The Role, Functions and Powers of the Mental Health Review Tribunal in Northern Ireland.

A Young Bar Perspective.

1. Members of the Young Bar, I am delighted to be asked to give a talk this afternoon on the subject of the Mental Health Review Tribunal. It is a refreshing change not to be addressing you on the challenges facing the Bar and the Young Bar in particular and, instead, to be able to give you what I hope is some useful advice and guidance on how you as members of the Young Bar can effectively represent patients and perhaps even Trusts before the Tribunal. I wish to thank Louise Maguire for her kind introduction and you will appreciate from that introduction that I have been sitting as a Legal President of the Mental Health Review Tribunal since 2014. I must say I have always felt uncomfortable being addressed at a Tribunal hearing as "Mr President" and the recent election of Donald Trump only serves to add to my discomfiture; but according to paragraph 6 of Schedule 3 of the Mental Health (Northern Ireland) Order 1986, the legal member of the panel appointed to sit on any Tribunal is to be known as the President of the Tribunal, so both you and I are stuck with that nomenclature.

2. The jurisdiction and operation of the Mental Health Review Tribunal are, for the time being, set out in the Mental Health (Northern Ireland) Order 1986 and the Mental Health Review Tribunal (Northern Ireland) Rules 1986. I say "for the time being" because the whole statutory framework within which the Tribunal operates is set to change with the recent enactment of the Mental Capacity Act (Northern Ireland) 2016. The provisions of the 2016 Act relating to the functions of the Tribunal have yet to be brought into effect and this will take some time as a considerable

amount of preparatory work including the development of detailed guidance and codes of practice has still to be undertaken. As a member of the Mental Capacity Act (Northern Ireland) 2016 Implementation Reference Group, I am involved in this process. However, I do not intend to expand on the significant changes brought about by the 2016 Act in this talk. That, I think, is a subject for another talk and whether I will be invited to give that talk on some future occasion will to a large extent depend on how many of you are still awake at the end of this address.

3. So, back to the 1986 Order and Regulations. An important matter to note is that the Tribunal is a creature of statute and as such it has no powers or functions beyond those granted to it by legislation. The Tribunal consists of a panel of legal members (two of whom are appointed as Chair and Deputy Chair respectively), medical members and lay members. Appointments were previously made by the Lord Chancellor but are now made by the Northern Ireland Judicial Appointments Commission. The Review Tribunal when sitting for the purpose of proceedings under the 1986 Order consists of a legal member (the President), a medical member and a lay member. The medical members are invariably Consultant Psychiatrists, usually, but not necessarily, retired from NHS practice in Northern Ireland. So, in brief terms, that is the constitution of a Mental Health Review Tribunal. The next question I will attempt to address is what does a Mental Health Review Tribunal do?

4. The first point I wish to make is that the Tribunal deals with patients. Under the present legislation, when it comes to identifying what that means for the purposes of describing the function of the Mental Health Review Tribunal, a patient is a person suffering from or appearing to suffer from a mental disorder. What is a mental disorder? We must look to Article 3 of the 1986 Order.

Definition of "mental disorder" and related expressions

3.—(1) In this Order—

- "mental disorder" means mental illness, mental handicap and any other disorder or disability of mind;
- "mental illness" means a state of mind which affects a person's thinking, perceiving, emotion or judgment to the extent that he requires care or medical treatment in his own interests or the interests of other persons;
- "mental handicap" means a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning;
- "severe mental handicap" means a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning;
- "severe mental impairment" means a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.

(2) No person shall be treated under this Order as suffering from mental disorder, or from any form of mental disorder, by reason only of personality disorder, promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs.

5. I would wish to draw two matters to your attention at this stage. Firstly, in relation to the definitions of "mental handicap", "severe mental handicap" and "severe mental impairment", there are references to impairment of intelligence and social functioning and there are references to these impairments being either "significant" or "severe". One might wonder whether impairment of intelligence and social functioning are distinct ingredients of the definition or whether an impairment of intelligence and social functioning must be regarded as a composite ingredient of the definition. One might also wonder how one differentiates between significant and a severe impairment of intelligence.

6. These issues were the subject of a Judicial Review before Weatherup J in 2003. (In the matter of an application by the North and West Belfast Health and Social Services Trust for Judicial Review).

Weatherup J, as he then was, held that the requirement to establish an impairment of intelligence is separate and distinct from the requirement to establish an impairment of social functioning. In relation to the question of what amounts to a severe impairment of intelligence, the Court considered whether this was to be assessed solely and simply by reference to the individual's IQ test results having regard to guidelines promulgated by the British Psychological Society which stated that an IQ of 54 and below represented a severe impairment of intelligence and an IQ of 55 to 69 represented a significant impairment of intelligence.

