IN THE UPPER TRIBUNAL
ADMINISTRATIVE APPEALS CHAMBER

Case No. HM/1885/2014

Before Mr Justice Charles (President of the UT(AAC))

AMA v Greater Manchester West Mental Health NHS Foundation Trust and Others [2015] 0036 UKUT (AAC)

Attendances

For the Appellant:	Simon Burrows instructed by O'Donnells
For the First Respondent:	not represented
For the Second Respondent:	In person
For the Third Respondent:	Laura Davidson instructed by the Office of the Public Guardian
For the Fourth Respondent:	Jack Anderson instructed by the Department

Decision:

(1) The First-tier Tribunal erred in law in the manner set out in this Decision.
(2) In exercise of my discretion under section 12(2) of the Tribunals, Courts and Enforcement Act 2007 I do not set aside the decision of the First-tier Tribunal

REASONS FOR DECISION

Introduction

1. Permission to appeal was given by the First-tier Tribunal (the FtT) and in doing so the judge remarked that although it is an unusual case the importance of the issues raised and the need for guidance warranted the giving of permission. I agree and it was for these reasons that I joined the third and fourth Respondents. Both put in written submissions and the third Respondent appeared before me by counsel. Shortly before the hearing the Department of Health had been represented by the same counsel in an appeal before me that had some overlapping issues (*YA v Central and NW London NHS Trust and Others* [2015] UKUT 0037 (AAC)).

2. The second Respondent (DRW) is the Appellant's (AMA's) mother. She was appointed to act as his deputy to make personal welfare decisions by an order of the Court of Protection dated 18 June 2008 (the CoP Order). It is set out in the annex hereto and is in fairly standard terms. She appeared before me in

person. She is also AMA's nearest relative within the meaning of section 28 of the Mental Health Act 2003 (the MHA) and is AMA's full time carer. She supported the application for permission to appeal to obtain guidance on her role as AMA's welfare deputy.

3. The Appellant attended the hearing and was represented by solicitors and counsel who acted pro bono because he had been refused funding by a decision of the Special Controls Review Panel of the Legal Aid Agency dated 7 October 2014 and sent on 14 October 2014 (six days before the hearing). I am very grateful to them for so acting, as no doubt are AMA and his mother. In my view, others are also likely to be grateful because, in agreement with the FtT judge and them, and in disagreement with the Legal Aid Agency decision maker, this appeal is one that raises issues on which it is appropriate for the Upper Tribunal to give guidance. Understandably there is no prospect that either AMA or his mother could themselves advance the relevant legal arguments.

4. It is troubling, and this is not the first occasion that I have come across this, that legal aid is refused on appeals to the Upper Tribunal where it and the FtT consider that guidance is appropriate and absent representation pro bono the parties to the appeal and the Upper Tribunal would not have the benefit of necessary representation and argument. Given that one of the functions of the Upper Tribunal is to give guidance that can be applied by the FtT in cases where parties may well not be represented I invite the Legal Aid Agency to consider whether in such "guidance cases" it should factor in and so expressly deal with the view of the judge (of the FtT or the Upper Tribunal) giving permission to appeal that the case is a "guidance case".

The facts of this case

5. In 2005, when he was 16, AMA was involved in a serious road traffic accident the injuries from which resulted in him being in hospital for 15 months. He was diagnosed with brain damage and in particular with frontal lobe damage which affects his behaviour, memory, executive functioning and ability to process a situation. As a result, it is not uncommon that if he cannot remember a situation he will simply make something up but is unaware that he is doing this. This means that he is a very unreliable historian and is one of the reasons why much of the documented evidence contains a number of inconsistencies. After his return home from hospital in 2006, AMA was very frustrated with his life and the circumstances he found himself in and he has had numerous mental health admissions to hospital. Initially these were on a voluntary basis. He used to make 999 calls on a regular basis making complaints such as not liking his tea or not being allowed to go out drinking. He has little insight into his brain injuries and how they affect him and this has caused him upset. He has also on occasions self harmed without any warning. He has made two serious attempts at ending his life and resultant nerve damage to his wrist has required corrective surgery.

