Neutral Citation Number:
[2025] UKUT 128 (AAC)

Appeal Nos. UA-2023-001364-HM
UA-2024-001271-HM

IN THE UPPER TRIBUNAL
ADMINISTRATIVE APPEALS CHAMBER

Between:

(1) KH
(2) AH

Appellants

- v -

(1) Nottinghamshire Healthcare NHS Foundation Trust
(2) Avon & Wiltshire Mental Health Partnership NHS Trust

Respondents

- v -

The Law Society of England and Wales

Interested Party

Before:	**Upper Tribunal Judge Church**
Hearing date(s):	10 February 2025
Mode of hearing:	Remote oral hearing by CVP

Representation:

First Appellant:	Roger Pezzani of counsel, instructed by Ms Amero of Bison Solicitors
Second Appellant:	Ollie Persey of counsel, instructed by Mr Nicholas of GN Law
Respondents:	Not represented
Interested Party:	Neil Allen of counsel, instructed by Ms Hobey-Hamash of Bindmans LLP and Ms Turner of The Law Society

UA-2023-001364-HM (KH's appeal) is on appeal from:

Tribunal:	First-tier Tribunal (HESC) (Mental Health)
Tribunal Case No:	MM/2023/03436
Tribunal Venue:	Herschel Prins Centre
Decision Date:	27 July 2023

UA-2024-001271-HM (AH's appeal) is on appeal from:

Tribunal:	First-tier Tribunal (HESC) (Mental Health)
Tribunal Case No:	MM/2024/11673
Tribunal Venue:	Fountain Way
Decision Date:	20 June 2024

RULE 14 Order

Rule 14(7) of the Tribunal Procedure (Upper Tribunal) Rules 2008 provides that information about mental health cases and the names of any persons concerned in such cases must not be made public unless the Upper Tribunal gives a direction to the contrary.

The Upper Tribunal DIRECTS that this decision, which does not refer to the patients by name, may be made public.

SUMMARY OF DECISION

MENTAL HEALTH (80); TRIBUNAL PRACTICE AND PROCEDURE (34) *(fair hearing 34.2; representatives 34.6)*

Judicial summary

These appeals are about what a mental health tribunal must do when faced with a patient for whom a representative has been appointed under rule 11(7)(b) but where:

a. there is conflicting evidence as to whether the patient has, since that appointment, regained capacity to appoint a representative, or

b. the patient objects to the representative acting in his or her best interests, and refuses to engage with the representative.

They raise issues of general application and importance about how a patient's rights to effective representation and to a fair trial must be balanced against the imperative of maximising the patient's meaningful participation in the proceedings and avoiding unnecessary delay.

The Upper Tribunal gives guidance to participants in proceedings before mental health tribunals on:

a. the proper approach to assessing mental capacity

b. the tests of capacity applicable to proceedings before the mental health tribunal

c. when mental capacity needs to be assessed

d. the implications of fluctuations in capacity for a rule 11(7)(b) appointment

e. the duties of the rule 11(7)(b) representative who considers the continuation of their appointment not to be in the patient's best interests or otherwise inappropriate.

It also gives guidance on what is required of a tribunal's reasons for them to be adequate.

Please note the Summary of Decision is included for the convenience of readers. It does not form part of the decision. The Decision and Reasons of the judge follow.

DECISION

The decision of the Upper Tribunal is to allow both appeals. The decisions of the First-tier Tribunal in both appeals involved errors of law.

Under Section 12(2)(a) and (b)(i) of the Tribunals, Courts and Enforcement Act 2007, I set the decision in appeal number UA-2023-01364-HM aside and remit the case to be reconsidered by a fresh tribunal in accordance with this decision.

Under Section 12(2)(a) of the Tribunals, Courts and Enforcement Act 2007, I record that the decision of the First-tier Tribunal in appeal number UA-2024-01271-HM involved an error of law, but I do not set the decision aside.

REASONS FOR DECISION

Introduction

1. Both appeals concern rule 11(7)(b) of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 (the **"HESC Rules"**). That rule permits a mental health tribunal to appoint a representative to represent an unrepresented patient who lacks relevant capacity if the Tribunal believes it is in the patient's best interests to be represented.

2. The appeals are about what a mental health tribunal must do when faced with a patient for whom a representative has been appointed under rule 11(7)(b) but where:

    a. there is conflicting evidence as to whether the patient has, since that appointment, regained capacity to appoint a representative, or

    b. the patient objects to the representative acting in his or her best interests, and refuses to engage with the representative.

3. In both cases, a rule 11(7)(b) legal representative had been appointed. In KH's case, the tribunal decided it was in his best interests for the appointment to continue, but KH refused to engage with the representative. In AH's case, the

tribunal decided to discontinue the appointment. In both cases, the tribunal proceeded to hear the application on the day.

4. These appeals are of importance not only to the appellants themselves: they raise issues of general application and importance about how a patient's rights to effective representation and to a fair trial must be balanced with the imperative of maximising the patient's meaningful participation in proceedings and avoiding unnecessary delay. Because they raise overlapping issues I agreed to a late application to hear them together.

5. Issues of mental capacity present patients, representatives and mental health tribunals with difficult challenges. When legal representation would be in a patient's best interests, but the patient becomes distressed at the prospect of that representation, their distress is often linked either to the very fact of their detention or to the mental disorder from which they suffer. These are the very same factors that make the patient vulnerable and in need of representation. A careful and sensitive approach is required by all involved.

6. Given the following matters, I decided it was appropriate to join The Law Society as an Interested Party:

    a. the nature of the issues raised being of general application;

    b. the fact that solicitors provide representation in most mental health tribunals;

    c. The Law Society's role as the representative body of solicitors in England and Wales;

    d. the fact that The Law Society maintains a Mental Health Accreditation Scheme; and

    e. the fact that The Law Society has issued two sets of relevant guidance for practitioners ('Representation before Mental Health Tribunals' (23 February 2024) and 'Meeting the needs of vulnerable clients' (29 November 2022).

7. I directed The Law Society to make submissions on the professional obligations of a legal representative who, having been appointed under rule 11(7)(b) of the

HESC Rules, comes to believe that the patient has relevant capacity (as in AH's case) or who believes that, notwithstanding the patient's lack of relevant capacity, continued representation under rule 11(7)(b) was either not in his best interests or, while being in his best interests, should not continue. I also invited it to comment on any other issues of general importance raised by the appeals which it considered appropriate.

8. The Law Society took a neutral position on the merits of the appeals, but their counsel settled helpful and considered submissions on the issues I had directed them to address, as well as other issues of general importance about the proper tests to be applied.

