunal made on 29 November 2022 under number MM/2022/06325 was made in error of law.

OO -v- (1) Central and North West London NHS Foundation Trust (2) SSJ

Under section 12(2)(a) and (b)(i) of the Tribunals, Courts and Enforcement Act 2007 I **set that decision aside** and **remit** the matter to the First-tier Tribunal for re-hearing before a differently constituted panel.

REASONS FOR DECISION

What this case is about

1. This case is about the issue of "equality of arms" in terms of expert evidence at mental health tribunals, and in what circumstances fairness might necessitate adjourning to give a patient an effective opportunity to challenge the detaining authority's case.

Factual and procedural background

2. OO is a detained patient with a diagnosis of paranoid schizophrenia and a long history of compulsory detention in psychiatric hospitals, convictions for sexual offences and recalls from conditional discharge.

3. At the material time OO was detained at The Riverside Centre under the terms of a hospital order (under section 37 of the Mental Health Act 1983 (**"MHA 1983"**)) with a restriction order (under section 41 MHA 1983) made on 11 January 2010.

4. On 12 November 2021, while subject to a conditional discharge, OO was arrested for a sexual offence. On 26 February 2022 he was admitted to hospital under section 2 MHA 1983. On 8 March 2022 the Secretary of State recalled OO to detention in hospital pursuant to his discretion under section 42(3) MHA 1983.

5. On 9 March 2022 the Secretary of State made a referral to the First-tier Tribunal pursuant to his duty under section 75(1)(a) MHA 1983. These proceedings arise from that reference.

6. On 31 May 2022 OO was convicted following a trial of an offence of sexual assault on a female contrary to section 3 of the Sexual Offences Act 2003 and was made subject to a restricted hospital order under sections 37 and 41 MHA 1983.

7. This means that OO is now subject to two separate restricted hospital orders. Each such order gives rise to a right for OO to apply to the First-tier Tribunal for a review of his detention.

8. The hearing of the reference was adjourned or postponed several times for various reasons. The two most important decisions made by the First-tier Tribunal in relation to this reference were those made by the three-member panel of the First-tier Tribunal which convened to hear the reference on 13 July 2022, adjourned part-heard, and reconvened on 29 November 2022 (the **"Tribunal"**).

9. The decisions made by the Tribunal on those two dates comprise the decision on the reference (the **"FtT Decision"**). The upshot of the FtT Decision was that the statutory conditions to OO's continued detention were satisfied and OO should remain in hospital.

The 13 July 2022 hearing

10. The Tribunal recorded Dr Padayatchi,, OO's then responsible clinician, as having said that she was in agreement with the assessment of Dr Kottalgi (a consultant forensic psychiatrist) that OO could be conditionally discharged. She was "confident that it will be possible to put in place a suitable care package in the community which will permit safe management of the risks" and she "did not think that testing by unescorted leave" was a necessary preliminary to discharge". However, three obstacles lay in the way of an immediate conditional discharge:

a. an assessment by the community forensic team was outstanding;

b. funding for OO's accommodation in the community had yet to be secured; and

c. OO had yet to be sentenced in relation to his conviction of 31 May 2022.

11. Rather than order a deferred conditional discharge, the Tribunal decided to adjourn the matter and make directions for the provision of further information because it could see that "with further information and clarification an immediate or deferred conditional discharge might be appropriate, which is what the care team suggest" (see paragraph [6] of the 13 July 2022 decision notice).

Events between the 13 July 2022 hearing and the 29 November 2022 hearing

12. The matter was listed for hearing on 29 November 2022. In the reports prepared for that hearing, the team caring for OO indicated their continued support for the grant of a conditional discharge, albeit that it was considered that the discharge may need to be deferred due to matters related to OO's sentencing for the 31 May 2022 conviction (see paragraph [2] of the 5 December 2022 decision notice).

13. Given the in-patient team's apparent support for his being granted an immediate or deferred conditional discharge, OO decided on advice from his solicitor not to instruct an independent expert psychiatrist.