6. The immediate history to his detention under section 2 of the MHA on 27 January 2014 started when his mother was away on a short break over the 21 and 22 January 2014. On the second night his brother told his carer that she

could have the night off and that he would care for AMA, but unfortunately an argument that led to a fight between the brothers took place. The police were called and a neighbour took AMA to accident and emergency. His mother returned early from her short break and went to accident and emergency. AMA was discharged and came home. On the next day, AMA telephoned the police to report an assault on him by his brother; he did not at that stage remember that the police had been involved the night before. He told the police that he wanted to go to hospital and that he wanted to do this alone. A record of the Bolton Assessment Tool relating to his assessment on 23 January states that he presented to accident and emergency accompanied by the police and that he had been reported to have been found lying in the middle of the road with a lighter threatening to set himself on fire. His mother does not doubt this account, but she does not know the circumstances in which it took place. She believes that it was after his first visit to accident and emergency on that day. His mother went to see him at the hospital. He wanted assurances that his brother was to be prosecuted for assaulting him but as his mother could not give these he decided to remain in hospital on an informal basis. However, on 24 January he set fire to his bedding, refused to leave his room and said he wished to kill himself. As a result he was sectioned under section 5(2) of the MHA. That detention ended on 27 January when he was detained under section 2. Whilst he was in hospital on this occasion his mother discovered that he was hiding large knives in his room and she was therefore of the view that he required sectioning for his safety and the safety of others. This is recorded in the assessment relating to this detention which also records that AMA was deemed to lack capacity due to his brain injury and mental state at the time of the assessment.

7. AMA told nursing staff that he did not want to be in hospital and as a consequence the hospital, in accordance with standard practice, submitted an application on his behalf to the FtT.

8. At the request of AMA's independent health advocate an experienced solicitor (Mr O'Donnell) who is on the Law Society Mental Health Accreditation Scheme Panel met AMA on 30 January when AMA informed him that he wished to be discharged from his section. During that interview Mr O'Donnell formed the view that AMA had the capacity to instruct him to act on his behalf in the tribunal proceedings. Accordingly, he agreed to act for AMA and represent him at the FtT hearing. So, Mr O'Donnell was appointed by AMA and not the tribunal under Rule 11(7) of the Tribunal Procedure (First-Tier Tribunal) (Health Education and Social Care Chamber) Rules 2008 (the Rules).

9. On 31 January 2014, Mr O'Donnell wrote to AMA's mother. She attempted to contact Mr O'Donnell in response and left a message stating that as well as being AMA's nearest relative (which Mr O'Donnell refers to in his letter) she was also his welfare deputy.

10. That letter from Mr O'Donnell referred to a tribunal which would meet at the hospital on a date to be fixed. The first time that AMA's mother knew that a tribunal hearing was going to take place was on 6 February when she attended AMA's ward round.

11. The tribunal sat at 2 pm on 6 February and on that morning AMA gave differing accounts of what he wanted to, on the one hand, his mother and social worker and, on the other, to Mr O'Donnell. AMA told his mother and social worker that he did not want the tribunal to go ahead. The social worker telephoned Mr O'Donnell's office and as a result he, AMA and AMA's mother all spoke to a lady at the office over the telephone. The accounts of those conversations do not fully accord but the differences do not matter. After them, AMA's mother telephoned the tribunal service and the Office of the Public Guardian and at 4.21 pm (and so after the tribunal had sat) she sent an email to a doctor at the hospital on behalf of AMA stating a wish to withdraw the matter before the tribunal.

12. After AMA's mother's discussions on the ward and before the hearing, Mr O'Donnell saw AMA on the ward. At that meeting, AMA told Mr O'Donnell that if he was discharged from his section he would stay in hospital as a voluntary patient until a better care plan was put in place. He told Mr O'Donnell that his main aim was to have more support in the community upon leaving hospital. Mr O'Donnell gave him some advice and on that basis AMA told him that he wanted to proceed with the tribunal hearing. AMA queried whether he needed to attend the hearing but following reassurances about being able to sit next to Mr O'Donnell, about being able to leave if he wanted and that the panel would make him feel relaxed, he wanted to attend.

13. The responsible clinician and the care coordinator had not prepared reports for the tribunal as they had assumed the hearing was not going ahead. The tribunal however did have a report from AMA's named nurse dated 4 February, which Mr O'Donnell had discussed with AMA on the ward. It stated that the circumstances around AMA's admission/detention in hospital had lapsed, consequently further detention would be unnecessary and that AMA had a care package in the community that would support him on discharge from hospital.

14. At the hearing preliminary issues were raised, namely: whether AMA had capacity and whether he wanted to withdraw. Information was given that AMA's mother had been appointed a welfare deputy by the Court of Protection and that she wanted to exercise her son's right to withdraw. The medical member was of the view that AMA lacked capacity and emphasised the fact that he had told her clearly that he wanted to withdraw. Mr O'Donnell submitted that he had instructions and the tribunal should proceed or, if there were doubts over capacity or more time was needed to prepare written reports, the hearing should be adjourned. Even if the tribunal were of the view that AMA lacked capacity, Mr O'Donnell disputed that a welfare deputyship order authorises the deputy to withdraw an application to a mental health review Tribunal.

15. The Tribunal's decision is headed "Consent to Withdrawal" and records that AMA was represented by Mr O'Donnell and that the Responsible Authority was not represented. It then states:

> Notice of Withdrawal.