9. I am hugely grateful to The Law Society and their counsel, Mr Allen, as well as to Mr Pezzani and Mr Persey (counsel to KH and AH, respectively) and those instructing them for the valuable assistance they have provided in exploring these important issues with a view to the Upper Tribunal giving guidance to those who find themselves involved in proceedings before the mental health tribunal where issues of mental capacity are relevant.

The Legal framework

The Mental Health Act 1983

10. The Mental Health Act 1983 (the **"Mental Health Act"**) includes powers for the compulsory detention of patients who suffer from mental disorder (or, in the case of patients detained under section 2, who are suspected to suffer from mental disorder). Those powers are tightly circumscribed because, generally speaking, people are entitled to enjoy their liberty unless they have been found to have committed a crime for which they have been sentenced to detention by a competent court (see Article 5(4) of the Convention for the Protection of Human Rights and Fundamental Freedoms (the **"Convention"**), set out below).

11. To ensure that patients' Article 5 rights are protected, the Mental Health Act provides a framework for the periodic review of the lawfulness of mental health detention. A detained patient has rights in various time periods to apply for a mental health tribunal to consider whether the conditions to their continued detention are satisfied at the time of review. The Mental Health Act also provides for references to be made to a tribunal to ensure that the lawfulness of a patient's

detention is reviewed periodically, even if the patient hasn't exercised their right to make an application. Both appeals before me are in respect of references to a tribunal.

12. I do not set out these provisions of the Mental Health Act, as neither of the appeals before me turns on them.

The Mental Capacity Act 2005

13. The Mental Capacity Act 2005 (the **"Mental Capacity Act"**) concerns the mental capacity to make decisions, the circumstances in which decisions may be made for those who lack relevant capacity, and the rights of those who lack capacity.

14. Section 1 sets out some broad principles:

> **"The principles**
>
> **1.**- (1) The following principles apply for the purposes of this Act.
>
> (2) A person must be assumed to have capacity unless it is established that he lacks capacity.
>
> (3) A person is not to be treated as unable to make a decision unless all practical steps to help him to do so have been taken without success.
>
> (4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
>
> (5) An act done, or decision made under this Act for or on behalf of a person who lacks capacity must be done or made in his best interests.
>
> (6) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that I less restrictive of the person's right and freedom of action."

15. Lack of capacity is explained in section 2 of the Mental Capacity Act as follows:

> **"People who lack capacity**
>
> **2.**- (1) For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.
>
> (2) It does not matter whether the impairment or disturbance is permanent or temporary.
>
> (3) A lack of capacity cannot be established merely by reference to-

(a) a person's age or appearance, or

(b) a condition of his, or an aspect of his behaviour which might lead others to make unjustified assumptions about his capacity.

(4) In proceedings under this Act or any other enactment, any question whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities.

(5) No power which a person ("D") may exercise under this Act-

(a) in relation to a person who lacks capacity, or

(b) where D reasonably thinks that a person lacks capacity, is exercisable in relation to a person under 16.

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

16. Section 3 of the Mental Capacity Act explains when a person is to be considered unable to make a decision for him or herself. It provides:

"Inability to make decisions

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

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

(b) to retain that information,

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

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

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

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

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

(a) deciding one way or another, or

(b) failing to make the decision."

The Convention

17. Article 5 of the Convention provides for an individual's right to liberty and security. Paragraph 4 of Article 5 provides:

> "Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful."

18. Article 6 of the Convention provides for an individual's right to a fair trial. Paragraph 1 provides:

> "In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law."

The HESC Rules

19. The HESC Rules set out the rules with which the Health, Education and Social Care Chamber of the First-tier Tribunal (which includes the mental health tribunal) and the parties to proceedings before it, must comply. For the convenience of those unfamiliar with them, I set out below the text of the provisions most relevant to these appeals.

20. Rule 2 of the HESC Rules sets out the 'overriding objective' of the HESC Rules. It provides:

> **"Overriding objective and parties' obligation to co-operate with the Tribunal**
>
> **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."

21. Rules 5 of the HESC Rules gives the First-tier Tribunal extensive case management powers. It provides:

"Case management powers

5.- (1) Subject to the provisions of the [Tribunals, Courts and Enforcement Act 2007] 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-

[...]

(d) permit or require a party or another person to provide documents, information or submissions to the Tribunal or a party;

(e) deal with an issue in the proceedings as a preliminary issue;

(f) hold a hearing to consider any matter, including a case management issue;

(g) decide the form of any hearing;

(h) adjourn or postpone a hearing;

[...]"

22. Rule 11 of the HESC Rules deals with the appointment of representatives. It provides, so far as relevant to the circumstances of this case:

"Representatives

11. …

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

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

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

23. Rule 34 of the HESC Rules deals with when a pre-hearing examination is required. It provides:

"Medical examination of the patient

34.- (1) Where paragraph (2) applies, an appropriate member of the Tribunal must, so far as practicable, examine the patient in order to form an opinion of the patient's mental condition, and may do so in private.

(2) This paragraph applies-

(a) in proceedings under section 66(1)(a) of the Mental Health Act 1983 (application in respect of an admission for assessment) ,unless the Tribunal is satisfied that the patient does not want such an examination;

(b) in any other case, if the patient or the patient's representative has informed the Tribunal in writing, not less than 14 days before the hearing, that –

(i) the patient; or

(ii) if the patient lacks the capacity to make such a decision, the patient's representative,

wishes there to be such an examination; or

(c) if the Tribunal has directed that there be such an examination."

KH's appeal: a brief factual background

24. KH is a patient detained under Sections 37 (a hospital order) and 41 (a restriction order) of the Mental Health Act. Psychiatrists have diagnosed KH with paranoid schizophrenia and paranoid personality disorder, but KH disputes both diagnoses and says he has no mental disorder.

25. KH was made subject to his restricted hospital order in January 2000, having been convicted of manslaughter and two counts of attempted murder. He was conditionally discharged in September 2019 and was recalled in September 2020. He was discharged again in November 2022, and was recalled again on 6 February 2023.

26. Following his most recent recall to hospital, KH's case was referred to the First-tier Tribunal on 7 February 2023.

27. Mr Lawlor, a solicitor, was appointed by the First-tier Tribunal under rule 11(7)(b) of the HESC Rules to act in KH's best interests. Before the date on which the reference was due to be heard, Mr Lawlor made an application to the First-tier Tribunal to withdraw from his rule 11(7)(b) appointment on two grounds:

    a. he assessed KH as having relevant capacity; and

    b. KH objected to being represented by Mr Lawlor.