14. However, in the days immediately preceding the scheduled hearing there was a series of significant developments:

a. on Friday 25 November 2022 the responsible authority made an application for the postponement of the 29 November 2022 hearing on the grounds that:

   i. OO's sentencing had been postponed; and

   ii. it required to arrange "a further meeting with the Forensic Team at West London" which it said was "of the opinion that the patient is not suitable at the moment for a Community Placement".

b. The application indicated that Dr Nyein, who was OO's new responsible clinician, would submit an addendum report within 24 hours;

c. OO's solicitor was notified of the adjournment application at 16:44 on Friday 25 November 2022, and received Dr Nyein's addendum psychiatric report, which gave the first indication that Dr Nyein no longer supported OO's discharge, at 17:36;

d. on Sunday 27 November 2022, OO's solicitor emailed the responsible authority and the Tribunal to inform them that OO supported the application for postponement of the 29 November 2022 hearing. He proposed directions, including a direction for the filing of independent evidence on OO's behalf;

e. on Monday 28 November 2022 at 15:39 the responsible authority's application for a postponement was refused on the basis that it was more appropriate for the application to be renewed at the hearing listed for the following day, and for the Tribunal to rule on it;

f. at 15:44 on Monday 28 November 2022 the responsible authority made a further application for a postponement, which was also refused.

The 29 November 2022 hearing

15. On Tuesday 29 November 2022 the Tribunal reconvened.

16. OO attended the hearing, represented by Mr Nicholas, and he and his sister gave evidence. Dr Nyein and Nurse Patrick Iwu attended and gave evidence on behalf of the responsible authority. Dami Solamin (a forensic social worker from Brent's adult social care team) also attended and gave evidence.

17. At the beginning of the hearing the responsible authority applied for an adjournment on the same basis as its earlier applications for postponement, and this application was gain supported by Mr Nicholas on behalf of OO, with additional reasons. This application for an adjournment was also refused.

18. Mr Nicholas then made an application for an adjournment on OO's behalf at the end of the hearing, but this too was refused. The Tribunal went on to make its decision on the Secretary of State's reference. The Tribunal recorded the reasons for its decision in a decision with reasons dated 5 December 2022 (the **"FtT Decision Notice"**).

19. From what it says in the FtT Decision Notice, it appears that the Tribunal was under the misapprehension that all the applications for postponement/adjournment were made on behalf of OO. However, it is apparent from the documents in the bundle that all but the final adjournment application (made by Mr Nicholas on behalf of OO at the end of the hearing) were in fact made by the responsible authority. I am satisfied that, to the extent that the Tribunal did indeed labour under this misapprehension and in doing so it was in error of law, such error was not material. I mention this only to avoid confusion.

20. The Tribunal explained its decision making on the adjournment applications as follows:

> "3. On the day before the hearing, at the beginning of the hearing and at its conclusion Mr Nicholas on behalf of his client requested an adjournment. This was on the basis that there had been late disclosure of evidence, as a result of which the clinical team were now arguing in favour of continued detention, rather than a conditional discharge. He argued that in those circumstances on the basis of the fresh evidence there was in reality little alternative for the tribunal but to continue the detention. Mr Nicholas argued in the alternative that if we did

not adjourn we could nevertheless grant a deferred conditional discharge. We could rely upon his client's commitments to comply and engage, and the testing and leave suggested will not be preconditions to discharge but merely part of the transitional process to ensure that it was successful and the degree and nature of support required in the community was clarified.

4. The argument as to unfairness rested on the assumption that until the recent change in evidence his client would have been entitled to a deferred conditional discharge. He suggested that an adjourned hearing should not take place until after the Crown Court proceedings, and perhaps the instruction of an independent expert, but he could give no indication when that adjourned hearing would take place and suggested we did not seek to fix a date.

5. In our judgement, although the clinical team were suggesting a conditional discharge until recently, in reality the written evidence clearly suggested that at the least a full risk assessment was required before the discharge could take place. The second condition set out in paragraph 19 of Dr Padayatchi's 9/9/22 [sic] made it plain "discharge is also dependent on the sexual violence risk assessment and the mitigation required based on this assessment". However phrased there was the real possibility that that risk assessment would suggest that there were no community arrangements which could safely manage the risk. Further [OO] had received no unescorted community leave. Trial leave to proposed accommodation was required. In our judgement a discharge on the basis of previous evidence was by no means certain. We adjourned because we were not satisfied that the Clinical team had really thought through their argument and there were many uncertainties.