> The patient gave notice of their wish to withdraw their application, at the hearing.
>
> Decision
>
> The tribunal consents to the withdrawal of the application. This is a rather unusual case and an application to withdraw (sic). AMA is being detained under section 2. From his own evidence and that of [a treating doctor] it was clear that he does not have capacity. He had expressed different intentions to our medical member, to the RC and to his solicitor which [were] mutually inconsistent as to his wish to proceed or withdraw the application. Upon further enquiries it became clear that on 22 April 2008 the Court of Protection had appointed his mother DRW as deputy to make, inter alia, personal welfare decision[s] on his behalf. She wanted to withdraw the application as she had agreed with MDT the care plan that morning. After listening to the Appellant's solicitor and careful consideration of the evidence, we were satisfied that the patient did not have capacity and that his mother had the right to withdraw the application on his behalf. We therefore consent to the withdrawal of the application.

16. On 7 February 2014, Mr O'Donnell wrote to AMA. The opening sentence of that letter was as follows: "There was a very great deal of confusion at your tribunal on Thursday." Mr O'Donnell went on to explain that the argument he wished to put on AMA's instructions was as follows:

> "We were not arguing for you to leave hospital because you were going to stay in hospital anyway. We were simply arguing for the section to be removed so that you could live your life without the stigma and indignity of being detained under the Mental Health Act."

17. On 11 February 2014, Mr O'Donnell wrote to AMA's mother recognising the obvious distress that the tribunal process appeared to have caused and giving extra information about the position as he saw it.

18. AMA was discharged from hospital on 20 February 2014.

19. I do not know what, if any, changes were made between 6 and 20 February, arising from discussions between DRW and others (or otherwise) to the details of AMA's care regime and thus in terms of what AMA told Mr O'Donnell about any changes in the support AMA would receive in the community. His mother (DRW) has remained his main carer and he attends outpatient appointments.

20. Before me and the FtT, no issue was raised as to AMA's continuing lack of capacity for the purposes of the CoP Order and thus as to matters such as where he should live, his care package and so the level of support he should have in the community. The evidence indicates that he continues to lack that capacity.

21. Also before me, no question was raised as to AMA's capacity to instruct a solicitor for the purposes of this appeal. (Perhaps I should have raised this as I did in *YA*, but as appears later I accept that the evidence suggests that he has the capacity to instruct Mr O'Donnell to take and pursue arguable points

that the FtT erred in law and on the more general points that arise on this appeal.)

22. It is clear that both AMA's mother and Mr O'Donnell were at all times acting in what they thought were AMA's best interests and that they, the tribunal and the treating team were faced with a changing and confusing situation on 6 February 2014. The positions of respectively AMA's mother and Mr O'Donnell are readily understandable. Based on her love for her son and her detailed and extensive knowledge of his history his mother for persuasive and understandable reasons was of the view that his section 2 statement and so detention should continue. On the other hand, on his necessarily much more limited knowledge of AMA, Mr O'Donnell was of the understandable view based on his conversations with him that AMA had capacity to appoint and instruct him, that AMA would remain at the hospital for assessment on a voluntary basis and so the section was not necessary and should be discharged.

23. There was no discussion between AMA's mother and Mr O'Donnell about AMA's history and thus his problems relating to the giving of an accurate account of day to day events affecting him, his lack of capacity to make decisions about where he should live and so his care plan (and so many points about including possible or proposed changes or improvements to it, when they should occur and how they should be linked to his discharge from hospital), his changeability, his earlier suicide attempts and the knives that DRW had found he had hidden at home. Those matters and AMA's history generally are relevant to:

    i) the likelihood that he would in fact remain at the hospital for assessment on a voluntary basis,

    ii) his capacity to make decisions concerning his care plan and to make and stick to a decision to remain in hospital whilst changes in his care plan and support in the community were negotiated and put in place,

    iii) his risks of self harm on an early return home,

    iv) whether he or any member of his family would think that there was stigma or indignity attached to a continuation of AMA's section 2 detention, or

    v) his capacity to consent to his deprivation of his liberty pursuant to the assessment regime in hospital and whether any authorisation of his continued stay in hospital would be required under the MCA.

24. The circumstances in which he was found lying in the road, had set fire to his bed and in which his mother found the knives at home would be relevant to those issues as would the details of any proposed changes in AMA's care plan and his wishes and feelings relating to them and his contact with his brother. As to point (iv), on investigation the history of this family and AMA may well indicate that for them it is not a particularly relevant point.