28. That application was refused in a case management decision made prior to the hearing date. Reasons were given for that decision, but I do not analyse them here because this decision is not under appeal.

29. On 27 July 2023 a three-member panel of the First-tier Tribunal convened at Phoenix Ward at the Hershel Prins Centre (KH's **"Tribunal"**) to review KH's detention pursuant to the reference.

30. At the beginning of the hearing, KH's Tribunal reassessed KH's capacity based on evidence from KH's responsible clinician, from the Tribunal's medical member, and from Mr Lawlor.

31. The Tribunal decided that KH "did not have capacity to deal with the hearing" and that it remained in his best interests to be represented. It decided Mr Lawlor's appointment should continue, and the hearing of the reference should proceed.

32. The hearing proceeded. KH argued for discharge. His case was partly one of principle (he denied having any mental disorder), partly one of pragmatism (he acquiesced in medical treatment on the basis that, even though he had no mental disorder, treatment would likely be forced on him if he didn't agree to it), and partly one of fact (he disputed certain findings made about the circumstances of his recall and about his compliance with depot medication in the community).

33. Despite what KH said, his Tribunal ultimately found all the statutory criteria to continued detention to be satisfied and upheld his section.

34. KH was unhappy with that outcome and made a lengthy and detailed application for permission to appeal. He submitted extensive evidence which he said supported his case. Permission was refused by the First-tier Tribunal on 16 August 2023.

35. KH exercised his right to apply to the Upper Tribunal for permission to appeal, which came before me at an oral hearing. I granted permission to appeal and directed an oral hearing of the substantive appeal. I also directed that The Law Society be joined as an Interested Party, for the reasons explained in paragraph 6 above.

KH's appeal: the Tribunal's decision

36. The key passage in the Tribunal's decision in KH's case, for the purposes of this appeal, is under the heading *'Jurisdiction, Preliminary and Procedural Matters'* (see pages 43-44 of the appeal bundle for KH's appeal):

> "Jurisdiction, Preliminary and Procedural Matters
>
> 1. The tribunal is satisfied that it has jurisdiction to consider this reference.
>
> 2. This case had a protracted history and had been adjourned a number of times. The patient had previously indicated that he wished to represent himself and did not wish to be legally represented, Nevertheless, it was apparent from previous directions that a legal representative had been appointed under Rule 11(7)(b) and that representative had previously applied to withdraw as firstly, it was advanced by them that the patient was in fact capacitous, and secondly, the patient would not engage with them. That application had been refused.
>
> 3. We decided that we needed to establish whether the patient had capacity to represent himself in the proceedings on the day of the hearing as a starting point. In making our decision, we had in mind Dr Swamy's (Responsible Clinician) view that […] although the patient's capacity fluctuated, he did not have capacity. We also had the opinion of the Tribunal Doctor. The Tribunal Doctor had attended on the patient on the morning of the hearing to carry out a pre-hearing examination and within an hour of the hearing commencing. It was also the Tribunal Doctor[']s opinion that the patient did not have capacity. As such, we concluded that the patient did not have capacity to deal with the hearing and that it was in the patient's interests

for the patient to be represented. We therefore informed the legal representative, Mr Lawlor, that their role continued under Rule 11(7)(b).

4. At the commencement of the hearing, the patient was informed of our decision, that […] Mr Lawlor remained appointed, that it would be Mr Lawlor who was permitted to question the professional witnesses and it was Mr Lawlor's role to act in his best interests. The patient was not happy with our decision. Prior to the cross-examination of the first professional witness, the patient was given a break to put forward his concerns to Mr Lawlor, however, although the patient took the break, it was our understanding that the patient refused to engage with Mr Lawlor. As such, we proceeded with the hearing."

AH's appeal: a brief factual background

37. AH was also detained under sections 37 and 41 of the Mental Health Act, having been made subject to a hospital order with a restriction order. On 20 June 2024 a three-member panel of the First-tier Tribunal convened to hear a reference in relation to AH's section at Fountain Way (AH's **"Tribunal"**). It is agreed that at the date of his hearing before the Tribunal AH lacked capacity to make the decisions required of him in the context of his involvement in the proceedings, including capacity to appoint a representative (I'll refer to this as having capacity **"in material domains"**).

38. A solicitor had been appointed to act in AH's best interests under rule 11(7)(b) but at the time of his hearing before the Tribunal AH was firmly of the view that he should not be represented.

39. The Tribunal decided to terminate the rule 11(7)(b) appointment on the basis of AH's clear wish not to be represented and AH's responsible clinician's opinion that having legal representation forced upon him would cause AH distress. The Tribunal proceeded with the hearing of the reference and decided to confirm AH's section.

40. AH subsequently regained capacity in material domains and instructed Mr Nicholas of Guile Nicholas, Solicitors to appeal the Tribunal's decision. In his application for permission to appeal to the Upper Tribunal, he argued that the Tribunal had erred in law by failing to consider two relevant matters:

    a. whether AH might regain capacity in material domains with support; and

b. whether adjourning the hearing might lead to AH regaining capacity or might facilitate his participation in the decision-making regarding representation.

41. It was argued that, since these two matters were mandatory considerations when making a best interests decision under the Mental Capacity Act, they were at least relevant considerations for AH's Tribunal when balancing AH's Article 5 right to a swift and effective review of his detention with his Article 6 right to a fair hearing.

42. AH has since been conditionally discharged from detention under the Mental Health Act.

AH's appeal: the Tribunal's decision

43. The relevant passages of the Tribunal's decision, insofar as relevant to the issues in this appeal, read as follows:

> "Patient: Not represented (Mr Markham was present initially but the Patient very firmly did not wish to be represented and the Tribunal decided it would not be in his best interests to be represented. Accordingly the Rule 11(7)(b) appointment was rescinded and Mr Markham withdrew."
>
> […]
>
> "As set out above, Mr Markham was present initially but the Patient very firmly did not wish to be represented. Dr McIntyre confirmed that in his view the patient did not have capacity as per the MH3. He also lent support to the notion that it would not assist [AH] to have representation essentially forced upon him. [AH] would be more likely to be unable to cope with the hearing with a solicitor present. Mr Markham said he agreed and he was happy to withdraw. The Tribunal decided it would not be in [AH]'s interests or in the interests of justice for [AH] to have a representative appointed under Rule 11(7)(b) and therefore the Rule 11(7)(b) appointment was rescinded and Mr Markham withdrew."

Analysis

<u>The proper approach to assessing mental capacity</u>

44. The proper approach to assessing mental capacity is established by the common law and confirmed by the Mental Capacity Act (see *Dunhill v Burgin (Nos 1 and 2)* [2014] UKSC 18, [2014] 1 WLR 933 at §13).