6. The view of the current care team was expressed by Dr Nyein, a general adult psychiatrist. He has known [OO] as a patient since June 2022 and took over as RC in September. Dr Padayatchi is the medical director. His report of 18/11/22 did not express a view. He noted Dr Brown's concerns but did not appear to depart from Dr Padayatchi's opinion in supporting a discharge. But it was the exchange of emails with Dr Brown and Dr Baruad and the receipt of Dr Brown's full report that caused him to change his mind, as now expressed in his report of 25/11/22. There has been no change in [OO]'s presentation and no significant incident. It is clear he relies very heavily on those documents and discussions he has had. It is now his case that there must be a full sexual violence risk assessment before discharge can be considered.

7. We have considerable sympathy for [OO] who had hoped that he would receive a discharge. The reality appears to us that he is poorly placed on a general adult psychiatric ward. This appears to have arisen because his initial admission was under section 2. The difficulty for [OO] is that the report of Dr Kottalgi dated 12/5/22 (based upon a video meeting with interpreter) did not support transfer to a forensic psychiatric unit, although he did make other suggestions.

8. There has been considerable delay in this matter. Mr Nicholas suggests an open ended adjournment with perhaps the instruction of an independent expert for [OO]. Mr Nicholas does not represent [OO] in the Crown Court. Dr Brown was instructed by Reeds solicitors who are so acting. It is in our judgement

> unlikely that an adjournment would benefit anyone, least of all [OO]. The Crown Court judge, on the basis of Dr Brown's report may well feel it desirable to adjourned [sic] sentence until the tribunal (with access to greater information and expertise than is before him) has decided what to do. Or he may just impose another Hospital order. With the current detention in place there is little he can do. In our judgement the sooner the treating team grasp the issues the sooner his assessment and entitlement to discharge or not will be established."

21. The upshot of the FtT Decision was that the Tribunal upheld OO's section.

The Permission stage

22. OO applied for permission to appeal the FtT Decision to the Upper Tribunal. Having been unsuccessful in his application to the First-tier Tribunal, he renewed his application to the Upper Tribunal and the matter came before me.

23. I directed an oral hearing of the permission application, at which Mr Pezzani represented OO. Neither Respondent was represented at the hearing.

24. I decided to allow the application. In my grant of permission, I explained my reasons as follows:

> "6. The factual background to the hearing on 5 December 2022 [sic] was that the responsible clinician, having until then supported the Applicant receiving a conditional discharge (albeit considering that such discharge may need to be deferred), changed position and issued an updated report opposing conditional discharge just days before the hearing.
>
> 7. The thrust of Mr Pezzani's submissions was that the Decision involved procedural unfairness because the Applicant was denied the opportunity to arm himself with expert evidence to support his case for conditional discharge by the First-tier Tribunal's refusal of both his, and the Responsible Authority's, applications for adjournment.
>
> 8. Mr Pezzani says that it was wholly appropriate for the Applicant to choose not to instruct his own expert when the responsible clinician and the other witnesses for the Responsible Authority supported conditional discharge, but it was equally reasonable for him to want to instruct his own expert when the responsible clinician's position changed. His representative acted with all expedition but the First-tier Tribunal's decision to go ahead and determine the appeal without adjourning to allow the Applicant to obtain his own expert evidence, or indeed to give his representative an opportunity to challenge the expert evidence of the forensic clinical psychiatrist (who was not present to be questioned at the hearing) upon whom the responsible clinician relied denied him a fair hearing and ran counter to the principle of *parity inter partes* in matters of forensic science. He also submitted that the First-tier Tribunal's reasons for refusing the adjournment applications were inadequate.
>
> 9. I am persuaded by Mr Pezzani's arguments that it is arguable with a realistic (as opposed to fanciful) prospect of success that the First-tier Tribunal erred in law and that this error may have been material."