The most relevant Rules

25. Rule 11 provides that:

> (1) A party may appoint a representative (whether a legal representative or not) to represent that party in the proceedings.
>
> (2) If a party appoints a representative, that party (or the representative if the representative is a legal representative) must send or deliver to the Tribunal and to each other party written notice of the representative's name and address.
>
> (3) Anything permitted or required to be done by a party under these Rules, a practice direction or a direction may be done by the representative of that party, except—
>
> (a) signing a witness statement; or
>
> (b) signing an application notice under rule 20 (the application notice) if the representative is not a legal representative.
>
> (4) A person who receives due notice of the appointment of a representative—
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> (a) must provide to the representative any document which is required to be provided to the represented party, and need not provide that document to the represented party; and
>
> (b) may assume that the representative is and remains authorised as such until they receive written notification that this is not so from the representative or the represented party.
>
> (5) At a hearing a party may be accompanied by another person whose name and address has not been notified under paragraph (2) but who, subject to paragraph (8) and with the permission of the Tribunal, may act as a representative or otherwise assist in presenting the party's case at the hearing.
>
> (6) Paragraphs (2) to (4) do not apply to a person who accompanies a party under paragraph (5).
>
> (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—
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> (a) the patient has stated that they do not wish to conduct their own case or that they wish to be represented; or
>
> (b) the patient lacks the capacity to appoint a representative but the Tribunal believes that it is in the patient's best interests for the patient to be represented.
>
> (8) In a mental health case a party may not appoint as a representative, or be represented or assisted at a hearing by—
>
> (a) a person liable to be detained or subject to guardianship, or who is a community patient, under the Mental Health Act 1983; or
>
> (b) a person receiving treatment for mental disorder at the same hospital as the patient.

26. Rule 17 provides that:

> **17.** (1) Subject to paragraphs (2) and (3), a party may give notice of the withdrawal of its case, or any part of it—
>
> (a) by sending or delivering to the Tribunal a written notice of withdrawal; or
>
> (b) orally at a hearing.
>
> (2) Notice of withdrawal will not take effect unless the Tribunal consents to the withdrawal except —
>
> (a) [not relevant here]

(b) [not relevant here]

(3) [not relevant here]

(4) A party which has withdrawn its case may apply for it to be reinstated

27. So as appears from Rule 11, an appointment by the FtT under Rule 11(7) is limited to the appointment of a *legal representative* (as defined by Rule 1(3)). It should also be noted that the power to do so only exists when the patient has not appointed a representative (who need not be a legal representative), and either

i) the patient has said that he does not want to conduct the case himself or wants to be represented,

ii) the patient does not have capacity to appoint a representative.

28. For sensible pragmatic reasons the appointment under Rule 11(7) is regularly made by a member of the tribunal staff pursuant to Rule 4 and practice direction. This did not happen here as Mr O'Donnell accepted instructions directly from AMA.

29. This was a section 66(1)(a) case so the change in Rule 34 has no impact, but needs to be remembered when it does.

Relevant provisions of the Mental Capacity Act 2005

30. Sections 1, 2 and 3 relate to capacity, and section 4 to best interests.

31. Sections 4A, 16, 16A, 20 and 28 provide as follows:

4A Restriction on deprivation of liberty
(1) This Act does not authorise any person ("D") to deprive any other person ("P") of his liberty.

(2) But that is subject to—

(a) the following provisions of this section, and

(b) section 4B [which does not apply here]

(3) D may deprive P of his liberty if, by doing so, D is giving effect to a relevant decision of the court.

(4) A relevant decision of the court is a decision made by an order under section 16(2)(a) in relation to a matter concerning P's personal welfare.

(5) D may deprive P of his liberty if the deprivation is authorised by Schedule A1 (hospital and care home residents: deprivation of liberty).

Section 16 powers: personal welfare
(1)The powers under section 16 as respects P's personal welfare extend in particular to—

(a) deciding where P is to live;

(b) deciding what contact, if any, P is to have with any specified persons;

(c) making an order prohibiting a named person from having contact with P;

(d) giving or refusing consent to the carrying out or continuation of a treatment by a person providing health care for P;

(e) giving a direction that a person responsible for P's health care allow a different person to take over that responsibility.

(2) Subsection (1) is subject to section 20 (restrictions on deputies).

16A Section 16 powers: Mental Health Act patients etc
(1) If a person is ineligible to be deprived of liberty by this Act, the court may not include in a welfare order provision which authorises the person to be deprived of his liberty.

(2) If—

(a) a welfare order includes provision which authorises a person to be deprived of his liberty, and

(b) that person becomes ineligible to be deprived of liberty by this Act,

the provision ceases to have effect for as long as the person remains ineligible.

(3) Nothing in subsection (2) affects the power of the court under section 16(7) to vary or discharge the welfare order.