45. When assessing a person's capacity to make a decision, the assessor must apply the three main principles set out in section 1 of the Mental Capacity Act:

    a. assume capacity unless its absence has been established;

    b. refrain from assessing a person as lacking capacity to make a decision unless all practical steps have been taken (without success) to help them to do so; and

    c. refrain from assessing a person as lacking capacity just because they make decisions that are unwise.

The tests of capacity applicable to proceedings before the mental health tribunal

46. The Mental Capacity Act takes a decision-specific approach to capacity. In *YA v Central and North West London NHS Trust* [2015] UKUT 37 (***"YA"***) Charles J, then President of the Upper Tribunal (Administrative Appeals Chamber), highlighted the importance of the capacity assessor identifying with precision what the subject of the capacity assessment was (see §(6) of the 'Overview' section, and §34 of *YA*):

> "The identification of the specific decision, issue or activity that is the subject of the capacity assessment is important because it identifies the matters that have to be sufficiently understood, taken into account and weighed by the decision maker."

47. As I explained in *IN v St Andrews Healthcare and others* [2024] UKUT 411 (AAC) (***"IN"***) at §60, there are three principal capacity matters that are relevant to patients involved in mental health tribunal proceedings:

    a. the initial decision of whether to make an application to the tribunal;

    b. once an application or referral has been made, the decision whether to appoint a representative, or to conduct their own case; and

    c. conducting the proceedings, whether in person or through a representative.

48. The first matter was addressed in *VS v St Andrew's Healthcare* [2018] UKUT 250 (AAC) at §19 and in *SM v Livewell Southwest CC* [2020] UKUT 191 (AAC) at

§77(e). Since both these cases proceeded by way of reference, I need say no more about that matter.

49. In respect of the second matter, pursuant to rule 11(1) of the HESC Rules, a relevantly capacitous patient "may appoint a representative (whether a legal representative or not) to represent that party in the proceedings."

50. Rule 11(7) provides for the situation where a patient has not appointed a representative.

51. The power to appoint a representative under rule 11(7) is discretionary ("the Tribunal *may*", not "shall" or "must"). Whenever a tribunal considers exercising its discretion under rule 11(7) it must ask itself three questions:

    a. whether the patient lacks capacity to appoint a representative (the first limb of rule 11(7)(b));

    b. the second question depends on the answer to the first question in a. above:

        i. if the answer to a. is "yes", it must then ask whether it is in the patient's best interests to be represented (the second limb of rule 11(7)(b)).

        ii. if the answer is "no", then the tribunal must consider instead whether to make an appointment under rule 11(7)(a), which is available only if the patient has stated that they do not wish to conduct their own case or they wish to be represented; and

    c. whether the discretion should be exercised in favour of the appointment (the first sentence in rule 11(7)).

52. In *YA* Charles J considered the question that had to be answered in terms of capacity for the power to make an appointment under rule 11(7)(b) to be triggered. That rule refers to a person lacking capacity "to appoint" a representative (see paragraph 51 a. above), and makes no reference to the patient's capacity to conduct the proceedings. However, the Upper Tribunal in *YA* explained that capacity to appoint a representative and capacity to conduct proceedings were "inextricably linked". It said at §(7) of its 'Overview':

> "An assessment of a person's capacity to appoint a representative must involve an assessment of their capacity to decide whether or not to appoint one, and it is this choice that identifies the specific decision that is the subject of the capacity assessment set as the trigger to the power conferred by in Rule 11(7)(b). To have the capacity to make that choice the decision maker has to be able to sufficiently understand, retain, use and weigh the reasons for and against the rival decisions and thus their advantages, disadvantages and consequences. So to have capacity to appoint a representative a patient needs to have more than only an understanding that they can make an application to a mental health review tribunal or have someone else make it for them, and thus the limited capacity referred to in *R(H) v SSH* [2006] 1 AC 441."

53. Charles J said that, in practice, the distinction between these two aspects of capacity "narrows" and can be "theoretical rather than real" (see §57-60). Since a decision whether to appoint a representative requires some understanding of the consequences of not appointing one, the relevant person's capacity to conduct the proceedings for themselves is also relevant.

54. When assessing capacity to appoint a representative (and to conduct proceedings), the nature of the proceedings and the demands they make on participants must be considered. Macdonald J observed as follows in *TB v KB and LH* [2019] EWCOP 14 at §29:

> "I accept Dr Barker's characterisation of legal proceedings as not being simply a question of providing instruction to a lawyer and then sitting back and observing the litigation, but rather a dynamic transactional process, both prior to and in court, with information to be recalled, instructions to be given, advice to be received and decisions to be taken, potentially on a number of occasions over the span of the proceedings as they develop."

55. "Capacity to appoint a representative" may, therefore, include "capacity to conduct proceedings". Otherwise, there would be no mechanism for appointing a representative for a person who was judged to have capacity to make a decision about whether to appoint a representative, but to lack capacity to conduct the proceedings. This would run counter to the principles of procedural fairness and could result in a breach of the patient's Article 5 right not to be deprived of their liberty in an arbitrary manner. The Tribunal Procedure Committee may wish to consider amending the HESC Rules to make this explicit.

When to assess capacity

56. Even if the tribunal representative possesses evidence suggesting that the patient lacks capacity to conduct the proceedings, the tribunal representative has a duty to satisfy him or herself as to the client patient's capacity to make relevant decisions. Because capacity is decision specific, and because a patient's capacity may fluctuate, the duty to assess the client's capacity is necessarily an ongoing one.

57. The Tribunal must decide the capacity issue at an appropriate time. That may be possible at an early case management stage, for example where it has long been established that the patient lacks the requisite capacity, so the issue is unlikely to be controversial.

58. However, the Tribunal must keep capacity under review throughout the proceedings in the same way as the representative must do (see *YA* at §§32-34). This analysis applies whether the concern is that the patient has lost capacity or has regained it.

59. A decision may also be required to be made on the day of the hearing, for example where the patient's capacity is liable to fluctuation, or where the impact of the appointment emerges as an issue.

60. The Tribunal must address its determination of the capacity issue in an orderly manner. As well as the requirement for clear (i.e. adequate and intelligible) reasons, the Tribunal must carry out its assessment of capacity in compliance with section 3(2) of the Mental Capacity Act. This includes taking all practicable steps to help the patient to understand the decision required of him or her (including "using simple language, visual aids or any other means") before the capacity assessor arrives at a decision about capacity. This duty applies not only to the patient's representative, but to anyone involved in assessing capacity, including the Tribunal and the patient's responsible clinician.