The hearing of the substantive appeal before the Upper Tribunal

25. I directed a remote oral hearing of the substantive appeal, which took place on the Cloud Video Platform. Mr Pezzani represented OO. Neither Respondent was represented at the hearing, although each produced a brief written submission.

26. By the date of the hearing OO had been sentenced in respect of the sexual offence of which he had been convicted on 31 May 2022. For that conviction he received another hospital order with a restriction order (section 37/41).

27. Following the hearing, I directed the parties to make written submissions on the issue of relief (should I decide to allow the appeal), which they duly did.

28. Mr Pezzani, on behalf of OO, argued for the setting aside of the FtT Decision and the remittal of the matter to the First-tier Tribunal for re-hearing on the basis that OO had not yet had the lawful judicial consideration of his detention to which he was entitled, and any other result would not be just. He did not argue for the remaking of the FtT Decision by the Upper Tribunal.

29. Weightmans LLP, on behalf of the First Respondent, took a neutral position on the appeal.

30. Ms Munley of the Mental Health Casework Section of the Ministry of Justice, for the Second Respondent, made a written submission to the effect that should the appeal be allowed and the matter remitted to the First-tier Tribunal for re-hearing, the Secretary of State was willing to make a discretionary referral in relation to the second detention authority.

31. Mr Pezzani acknowledged that, as a practical matter, the First-tier Tribunal could be expected to consolidate multiple applications/references under rule 5(3)(b) (see paragraph [33] below).

The relevant law and procedure rules

32. MHA 1983 provides, so far as is relevant for the purposes of this appeal:

> **"Powers of tribunals**
>
> **72.-** (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 …, the tribunal may in any case direct that the patient be discharged, and-
>
> …
>
> (b) the tribunal shall discharge 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 and degree which makes it appropriate for him to receive medical treatment; or
>
> (ii) that it is necessary for his health or safety or for the protection of other persons that he should receive such treatment; or
>
> (iia) that appropriate medical treatment is available for him;
>
> …

(1A) In determining whether the criterion in subsection (1)(c)(iii) above is met, the tribunal shall, in particular, consider, having regard to the patient's history of mental disorder and any other relevant factors, what risk there

would be of a deterioration of the patient's condition if he were to continue not to be detained in a hospital (as a result, for example, of his refusing or neglecting to receive the medical treatment he requires for his mental disorder).

…

(3) A tribunal may under subsection (1) above direct the discharge of a patient on a future date specified in the direction…"

"Power to discharge restricted patients

73.- (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.

…

(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"

"Applications and references concerning conditionally discharged restricted patients

75.- (1) Where a restricted patient has been conditionally discharged under section 42(2), 73 or 74 above and is subsequently recalled to hospital-

(a) the Secretary of State shall, within one month of the day on which the patient returns or is returned to hospital, refer his case to [the appropriate tribunal]; and

(b) section 70 above shall apply to the patient as if the relevant hospital order [, hospital direction] or transfer direction had been made on that day.

…"

"Visiting and examination of patients

76.- (1) For the purpose of advising whether an application to the appropriate tribunal should be made by or in respect of a patient who is liable to be detained or subject to guardianship under Part II of this Act or a community patient, or of furnishing information as to the condition of a patient for the purposes of such an application, any registered medical practitioner or approved clinician authorised by or on behalf of the patient or other person who is entitled to make or has made the application –

(a) may at any reasonable time visit the patient and examine him in private and

(b) may require the production of and inspect any records relating to the detention or treatment of the patient in any hospital or to any after-care services provided for the patient under section 117 below."

"Obstruction

129.- (1) Any person who without reasonable cause-

…

(b) refuses to allow the visiting, interviewing or examination of any person by a person authorised in that behalf by or under this Act [or to give access to any person to a person so authorised]; or

…

(d) otherwise obstructs any such person in the exercise of his functions, shall be guilty of an offence.

…

(3) Any person guilty of an offence under this section shall be liable on summary conviction to imprisonment for a term not exceeding three months or to a fine not exceeding level 4 on the standard scale or to both."