(4) For the purposes of this section—

(a) Schedule 1A applies for determining whether or not P is ineligible to be deprived of liberty by this Act;

(b) "welfare order" means an order under section 16(2)(a).]

20 Restrictions on deputies
(1) A deputy does not have power to make a decision on behalf of P in relation to a matter if he knows or has reasonable grounds for believing that P has capacity in relation to the matter.

(2) Nothing in section 16(5) or 17 permits a deputy to be given power—

(a) to prohibit a named person from having contact with P;

(b) to direct a person responsible for P's health care to allow a different person to take over that responsibility.

(3) [not relevant here]

(4) [not relevant here]

(5) A deputy may not refuse consent to the carrying out or continuation of life-sustaining treatment in relation to P.

(6) The authority conferred on a deputy is subject to the provisions of this Act and, in particular, sections 1 (the principles) and 4 (best interests).

(7) A deputy may not do an act that is intended to restrain P unless four conditions are satisfied.

(8) The first condition is that, in doing the act, the deputy is acting within the scope of an authority expressly conferred on him by the court.

(9) The second is that P lacks, or the deputy reasonably believes that P lacks, capacity in relation to the matter in question.

(10) The third is that the deputy reasonably believes that it is necessary to do the act in order to prevent harm to P.

(11) The fourth is that the act is a proportionate response to—

(a) the likelihood of P's suffering harm,

(b) the seriousness of that harm.

(12) For the purposes of this section, a deputy restrains P if he—

(a) uses, or threatens to use, force to secure the doing of an act which P resists, or

(b) restricts P's liberty of movement, whether or not P resists,

or if he authorises another person to do any of those things.

(13) [not relevant here]

28 Mental Health Act matters
(1) Nothing in this Act authorises anyone—

(a) to give a patient medical treatment for mental disorder, or

(b) to consent to a patient's being given medical treatment for mental disorder,

if, at the time when it is proposed to treat the patient, his treatment is regulated by Part 4 of the Mental Health Act.

(1A) Subsection (1) does not apply in relation to any form of treatment to which section 58A of that Act (electro-convulsive therapy, etc.) applies if the patient comes within subsection (7) of that section (informal patient under 18 who cannot give consent).

(1B) Section 5 does not apply to an act to which section 64B of the Mental Health Act applies (treatment of community patients not recalled to hospital).

(2)"Medical treatment", "mental disorder" and "patient" have the same meaning as in that Act.

32. The relationship between the MCA and the MHA is notoriously difficult as is the interpretation and application of Schedules A1 and 1A to the MCA. The latter contains the provisions for determining whether a person is "ineligible to be deprived of liberty by the MCA". This is not the place to go into these difficulties further. I addressed a number of them in *AM v South London and Maudsley NHS Trust* [2013] UKUT 365 (AAC) and the notes to sections 2 and 131 in the Mental Health Act Manual 17th edition (Richard Jones) refer to that case and others on the issues that arise in respect of the relationship between the two Acts and the voluntary admission of a patient. They include issues relating to the patient's capacity and compliance with a proposed regime of care, treatment and a consequential deprivation of liberty.

The issues before the FtT

33. Certainly with the benefit of hindsight these included:

i) On what basis had AMA given the notice of withdrawal at the hearing recited in the consent to withdrawal.

ii) The role and powers of AMA's mother as his welfare deputy under the CoP Order.

iii) Whether AMA had appointed or purported to appoint his mother to act as his representative before the FtT as his mother and carer (as opposed to his welfare deputy).

iv) Whether AMA had appointed or purported to appoint Mr O'Donnell to act as his solicitor and his representative as well his mother or in place of his mother.

v) AMA's capacity:

a) to appoint a representative whether Mr O'Donnell or his mother,

b) to give instructions to his representative on issues arising and decisions to be taken in the conduct of the application to the FtT and thus the challenge to his detention under s. 2 MHA (his capacity to conduct proceedings or his litigation capacity), and in that context:

i) to make and maintain decisions to remain in hospital on a voluntary basis,

ii) to make a decision whether to pursue or to withdraw the proceedings before the FtT,

iii) to consent to a deprivation of his liberty at the hospital for the purposes of his continued assessment, and so

c) to sufficiently understand, retain and weigh the issues and factors relevant to those specific decisions including issues relating to where and with whom he should live and his support in the community.

34. It is clear that AMA had an *impairment of, or disturbance in the functioning of, the mind or brain* and so all the relevant capacity assessments relate to the impact of that on his decision making.