Implications for a rule 11(7)(b) appointment of fluctuations in capacity

61. If a representative has been appointed under rule 11(7)(b) on the basis that the patient lacks capacity to appoint a representative, the patient's capacity may yet fluctuate. If it does, the appointment continues unless and until the representative

is discharged from the appointment by the Tribunal. This process operates in the same way that an appointment as a litigation friend for a protected party continues under the Civil Procedure Rules (see CPR rule 21.9(2)). This may mean that they continue to act even where, at times, the patient could be considered to have a sufficient level of capacity to conduct the proceedings. Where this occurs, if the patient has regained sufficient capacity to allow him or her to conduct the proceedings in person, the representative should apply to the Tribunal for his or her rule 11(7)(b) appointment to be discharged. If the Tribunal order this, the patient may or may not decide to appoint that representative, or another representative, to act on his or her instructions.

62. Where a person has fluctuating capacity, subject to case management issues, it may be possible to delay a relevant decision until that person has regained capacity (see the Mental Capacity Act Code of Practice, at §4.27. Inevitably, there is a tension between this approach and the "snapshot" nature of the Tribunal's review of the statutory criteria, where hearings are required to take place according to specific timetables and where the requirements of Article 5(4) of the Convention are in play.

<u>The duties of the representative</u>

63. If the patient asserts that they have capacity for the purposes of rule 11, or if a rule 11(7)(b) representative considers, on meeting the patient (whether in person or remotely), or having read communications from them, that the patient may have relevant capacity, the representative should:

    a. review the MH3 for (if completed) and request a copy of the MH3 in order to review it (if not provided);

    b. take steps to speak to the patient directly to form a view as to their capacity;

    c. consult relevant sources of information about the patient's capacity including progress or case notes held by the detaining authority, an Independent Mental Health Advocate (IMHA) appointed for the patient or relevant family members or carers;

    d. decide whether there is information about the proceedings which the patient should be given, either orally or in writing, to support the patient's decision-making;

e. identify any other steps that may be needed by way of support for the patient to enable them to make a capacitous decision (for example, the form and format of the proceedings, and communication aids);

f. raise the issue of the patient's capacity with the Tribunal; and

g. if the representative considers the patient has capacity and the patient does not wish to instruct the representative, apply to be discharged as the patient's representative.

64. Once tribunal proceedings have been commenced, an appointed representative may submit an application to the tribunal office outlining any concerns they may have about the patient's capacity. They may also seek directions for the filing of evidence on capacity from the patient's responsible clinician, or indeed other members of the treating team (as to which see paragraph 73 and following below). Alternatively, they may use Legal Aid to obtain an independent expert's capacity assessment.

65. If, having received such evidence, the representative considers that the patient lacks capacity to conduct the ongoing proceedings, they will be subject to the obligations set out by Charles J in *YA* at §15. These obligations apply whether or not the representative has been appointed under rule 11(7)(b)):

> "i. So far as is practicable, do what a competent legal representative would do for a patient who has capacity to instruct him to represent him in the proceedings and thus for example (a) read the available material and seek such other relevant material as is likely to be or should be available, (b) discuss the proceedings with the patient and in so doing take all practicable steps to explain to the patient the issues, the nature of the proceedings, the possible results and what the legal representative proposes to do;
>
> ii. Seek to ascertain the views, wishes, feelings, beliefs and values of the patient;
>
> iii. Identify where, and the extent to which, there is disagreement between the patient and the legal representative;
>
> iv. Form a view on whether the patient has the capacity to give instructions on all the relevant factors to the decisions that found the disagreement(s);

v. If the legal representative considers that the patient has capacity on all those factors and so to instruct the representative on the areas of disagreement the legal representative must follow those instructions or seek a discharge of his appointment.

vi. If the legal representative considers that the patient does not have or may not have capacity on all those issues, and the disagreements or other problems do not cause him to seek a discharge of his appointment, the legal representative should inform the patient and the tribunal that he intends to act as the patient's appointed representative in the following way:

- he will provide the tribunal with an account of the patient's views, wishes, feelings, beliefs and values (including the fact but not the detail of any wish that the legal representative should act in a different way to the way in which he proposes to act, or should be discharged);

- he will invite the tribunal to hear evidence from the patient and/or to allow the patient to address the tribunal (issues on competence to give evidence are in my view unlikely to arise but if they did they should be addressed before the tribunal);

- he will draw the tribunal's attention to such matters and advance such arguments as he properly can in support of the patient's expressed views, wishes, feelings, beliefs and values, and;

- he will not advance any other arguments."

66. Unless there is a compelling reason not to, the representative should discuss with the patient both the evidence and any additional evidence and/or case management directions that might be sought. This should include an explanation as to the implications for the patient's application/reference (for example, the implications of an application for an adjournment). If the patient is content to proceed, the representative may make an application to be appointed as their rule 11(7)(b) representative. The representative is not, however, required to take this step. If the patient expresses distress at, or distrust of, the representative, it is open to the representative to make an application in advance of the hearing to be removed from the record.

67. If there is insufficient time to take the steps described above, the representative may appear before the Tribunal and apply for an adjournment and/or seek additional case management directions. Assessing and determining decision-

making capacity is not the sole province of medical experts (as to which see below at paragraph 73 and following paragraphs). One option open to the representative, however, is to request that the Tribunal medical member (if suitably trained in the Mental Capacity Act) assess the patient's capacity as part of the pre-hearing examination. This may require a brief adjournment and/or the re-listing of the hearing, for example if it is listed as a remote hearing and if the capacity assessment cannot properly be conducted remotely. The Tribunal has broad case management powers under the HESC Rules that it can draw upon to allow it to deal with cases fairly and justly.

The capacity assessment

68. The Mental Capacity Act places the burden of proof on the person asserting a lack of capacity. Where capacity arises as an issue before the Tribunal, it must be determined by the Tribunal on the balance of probabilities (section 2(4) Mental Capacity Act), subject to the presumption of capacity under section 1 of the Mental Capacity Act.

69. As Charles J observed in *YA* at §114: "it is important to remember that the decision on capacity is one for the tribunal and not the medical member".

70. To ensure compliance with Article 5(4) of the Convention, and to avoid the risk of bias, the tribunal medical member should ensure that she or he follows the *YA* guidance (at §58) as to the factors that a patient is likely to have to be able to understand, retain, use and weigh, when conducting the assessment. The patient should also be informed of the purpose of the assessment. See *London Borough of Wandsworth v M & Ors (Rev 2)* [2017] EWHC 2435 (Fam):

> "It seems to me that a prerequisite to evaluation of a person's capacity on any specific issue is at very least that they have explained to them the purposes and extent of the assessment itself" (per Hayden J at §49).