33. Proceedings in the First-tier Tribunal are governed by the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 (the **"FtT Rules"**), made pursuant to the Tribunals, Courts and Enforcement Act 2007 (the **"TCEA 2007"**). The FtT Rules provide, in so far as relevant to the issues in this appeal:

> **"Overriding objective and parties' obligation to co-operate with the Tribunal**
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> 2. – (1) The overriding objective of these Rules is to enable the Tribunal to deal with cases fairly and justly.
>
> (2) Dealing with a case fairly and justly includes-
>
> (a) dealing with the case in ways which are proportionate to the importance of the case, the complexity of the issues, the anticipated costs and the resources of the parties;
>
> (b) avoiding unnecessary formality and seeking flexibility in the proceedings;
>
> (c) ensuring, so far as practicable, that the parties are able to participate fully in the proceedings;
>
> (d) using any special expertise of the Tribunal effectively; and
>
> (e) avoiding delay, so far as compatible with proper consideration of the issues.
>
> (3) The Tribunal must seek to give effect to the overriding objective when it-
>
> (a) exercises any power under these Rules; or
>
> (b) interprets any rule or practice direction.
>
> (4) Parties must-
>
> (a) help the Tribunal to further the overriding objective; and
>
> (b) co-operate with the Tribunal generally."
>
> **"Case management powers**
>
> 5.— (1) Subject to the provisions of the 2007 Act and any other enactment, the Tribunal may regulate its own procedure.
>
> (2) The Tribunal may give a direction in relation to the conduct or disposal of proceedings at any time, including a direction amending, suspending or setting aside an earlier direction.
>
> (3) In particular, and without restricting the general powers in paragraphs (1) and (2), the Tribunal may-

(b) consolidate or hear together two or more sets of proceedings or parts of proceedings raising common issues, or treat a case as a lead case;"

…

(h) adjourn or postpone a hearing;

…"

"Withdrawal

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

(3) a party which started a mental health case by making a reference to the Tribunal under section 68, 71(2) or 75(1) of the Mental Health Act 1983 may not withdraw its case."

Discussion

34. A reference made by the Secretary of State under section 75(1)(a) MHA 1983 has two consequences:

a. first, the First-tier Tribunal gains jurisdiction, and has a duty to determine the reference using the section 73 MHA 1983 criteria;

b. second, section 70 MHA 1983 applies as if the hospital order had been made on the day of the recall (meaning that the patient isn't allowed to apply to the First-tier Tribunal himself until six months after the recall). Recall references also have a special character, because they may not be withdrawn and must proceed to hearing (see rule 17(3) of the FtT Rules.

35. After his recall, OO had a statutory and Convention right to an effective judicial determination of his right to liberty. In this context, 'effective' must equate to lawful (or free of material error).

36. Believing that the entire care team supported his conditional discharge, OO decided not to instruct an independent psychiatrist to provide evidence to the Tribunal. That was a perfectly reasonable position for him to take given the contents of the reports that had been produced by consultant forensic psychiatrist Dr Kottalgi (report dated 12 May 2022) and OO's then responsible clinician, Dr Padayatchi (report dated 9 September 2022), recommending conditional discharge. Generally, the courts discourage a proliferation of experts and reports, and indeed the overriding objective requires cases to be dealt with in ways that are proportionate (rule 2(2)(a) of the FtT Rules). No criticism can be made of OO's decision not to instruct an independent expert.

37. However, just because the members of the team caring for OO had previously indicated their support for his discharge doesn't mean they were bound to maintain that position: they were entitled to change their recommendations, whether due to a deterioration in OO's mental disorder (and attendant change in his risk profile), or because it is discovered that the aftercare that would be available to OO in the

community is less comprehensive than previously assumed, or simply because they changed their mind.

38. In this case there was no deterioration in OO's mental state, and there were no reports of significant incidents giving rise to concerns about OO's health or safety, or about the safety of other persons (as confirmed in paragraph [6] of the Tribunal's reasons). Rather, the change in position was prompted by OO's new responsible clinician, Dr Nyein, being influenced by the opinions of two other experts: Dr Brown (a consultant forensic psychiatrist in the West London Forensic Team) and Dr Baruah (another psychiatrist in the community forensic team).