The role of the FtT

35. The FtT is a tribunal that has the function of reviewing detentions under the MHA. It therefore plays an important role in fulfilling the substantive and procedural requirements of Article 5(4) ECHR, and the underlying purposes of the MHA and the procedural fairness required by the common law. As appears from *YA*:

i) The main purpose of Article 5 is to provide that no one should be deprived of their liberty in an arbitrary manner.

ii) The reviewing body, and so the FtT, must consider whether the reasons that initially justified detention continue and review the substantive and procedural conditions that are essential for the deprivation of liberty to be lawful.

iii) Article 5(4) applies to those reviews and is directed to ensuring that there is a fair procedure for reviewing the lawfulness of a detention.

iv) To my mind the most important principles to take into account in the decision making process of the FtT are: (a) the underlying purpose and importance of the review and so the need to fairly and thoroughly assess the reasons for the detention, (b) 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), (c) the need for flexibility and appropriate speed, (d) 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 (e) the tribunal is likely to be properly and sufficiently informed of the competing factors relating to the case before it and so able to carry out an effective review. (As to this the tribunal should when deciding the case review this prediction).

v) The presumption of capacity and the requirement for it to be assessed by reference to the relevant decision, issue or activity must be remembered but care needs to be taken not to embark on unnecessary assessments and to maintain flexibility to achieve the underlying purpose, namely a practical and effective review of a deprivation of liberty in an appropriate timescale.

The consideration of an application to withdraw an application to the FtT

36. Rule 17 provides that no notice of withdrawal will take effect unless the Tribunal consents to it. It is clear that this is intended to and does provide a safeguard for the patient as it means that such consent should not be given unless the FtT is itself satisfied that a review of a detention by an independent tribunal is not then necessary. The FtT's consent to a withdrawal is a decision (see for example *MB v BEH MH NST* [2011] UKUT 328 (AAC) at paragraph 16).

37. It follows in my view that:

i) the FtT must always ask for and consider who made the application to withdraw, how it was made, and perhaps most importantly the reasons for it and thus the continuation of a detention,

ii) the FtT must always make its own mind up on whether it should agree to it or conduct a review of the detention and give reasons for its decision, and

iii) if it is in doubt it should refuse consent and as a consequence carry out the review itself.

In effect the decision to give consent has to be based on a conclusion of the tribunal that continued detention under the MHA is justified for the reasons founding the application to withdraw (or other reasons).

Capacity

38. I have dealt with this in *YA*. It was common ground before me in this appeal that the approach in sections 1, 2 and 3 of the MCA should be applied and

most of my conclusions in *YA* were not controversial. An exception to this is that, as my analysis and conclusions in *YA* show, I do not accept the submission made on behalf of AMA that the threshold for capacity in the FtT is extremely low. That submission was directed to litigation capacity and in my view:

i) it does not flow from the points made by Baroness Hale in *R(H) v SSH* [2005] UKHL 60, [2005] 3 WLR 867 (in particular at paragraphs 2, and 23 to 260),

ii) it fails to take proper account of the approach to the assessment of the capacity of a person to conduct proceedings taken in *Dunhill v Burgin* [2014] UKSC 18, [2014] 1 WLR 933,

iii) it does not accord with the approach in ECtHR cases which shows the need to be flexible and to promote a practical and effective review of a detention and thus the need for representation of persons who do not have capacity to conduct proceedings themselves or to give instructions on all relevant matters to a representative,

iv) such a generalised statement does not fit with the fact sensitive decision, issue or activity specific approach that is required, and

v) it also does not flow from the presumption that a person has capacity.

39. Any assessment of capacity starts with the presumption of capacity and then has to address whether the relevant person (thus the patient) has the relevant capacity which will involve an identification of the relevant specific decision, issue or activity, its nature and complexity and thus of the issues and factors to be taken into account and weighed in the relevant decision making process.

40. This is a case and fact specific exercise. For example, it can found a different focus to assessments of the capacity of a person (a) to instruct a solicitor to represent him in proceedings and (b) to conduct proceedings himself.

41. I accept as submitted on behalf of AMA that the patient does not have to be able to fully appreciate or understand all aspects of the issues involved and that the capacity simply to instruct a solicitor to challenge a continuation of a detention on all available grounds can be described as very low or a very limited capacity.

42. However, different and more complex factors relating to both the capacity to instruct a solicitor and in respect of other decisions, issues or activities that are relevant to the application of the tests under the MHA and a best interests approach will or are likely to arise in, for example:

i) cases concerning compliance with a voluntary admission and consequential detention (deprivation of liberty),

ii) applications to withdraw and so the reverse of the position that a review of the detention is likely to promote the patient's interests,

iii) cases in which the wishes of the patient do not accord with the views of his representative as to what will promote his best interests and/or do not found arguable points, and

iv) in cases where a central factor to the argument that detention is not necessary involves an assessment of the patient's ability to weigh and act in relation to issues that underlie an argument that he will remain in hospital as a voluntary patient (here the resolution of arrangements relating to his care package on leaving hospital).