71. Charles J explained the need for the parties to be made aware of the medical member's views and to have the opportunity to address them:

> "Those involved must be informed of the views of the medical member and the reasons for them and thereby be given the opportunity to address them. This is a basic requirement of a fair procedure namely that the parties must know the case they have to meet and so matters that the tribunal will or may be giving weight to" (per Charles J in *YA* at §114).

72. Whether or not there has been a pre-hearing examination, where capacity is in issue the Tribunal should hear evidence from the responsible clinician, whom the legal representative should have the opportunity to question.

73. Indeed, the Tribunal's decision as to capacity should take into account all relevant evidence. It should not be assumed that a psychiatrist is necessarily any better placed to assess the patient's capacity than an Approved Mental Health Professional (AMHP) or a care co-ordinator (who is often an experienced psychiatric nurse or social worker), whose views may help the Tribunal make a holistic assessment. Those with a social care background may well be more experienced in applying the Mental Capacity Act test than many psychiatrists. For the same reason, it may well be that the tribunal specialist member is as well equipped to assess the patient's capacity as the Tribunal medical member.

74. There may be particular value in the Tribunal seeking the evidence of witnesses who have known the patient for a sustained period of time. Such evidence may well be more reliable than a snapshot taken on the day of the hearing (especially on matters such as fluctuation).

75. There will typically be a wealth of diverse expertise available at a Tribunal hearing, as there will typically be multiple psychiatrists, social care experts and lawyers present. Not all of them will necessarily be suitably trained or experienced in the application of the Mental Capacity Act, but at least some of them probably will. It will typically be the case, therefore, that the panel will be able to form a view as to the patient's capacity based on the "existing or immediately available evidence" (*YA* per Charles J at §112).

76. Should the Tribunal be unable to form that view, the HESC Rules give it a wide range of case management powers including directing further evidence, including from the responsible clinician or indeed a jointly appointed expert. However, since there is no provision for prior approval by the Legal Aid Agency of the cost of such an independent expert report, this approach presents considerable practical difficulties. Given, however, the wealth of evidence that is generally available to the Tribunal, it is unlikely that an independent expert report would be needed in many cases.

The duties of the rule 11(7)(b) representative who considers the continuation of their appointment not to be in the patient's best interests or otherwise inappropriate

77. Rule 11(7)(b) provides that a representative can be appointed if "the Tribunal believes that it is in the patient's best interests for the patient to be represented." Article 5(4) requires that the patient has the opportunity to be heard in person or though some form of representation. They should, unless there are special circumstances, receive legal assistance in the proceedings (see *MS v Croatia (No 2)* [2015] ECHR 196 at §153, *MH v United Kingdom* [2013] ECHR 1008 at §77c) and *RP v Nottingham City Council* [2008] EWCA Civ 462 at §115, per Wall LJ: "…the question of litigation capacity is one of considerable importance. When a person is treated as a protected person (previously a patient), he or she is thereby deprived of civil rights, in particular his right to sue or defend in his or her own name. These are important rights, long cherished by English law and now safeguarded by ECHR").

78. Charles J identified the considerations likely to be relevant to a decision whether the appointment of a legal representative is in a patient's best interests in *YA* at §119:

> "i. the underlying purpose and importance of the review and so the need to fairly and thoroughly assess the reason for the detention;
>
> ii. the vulnerability of the person who is its subject and what is at stake for that person (i.e. a continuation of a detention for an identified purpose);
>
> iii. the need for flexibility and appropriate speed;
>
> iv. whether, without representation (but with all other available assistance and the prospect of further reviews), the patient will practically and effectively be able to conduct their case and if not whether nonetheless
>
> v the tribunal is likely to be properly and sufficiently informed of the competing factors relating to the case before it and so be able to carry out an effective review. (As to this the tribunal should when deciding the case review this prediction).
>
> […] (a) the nature and degree of the objections and of the distress caused to a patient if his or her wishes are not followed,
>
> (b) the likely impact of that distress on his or her well being generally and

(c) the prospects that if a legal representative is appointed or not discharged that legal representative will seek a discharge of the appointment."

79. In its submission The Law Society acknowledged that there may be circumstances in which the appointment of a representative is not in the best interests of the patient, even though the patient lacks capacity to conduct the proceedings. It referred to its Practice Note on representation, which provides examples of circumstances in which a rule 11(7)(b) representative might seek a discharge of an appointment:

"This may be appropriate where:

- Attempting to represent the client would cause them distress or interfere with their ability to participate in proceedings
- The client's hostility is such that you cannot fulfil your professional obligations to them
- Continuing to attempt to represent the client puts your safety at risk and the risk cannot be managed using local policies at the unit where the client is detained."

80. I endorse The Law Society's position on this. In principle, a patient would benefit from being represented at a Tribunal hearing. In practice, however, if the patient has no trust in a representative imposed on him or her by the Tribunal and isn't willing to co-operate or engage with the representative, the theoretical advantages of representation will clearly not be realised. The situation risks resulting in a representative unable to represent and a patient who is unable to participate. That is inimical to the objective of rule 11(7)(b), and inimical to the overriding objective of the Tribunal.

81. If the representative considers that their continued appointment is not in the best interests of the patient, they should make submissions to the Tribunal, identifying their reasons why. If, conversely, the representative considers that their appointment is in the patient's best interests, despite the patient's objecting to it, the representative should set out why they take that view and also set out the patient's reasons for taking the contrary view.

82. In any case where a Tribunal is making a determination of capacity to appoint a representative or to conduct proceedings, or is deciding whether the continued appointment of a representative is in the best interests of an incapacitous patient, it must give clear reasons for what it decides. These should address each of the

three preconditional decisions required for exercise of the rule 11(7)(b) discretion identified in paragraph 51 above.

Analysis of KH's appeal

83. KH's capacity had been assessed on multiple occasions in the run up to his hearing before the Tribunal. Dr Swamy, KH's responsible clinician, assessed him to have capacity when he was assessed in May, but not to have capacity when he was assessed again in June. Mr Lawlor (KH's rule 11(7)(b) appointed representative) assessed KH to have capacity in July.