39. On 20 November 2022 Dr Brown issued a report in connection with OO's Crown Court proceedings (**"Dr Brown's Report"**), which opined that OO was not suitable for a community placement.

40. This precipitated the issue of an addendum psychiatric report by Dr Nyein, which relied upon Dr Brown's Report and opposed OO's discharge. As explained above, there was a flurry of applications to postpone or adjourn the hearing of the reference in the light of the change in the responsible clinician's position, but these were all refused.

41. The very significant change in the responsible clinician's position so close to the hearing of the reference (Dr Nyein's addendum report was received by OO's representative only one working day prior to the hearing), coupled with the refusal of the applications for postponement or adjournment of the hearing, meant that OO was hindered in his ability to mount an effective challenge to the case for his continued detention.

42. There are two aspects to the challenge facing OO: first, the issue of "equality of arms" in terms of expert evidence, and second, the lack of opportunity to challenge the evidence of some of the experts upon whom the detaining authority (and the Tribunal) relied. I shall deal with these aspects in turn.

Equality of arms

43. The importance of the principle of *parity inter partes* in matters of forensic science is almost as old as modern science itself. This aspect of procedural fairness was given judicial recognition by Lord Mansfield CJ in *Folkes v Chadd* (1782) 3 Doug 157 at [159]:

> "in matters of science the reasoning of men of science can only be answered by men of science".

44. MHA 1983 also makes express provision for the exercise of a patient's right to independent medical advice in section 76 MHA 1983 (see paragraph [31] above), as well as providing in section 129 MHA 1983 for criminal sanctions for those who obstruct the exercise of those rights (see paragraph [31] above).

45. In *Matytsina v Russia* [2014] ECHR 334 the European Court of Human Rights considered this issue in the context of the Article 6 right to a fair trial, and concluded in similar terms:

> "…the Court agrees with the Government that the "equality of arms" principle enshrined in Article 6§1 does not require that the defence should have exactly the same powers as the prosecution when it comes to collecting evidence. The

> ways in which the defence and the prosecution may participate in the collection of evidence are often different… However, what is important is that those differences do not place the defence at a net disadvantage *vis-à-vis* the prosecution. The rules on taking evidence and producing it at the trial should not make it impossible for the defence to exercise the rights guaranteed by Article 6 of the Convention. *In Khodorkovskiy and Lebedev v Russia (no.2*), [nos. 11082/06 and 13772/05), §731, 25 July 2013] the Court stressed as follows:
>
> > "[I]t may be hard to challenge a report by an expert without the assistance of another expert in the relevant field. Thus, the mere right of the defence to ask the court to commission another expert examination does not suffice. To realise that right effectively the defence must have the same opportunity to introduce their own 'expert evidence'.""

46. In the context of MHA 1983 this principle has particular importance because the statutory criteria to continued detention of patients set out in section 72(1)(b) (see paragraph [31] above) relate to clinical matters: diagnosis, prognosis, nature and degree, necessity of medical treatment, and whether such treatment is available in the hospital where the patient is detained.

Opportunity to cross-examine witnesses relied upon

47. It is clear from the Tribunal's reasons that significant reliance was placed upon the evidence of Dr Brown and of Dr Baruah, both by the witnesses at the hearing who argued for OO's continued detention (Dr Nyein and Mr Solarin), as well as the Tribunal itself. Indeed, reference is made not only to "reliance" but also to "deference". In paragraph [11] of the Tribunal's reasons it is stated:

> "Dr Nyein relied on Dr Brown's report and deferred to her greater expertise."

48. Reliance was also placed on an email written by Dr Baruah to Dr Nyein on 7 November 2022. The only mention of Mr Solarin's evidence in the FtT Decision is a reference to his having "relied upon views expressed by Dr Baruah" (see paragraph [13] of the Tribunal's reasons).

49. However, neither Dr Brown nor Dr Baruah was present at the 29 November 2022 hearing.

50. Even putting to one side the question whether OO should have been given the opportunity to instruct an independent forensic psychiatrist so that he would enjoy "equality of arms" with the detaining authority, this raises the issue whether a hearing at which neither Dr Brown nor Dr Baruah were present and available for questioning gave OO an adequate opportunity to test the expert evidence that underpinned the decision to uphold his section.