In all such cases it is likely that a sufficient appreciation by the patient of his impairment of, or disturbance in the functioning of, the mind or brain will be required if he is to have capacity to make the relevant decisions.

The role and powers of AMA's mother as his welfare deputy under the CoP Order and whether AMA had appointed or purported to appoint his mother to act as his representative before the FtT.

43. The FtT say that AMA's mother: "had the right to withdraw the application on his behalf. We therefore consent to the withdrawal of the application (my emphasis)". This may fail to take account of Rule 17 in that on one reading of that reasoning the FtT has failed to have regard to the need for it to make its own decision and the point that any right is limited to the giving of a notice of withdrawal. If that is the correct reading the FtT erred in law, whatever the extent of DRW's powers and authority as a welfare deputy under the CoP Order were.

44. However, it seems to me that on a fair reading, the core of the FtT's decision was that as AMA's welfare deputy his mother had the right to give notice of withdrawal on behalf of AMA, and that (as one would expect) the FtT was aware that it would not be effective if the FtT did not give its consent to it.

45. On that approach the FtT based its decision on the powers of a welfare deputy appointed by the Court of Protection. I agree that that is a central issue.

46. There is little guidance on the powers of such a deputy in this context. I was referred to paragraph 13.42 of the MCA 2005 Code of Practice and paragraph 9.6 of the MHA Code of Practice, both of which refer to the authority given under the relevant court order or power of attorney.

47. The extent of what a deputy or attorney can or should be authorised to do under the MHA or in respect of proceedings under the MHA on behalf of a patient by the original order of appointment, or any further order, is outside the ambit of this judgment. Further, as my decision in *AM* shows, it is dangerous to make general assertions about the relationship between the application of and the roles of persons under the statutory regimes of the MHA and the MCA.

48. Rule 11(3) empowers a representative appointed by the patient (or a legal representative appointed by the FtT) to do anything permitted or required to be done by a party (defined by Rule 1(3) to include the patient and any other

person who starts a mental health case). That would include the giving of a notice of withdrawal under Rule 17.

49. DRW did not start this case in any capacity and so was not a party who could give a notice of withdrawal through that route.

50. In my view, unless the order appointing a welfare deputy expressly so provides it does not appoint the deputy to act as the patient's representative in proceedings under the MHA. So, general powers to make personal welfare decisions (even if not cut down by specific provisions as to the authority of the deputy contained in the order) cannot be relied on by a personal welfare deputy to appoint himself or anyone else as such a representative.

51. The CoP Order did not do this and so DRW could not by that route give a notice of withdrawal as AMA's representative.

52. There is no evidence that AMA made a separate appointment of his mother to act as his representative and, in any event, no such appointment was relied on by the FtT as the basis for the notice of withdrawal.

53. Further, I agree with submissions made to me that:

i) distinctions can be drawn between the power of a welfare deputy of a person detained under the MHA (a) to initiate and (b) to seek to withdraw proceedings on behalf of that person under the MHA to review that detention and the authority of the deputy may cover the former but not the latter (even when the deputy has initiated the proceedings), and

ii) issues arise as to what a welfare deputy can be authorised to do by the CoP (and so can do) in respect of agreeing to or authorising (directly or indirectly and so arguably by serving a notice of withdrawal of tribunal proceedings) a regime of treatment or care package that involves a deprivation of liberty. (These issues engage (a) the limits of the jurisdiction of the MCA in this respect (namely it only extends to persons who are not ineligible to be deprived of their liberty under the MCA), the specific limitations on the powers of a deputy set out in sections 20(7) and 28 of the MCA and the impact of paragraph 5(5) of Schedule 1A thereto, and (b) points dealt with in *AM* in respect of what regime constitutes the least restrictive option and whether a deprivation of liberty pursuant to it has to be authorised under the MCA or whether a welfare deputy (if so authorised) could consent to it on the patient's behalf).

However the danger of generalisation I have referred to earlier means that these submissions are outside the ambit of this decision.

A reasons challenge

54. There is no explanation of why the FtT gave its consent to the withdrawal or of its finding that AMA lacked capacity or of the capacity the FtT was referring to. I agree that this would have founded a reasons challenge but as AMA had

been discharged this was not one of the grounds on which the FtT gave permission to appeal and it does not raise any need for guidance.

Pausing there

55. The FtT erred in law by proceeding on the basis that DRW as AMA's welfare deputy had a right to withdraw the proceedings.