84. On the day of the hearing of KH's reference the Tribunal decided, rightly, that it needed to assess capacity afresh.

The evidence on capacity

85. KH's Tribunal recorded in its decision notice that it had the following evidence:

    a. Mr Lawlor's opinion that KH was "in fact capacitous" (§2 of the decision notice for the Tribunal's decision in KH's appeal);

    b. Dr Swamy's view that KH "did not have capacity", although his "capacity fluctuated" (§3); and

    c. the Tribunal medical member's opinion that KH "did not have capacity to deal with the hearing" (§3).

86. In the case of a., it isn't entirely clear whether the Tribunal was reporting what Mr Lawlor had said about KH's capacity on 10th July 2023, or whether it was reporting an updated assessment by Mr Lawlor of KH's capacity as at the date of the hearing. Nor is the reported view of KH's capacity taken by Dr Swamy clearly anchored in time: was the reference to "Dr Swamy's view" a reference to the view set out in the MH3 form dated 13 June 2023 (and therefore speaking to KH's capacity as at that date? Or was it based on Dr Swamy's oral evidence at the hearing? If the latter, was it based on a fresh assessment of capacity as at the morning of the hearing, or an earlier assessment on the ward?

87. The only report as to capacity that was clearly anchored in time was the Tribunal medical member's assessment that he "did not have capacity", which was based

on an assessment carried out during the pre-hearing examination on the morning of the hearing. Unfortunately, the Tribunal's decision does not give any reasons for the medical member's opinion.

88. The most detailed assessment of capacity in the bundle is that set out in Dr Swamy's MH3 of 13 June 2023. As well as ticking the relevant "Yes" and "No" boxes set out in the form, Dr Swamy provided a considered narrative:

> "On balance, my view is that this case is very nuanced as [KH] appears to have a reasonable understanding of the tribunal and the procedural powers, but has also demonstrated, this can fluctuate with him becoming anxious, hostile and agitated at times which then negatively impacts his ability to understand, weigh and use the relevant information, the rival decisions that the Tribunal can make, their advantages, disadvantages and consequences. It is likely that his anxiety levels leading up to the tribunal could well impede his understanding of the relevant information further.
>
> On balance, my view is that due to the deterioration in his mental state as the Tribunal approaches, [KH] now lacks the capacity to appoint a solicitor or to present his case effectively himself. In my view he will become even more likely to struggle to conduct himself in an appropriate manner as the hearing date approaches and could become anxious, obstructive, or agitated which could lead to a further deterioration of his mental health."

KH's Tribunal's reasons

89. Having identified the conflicting evidence that it considered on the issue of KH's capacity, the Tribunal stated its own finding:

> "As such, we concluded that the patient did not have capacity to deal with the hearing and that it was in the patient's interests for the patient to be represented."

90. This gives rise to two questions:

    a. was the test of capacity that the Tribunal applied ("capacity to deal with the hearing") the correct test?

    b. what were its reasons for finding that KH lacked capacity, and that it was in his best interests to be represented?

91. In terms of the appropriate test, rule 11(7)(b) requires that the patient "lacks the capacity to appoint a representative", but the test the Tribunal applied was

whether KH had "capacity to deal with the hearing". That is a different test. But did asking the wrong question make a difference in this case? In other words, was it "material"?

92. As discussed in paragraph 55 above, "capacity to appoint a representative" may include capacity to conduct the proceedings, for the reasons set out comprehensively in *YA,* so perhaps the imprecision in the Tribunal's language about KH doesn't much matter. The real problem with its decision, though, is that we don't know how or why the Tribunal came to its decision. We therefore can't know whether it complied with the principles rehearsed above.

93. We know (largely) what evidence the Tribunal relied upon, but that evidence conflicted, and the evidence tending to support a finding that KH lacked capacity described the matter as "nuanced". Further, Dr Swamy's evidence indicates that she may have been applying a more demanding test of capacity than was warranted.

94. Dr Swamy's evidence raises a number of questions:

    a. does "negatively impact his ability to understand, weigh and use the relevant information" necessarily equate to an <u>inability</u> to understand, weigh and use the relevant information?

    b. is the concern about KH "conducting himself in an appropriate manner" relevant to the issue of capacity at all?

    c. given how common it is for litigants in person (and even, as Mr Pezzani suggested, even solicitors or barristers) to become "anxious, obstructive or agitated" during a hearing, does the concern about KH becoming so indicate a lack of capacity?

    d. even if they do indicate a lack of capacity, given that they are predictions of future behaviour, they do not amount to evidence of a lack of capacity at the time it was assessed.

95. The problem with the Tribunal's explanation of its decision making on the capacity issue is that the reasons for the decision are entirely missing. The words "As such" that introduce the penultimate sentence of §3 of the Tribunal's reasons suggest that they are preceded by some analysis or evaluation of the evidence.

They are not. Rather, they are preceded simply by a recitation of the conflicting evidence that was before the Tribunal.

96. There is no explanation of what the Tribunal made of the evidence or how it resolved the conflict between what Dr Swamy and the tribunal medical member concluded and what Mr Lawlor said. There is no explanation of why the tribunal medical member considered that KH lacked capacity, or any indication whether KH's Tribunal applied the presumption of capacity in section 1 of the Mental Capacity Act or the other principles set out in sections 1-3. Nor is there any indication as to whether KH's difficulties in terms of capacity were assessed to lie with his ability to understand the information relevant to the decision, or to retain it, or to use and weigh the information in the process of decision making, or in communicating his decision.

97. There is similarly a complete lack of explanation of why the Tribunal concluded that it was in KH's best interests to be represented. Instead the Tribunal simply made a bald statement that "It was in the patient's interests for the patient to be represented" (and, as Mr Pezzani pointed out, it referred to "interests" rather than "best interests"). These are not reasons, they are just a (generalised) statement of the Tribunal's conclusions.

98. The discretion under rule 11(7)(b) about whether the patient should be represented applies even where the Tribunal has concluded that representation would be in the patient's best interests. That might seem like an odd provision to anyone not familiar with mental health tribunals, but not to those who have participated in them. Those who have participated in hearings before the mental health tribunal will appreciate that hearings are not just about whether the patient will achieve discharge or a statutory or extra-statutory recommendation: often it is more about being seen and heard, and being afforded an opportunity of agency. That right might be less obvious than the right to liberty, but its importance should not be underestimated to someone who finds him or herself detained, especially if they are thought to have a delusional disorder, and especially if they don't agree with their diagnosis.

99. KH had been very clear indeed that he wanted to represent himself at the hearing of his reference, and that he didn't want to be represented by Mr Lawlor. He had expressed a sense of injustice, and it was abundantly clear that being able to put his case to the tribunal was of great importance to him.