51. Because Dr Nyein and Mr Solarin, the two witnesses who spoke in favour of continued detention, deferred to the evidence of other experts who were not present, the opportunity that the hearing gave for Mr Nicholas to probe their evidence was of limited value. What fairness required was for Mr Nicholas to have the opportunity to question Dr Brown and Dr Baruah, as their evidence underpinned the evidence of Dr Nyein and Mr Solarin. However, neither was made available. This meant OO was denied an effective opportunity to test the case for continued detention.

Conclusions on procedural fairness

52. Under rule 5 of the FtT Rules, the Tribunal had very broad case management powers, including a broad discretion as to how to determine applications for postponements and adjournments. Generally, the Upper Tribunal is slow to interfere with a tribunal's exercise of its discretion in such matters. However, such decisions can sometimes give rise to significant procedural unfairness, and in such circumstances intervention by the Upper Tribunal may be appropriate.

53. I am satisfied that this is such a case because the refusal of the applications to postpone or adjourn the hearing resulted in OO being denied the opportunity to seek to instruct a consultant forensic psychiatrist (a 'man/woman of science') whose opinion *may* have differed from the opinions of Dr Brown and Dr Baruah, and because it also denied him the opportunity to question those key witnesses. This meant that there was an imbalance in favour of the detaining authority, and this imbalance rendered the proceedings unfair.

Relief

54. OO is subject to two restricted hospital orders. Each of those restricted hospital orders brings a right to apply to the First-tier Tribunal for a review. OO has not exercised his right to apply to the First-tier Tribunal pending the outcome of this appeal.

55. Given OO's right to apply to the First-tier Tribunal for review of his section, this appeal against the determination of the Secretary of State's reference could be characterised as somewhat academic. However, the principle raised by the appeal is an important one. Because of the deficiencies identified above, OO was denied an effective judicial determination of his right to liberty following the 8th March 2022 recall which the MHA 1983 (and Article 6 of the Convention) requires. This may well have implications in respect of Article 5(4) of the Convention, because the right of appeal to the First-tier Tribunal forms part of a detained patient's network of effective access to the courts, which was what Keene LJ found made s.75(1) MHA 1983 compliant with Article 5(4) of the Convention in *Secretary of State for Justice v Rayner* [2008] EWCA Civ 176 (see paragraphs [45] and [46]).

56. OO has a right to apply to the FTT in relation to both the 2010 and the 2023 restricted hospital orders (the s.70(1)(a) 6-month period having now passed in both), but those rights to apply do not provide a remedy to an error of law in the decision that this appeal concerns. In *R (Citizens UK) v Secretary of State for the Home Department* [2018] EWCA Civ 1812; [2018] 4 WLR 123, Singh LJ rejected an approach that "assumes that fairness is not required at an earlier decision-making stage simply because fairness is required at a later decision-making stage":

> "In my view, in principle, a person is entitled to be treated fairly at all relevant decision-making stages" (per Singh LJ at [94].

57. Where a patient is subject to concurrent restricted hospital orders, and so has multiple rights to apply and/or have his case referred to the Tribunal, there is always a Gordian knot of potential procedural complications. But the First-tier Tribunal and the Secretary of State for Justice have the procedural tools to deal with anything that arises.

58. The First-tier Tribunal has a discretion to consolidate multiple sets of proceedings under r.5(3)(b) of the FtT Rules, and the Secretary of State has discretions in s.42(1) and (2) MHA to discharge a patient from liability to detention under a restricted hospital order, whether conditionally or absolutely.

59. It is unlikely that the First-tier Tribunal would end up making a decision in relation to only one of the two restricted hospital orders, but even if it did, and it decided that OO was entitled to discharge, the Secretary of State would have a discretion to discharge in relation to the other restriction order.

60. I presume that all those discretions will be exercised rationally and in accordance with OO's fundamental rights.

61. The appropriate remedy is set aside and remittal under s.12(2)(b)(i) of the TCEA 2007, which will result in OO having the hearing that the MHA 1983 requires him to have, albeit late.

Thomas Church
Judge of the Upper Tribunal

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