What was the correct approach in law

56. The correct approach would have been for the FtT to address the issues set out in paragraph 33.

57. If it had done so I do not accept that the capacity issues were as straightforward as was submitted on behalf of AMA or that the report of the named nurse effectively shows that the section should have been discharged. Rather, in my view, if those issues had been addressed it is likely that this would have shown that there was a need to investigate and determine:

    i) AMA's capacity to (a) decide to continue or withdraw the application, (b) to agree to remaining in hospital on a voluntary basis and (c) to agree to a deprivation of liberty,

    ii) the circumstances that led to his section and whether they continued and his risk of self harm on a return home, and

    iii) whether what the nurse refers to as AMA's care package in the community was in place or (and in line with what AMA told Mr O'Donnell and the argument he wished to put on AMA's behalf) when it would be in place.

58. The capacity issues go well beyond the capacity to instruct a solicitor to challenge the section on all available arguable grounds because in both the context of a withdrawal of the application and an argument based on a voluntary stay in hospital relevant factors engage AMA's understanding of the purpose and need for further assessment in hospital, elements of his care package and of his history of self harm and changeability. There are powerful pointers in the evidence that he did and does not have the capacity to sufficiently understand, retain or weigh such factors and so factors that are central to the choice between seeking:

    i) a withdrawal and so a continuation of the section, or

    ii) a discharge of the section on the basis of either a voluntary continuation of his stay in hospital (in circumstances that amount to a deprivation of his liberty) or an immediate return home.

59. In any event, there are powerful indicators in the evidence that it was not likely that AMA would remain compliant with a voluntary continuation of his assessment in hospital pending changes in his care plan being put in place.

60. I suspect that the solution would have been for the tribunal to refuse to consent to the withdrawal sought by DRW, to appoint Mr O'Donnell under rule 11(7)(a) and to then focus on the key issue underlying the argument Mr O'Donnell wanted to advance (i.e. a voluntary stay in the hospital or perhaps an immediate return home if the appropriate support in the community was available) against the counter argument of his mother (and as I understand it others) that the section should not be discharged. That would engage a number of the issues discussed in *AM*.

61. In the circumstances that existed on 6 February it is very doubtful that a properly informed assessment of the rival arguments could have been carried out at that hearing and so a short adjournment would have been necessary.

62. It seems to me that there would at least have been a strong possibility that on an adjourned hearing the effective result would have been the same as that which flowed from the withdrawal, namely that AMA would have remained in hospital under section until 20 February 2014.

Remedy

63. I acknowledge that that view on the outcome is not one that I can say a FtT would be bound to have reached. But I agree with the common ground before me that I should not in the exercise of my discretion set aside the decision of the FtT because there is now no point in doing so.

Dated 4 February 2015

Mr Justice Charles

(Signed on the original)

ANNEX

The CoP order provided:

WHEREAS

(1) An application has been made for an order under the Mental Capacity Act 2005.

(2) The court is satisfied that AMA is unable to make various decisions for himself in relation to a matter or matters concerning his personal welfare because of an impairment of, or a disturbance in the functioning of, his mind or brain.

(3) The court is satisfied that the purpose for which the order is needed cannot be as effectively achieved in a way that is less restrictive of his rights and freedom of action.

IT IS ORDERED that:

1. **Appointment of deputy**

(a) DRW of ---------- is appointed as deputy ("the deputy") to make personal welfare decisions on behalf of AMA that he is unable to make for himself subject to any conditions or restrictions set out in this order.

(b) The appointment will last until further order.

(c) The deputy must apply the principles set out in section 1 of the Mental Capacity Act 2005 and have regard to the guidance in the Code of Practice to the Act.

2. **Authority of deputy**

(a) The Court authorises the deputy to make the following decisions on behalf or AMA that he is unable to make himself when the decision needs to be made:

(i) Where he should live

(ii) With whom he should live

(iii) Decisions on day-to-day care, including diet and dress

(iv) Consenting to medical or dental examination and treatment on his behalf

(v) Making arrangements for the provision of care services

(vi) Whether he should take part in particular leisure or social activities

(vii) Complaints about his care or treatment

(b) For the purpose of giving effect to any decision the deputy may sign or execute any necessary deeds or documents.

(c) The deputy does not have authority to make a decision on behalf of AMA in relation to a matter if the deputy knows or has reasonable grounds for believing that he had capacity in relation to the matter.

(d) The deputy does not have the authority to make the following decisions or do the following things in relation to AMA:

(i) To prohibit any person from having contact with him

(ii) To direct a personal responsible for his healthcare to allow a different person to take over that responsibility

(iii) To make a decision that is inconsistent with a decision made within the scope of his authority and in accordance with the Act, by the donee of a lasting power of attorney granted by him (or, if there is more than one donee, by any of them)

(iv) To consent to specific treatment if he has made a valid and applicable advance decision to refuse that specific treatment

(v) To refuse consent to the carrying out or continuation of life sustaining treatment in relation to him

(vi) To do an act that is intended to restrain him otherwise than in accordance with the conditions specified in the Act.