100. However, no thought appears to have been given to the potential for causing KH distress by imposing an unwanted representative on him. This is (per *YA* at §§ 20, 99, 119 and 120) a relevant factor in a decision whether to appoint or continue an appointment under rule 11(7)(b), even if the patient lacks capacity. Charles J analysed this as part of the best interests assessment. Mr Pezzani preferred to see it as part of the overarching discretion in rule 11(7)(b). Either way, in practical terms it amounts to the same thing. If the Tribunal considered this factor, it has not explained what part it played in its decision making.

101. Even putting all of that to one side, having made a decision at the beginning of the hearing that Mr Lawlor would continue to act under rule 11(7)(b) the Tribunal should have kept the matter under review. It referred to giving KH a short break so that he could "put forward his concerns to Mr Lawlor" but it noted that KH had "refused to engage with Mr Lawlor". Even if the Tribunal had not considered it before, this lack of engagement should have alerted the panel to the risk that deciding to continue the rule 11(7)(b) appointment might limit KH's ability to participate effectively in the proceedings and might be having a serious impact on the fairness of the proceedings. There is no indication that the Tribunal did stop to reassess the rule 11(7)(b) issue. Instead, having recorded its understanding that KH had refused to engage with Mr Lawlor during the break given for that purpose, the Tribunal used the same phrase that it used when it recorded its decision on capacity: "As such, we proceeded with the hearing."

102. The Tribunal's reasons don't mention Mr Lawlor asking any questions of any of the witnesses. Nor is there any reference to him making any submissions on KH's behalf. So, the practical consequence of the Tribunal's decision that, against his wishes, KH should continue to be represented under rule 11(7)(b), appears to have been the opposite of what it was intended to achieve: namely the effective participation of the patient in the proceedings concerning his liberty.

103. Mr Pezzani summed the situation up aptly: both unwanted representation and self-representation involved peril to KH's effective participation in the hearing, but on the face of its reasons, the Tribunal gave no consideration to the need to strike a balance between the two, and it didn't even acknowledge that there was any peril at all to imposing unwanted representation on KH.

104. For all these reasons, the Tribunal's reasons were inadequate. Because of the extent of their inadequacy it is impossible to know what legal tests the Tribunal applied. That amounts to an error of law.

Materiality and disposal of KH's appeal

105. Having identified an error of law in KH's Tribunal's decision, I must decide whether that error was material in the sense of whether the outcome would have been any different had the tribunal not erred.

106. KH wanted to represent himself, and he appears to have tried to get across his case for discharge when giving his evidence. It might be asked what the difference is between that, and his being allowed to represent himself. However, I am persuaded that there is a material difference. That is because:

    a. mixing evidence and submissions offends against the basic principles of orderly litigation and tends to impede clarity. KH should have had the basic right of the litigant to ask questions and then make submissions on the evidence in closing; and

    b. KH was not allowed to ask the witnesses questions in the way that he could have done had he represented himself. It seems that the questions KH wanted to be put were not asked. It is possible that no questions were asked at all.

107. The decision to continue to impose representation on KH had a significant impact on the way that the proceedings unfolded. Did it have a material impact on the outcome of the reference? That might seem unlikely, given what the reports before the Tribunal said, but we can never know. As Lord Pearce observed in *Rondel v Worsley* [1969] 1 AC 191 (at §275):

> "It not infrequently happens that [...] those who have apparently hopeless cases turn out after a full and fair hearing to be in the right."

108. It cannot be said that it <u>couldn't</u> have made a difference, and this warrants the exercise of my discretion under section 12(2)(a) of the Tribunals, Courts and Enforcement Act 2007 (the **"TCEA 2007"**) in favour of setting aside the decision made by KH's Tribunal.

109. Under section 12(2)(b) I have a discretion either to remit the matter to the First-tier Tribunal for reconsideration or to remake the decision. The appropriate course is to remit the matter to the First-tier Tribunal, which will deploy an expert panel to hear evidence and make expert findings.

Analysis of AH's appeal

110. In AH's case there was no dispute that he lacked relevant capacity at the relevant time. Unlike KH's Tribunal, AH's Tribunal acknowledged AH's "very firm" objection to being represented and his responsible clinician's opinion that having legal representation would cause AH distress. The Tribunal exercised its discretion in favour of rescinding the rule 11(7)(b) appointment in accordance with AH's wishes.

111. AH's Tribunal proceeded to hear the reference without a representative present. It found all of the statutory criteria to continued detention to be satisfied and confirmed AH's section.

112. AH now appeals on the grounds that his Tribunal failed to factor two important considerations into its decision-making:

    a. whether AH might regain capacity in material domains with support; and

    b. whether, if the hearing were delayed (by way of an adjournment), AH might regain capacity, or achieve a greater ability to participate in the decision-making about his representation.

113. These considerations are mandatory considerations under the Mental Capacity Act when deciding matters on behalf of a person lacking capacity using the powers under that Act. As such they are, at least potentially, relevant considerations in the context of AH's Tribunal's management of the proceedings before it when striking the balance between the individual's right to a fair hearing under Article 6 of the Convention and the need for a swift and effective review of the individual's detention under Article 5 of the Convention.

114. A mental health tribunal can't properly adjourn a hearing on the basis that the patient's symptoms of mental disorder might have improved by the date of the adjourned hearing, thereby increasing the patient's chances of discharge. However, an adjournment in order to facilitate a patient's ability to participate meaningfully in the proceedings is not necessarily precluded.

115. Having decided to rescind Mr Markham's appointment, the Tribunal's reasons make no reference to it considering whether the interests of justice favoured proceeding to hear the reference, or whether an adjournment would further the overriding objective by permitting AH's increased participation in the proceedings.

It should be remembered that "ensuring, so far as practicable, that the parties are able to participate fully in proceedings" is one aspect of the overriding objective of "dealing with cases fairly and justly" (rule 2(2)(c) of the HESC Rules).

116. It may be that the Tribunal thought about these things. However, without any mention of them in its reasons it is impossible to know whether it did.

Materiality and disposal of AH's appeal

117. I conclude that either AH's Tribunal erred in failing to consider relevant factors when deciding whether to proceed to determine the case or in giving inadequate reasons for its decision, or both. Had the error been avoided, it cannot be said with confidence that the outcome would have been the same. That means the error was material. I therefore allow the appeal.

118. Having allowed AH's appeal, I have a discretion under section 12(2)(a) whether to set the decision aside.

119. Because AH has now been conditionally discharged from detention, it is not appropriate for me to set the decision aside. All that the interests of justice require is for me to identify the error and to acknowledge it, which I have done in this decision.

Thomas Church
Judge of the Upper Tribunal

Authorised by the Judge for issue on 10 April 2025