7. Weatherup J referred to the Guide to the 1986 Order published by the Department of Health and Social Services in 1986 and the Code of Practice to the Order published in 1992 and at paragraph 11 of the Judgment he stated:

[11] After the introduction of the 1986 Order the Department of Health and Social Service issued two publications, being a Code of Practice and a Guide, which concerned the operation of the Order, although neither would be definitive. Article 111 of the Order provides that the Department shall prepare a Code of Practice for the guidance of professionals. The Code of Practice at paragraph 1.13 refers to the term "severe impairment of intelligence and social functioning" and states that the words are - "not meant to restrict these definitions to persons whose intelligence level as measured by psychological tests fall below a particular figure. Assessment should take into account the total impairment both of intelligence and social functioning." Further the Department's Guide at paragraph 11 refers to the definition of "severe mental handicap" and emphasises that it includes <u>severe</u> instead of <u>significant</u> impairment of intelligence and social functioning and states that "it is entirely a matter of clinical judgment as to whether a person exhibits significant or severe impairment of intelligence and social functioning."

8. He then referred to the British Psychological Guidelines and stated at paragraph 17 of the Judgment:

[17] ……. I find that the Tribunal was entitled to take into account the guidelines, but had the Tribunal allowed the guidelines to become determinative of the issue it would have been in error. The conclusion that the guidelines are a relevant consideration is not contrary to the Code or the Guide, if each is interpreted to mean, as should be the case, that psychological tests do not determine the assessment, and clinical judgment should be based on all relevant considerations.

9. At paragraph 18 the Judge stated:

[18] …….. Taking into account psychological tests does not mean that establishing severe impairment of intelligence ceases to involve clinical judgment. In the first place the nature of "intelligence" need not be limited to the results produced by IQ tests. As stated by Simon Brown LJ in Megarry v Chief Adjudication Officer in considering a publication on the subject of autism, there is a real difference between "test intelligence" and "world intelligence" so that the results of IQ tests are not a true indication of useful intelligence. This is one aspect of the situation where the applicant's emphasis on the mental health context may be significant. Further, IQ tests are not determinative. In considering the significance of IQ tests in Megarry v Chief Adjudication Officer, Simon Brown LJ stated that "the claimant's IQ as conventionally tested is likely to be the essential starting point for considering the impairment of intelligence." In any event there may be alternatives to the classification of severe mental impairment as an IQ of 54 and below as proposed by the British Psychological Society. Even if the British Psychological Society classifications are adopted, they are stated to be guidelines only and the paper expresses reservations and exceptions in relation to the application of those guidelines. The paper warned that the guidelines should be used with care. It was stated that in some individuals their level of functioning did not permit formalised assessments. For certain groups specialised tests might be used. There is additional need for caution at the transition points of classification (i.e. 55, 70). Further, the paper notes that allowance should be made for the possibility of measurement error and IQ figures should only be quoted with explicit confidence limits based on the standard error of measurement.

10. What this means is that if the issue of whether a patient is suffering from "mental handicap", "severe mental handicap" and "severe mental impairment" has to be determined by the Tribunal, it is necessary to address the issues of impairment of intelligence and impairment of social functioning as separate ingredients of the any of these definitions and in relation to the assessment of the degree of impairment of intelligence, IQ scores are an important yardstick but they are not determinative of the issue which is a matter of clinical judgment based on all relevant considerations.

11. The second matter arising out of the definitions in Article 3 of the 1986 Order relates to the important exclusions contained in paragraph (2). Alcohol or drug dependency per se cannot form a lawful basis for the detention of an individual under the 1986 Order. And unlike England and

Wales, a diagnosis of a personality disorder in Northern Ireland cannot form a lawful basis for the detention of an individual under the 1986 Order.

12. So, the Tribunal deals with patients and, in general, the three categories of patient which the Tribunal usually deals with are detained patients (either detained for assessment or treatment), patients subject to guardianship, and restricted patients being patients who are the subject of a hospital order with restrictions by virtue of which discharge from hospital is restricted.

13. A patient's case falls to be considered by the Tribunal as a result of one of the following events:

(a) A patient's application for discharge when the patient is being detained for assessment or, following assessment, is being detained for treatment. It is important to note that a challenge to detention can now be made during the assessment period and any such challenge should be heard by the Tribunal within the assessment period and this recent development has the potential to add considerably to the workload of the Tribunal.

(b) A patient's application for discharge from guardianship.

(c) A patient's application for discharge when the patient is a restricted patient detained under a hospital order and subject to a restriction order for a specific time or, more commonly, without limit of time under Article 47 of the Order.

(d) An application by a patient's nearest relative as defined in Article 32 (1) of the 1986 Order in relation to a patient detained for treatment or subject to guardianship. See Article 71 (4).

(e) A reference by the Regional Health and Care Board or the relevant Health and Social Care Trust if the patient's status has not been considered by the Tribunal within the previous two years. Article 73.

(f) A reference by the Department of Justice in respect of a restricted patient at any time and mandated if the patient's status has not been considered by the Tribunal within the previous two years. Article 76.

(g) If a conditionally discharged restricted patient is subsequently recalled to hospital, the matter must be referred to the Tribunal within one month of the day on which the patient returns. Article 80 (1).

(h) A reference by the Attorney General, the Department of Health, or on the direction of the High Court, the Master (Care and Protection) at any time. Article 72 (1)

(i) A reference by the Regional Quality Improvement Authority under Article 86 (3).

14. When such an application or reference is made, as I have stressed at the outset, the powers of the Tribunal are quite specific and are governed by the Order and the Regulations. I will now address the statutory criteria that a Mental Health Review Tribunal that it empaneled to hear an application or reference is required to apply in order to reach a decision and I will also outline the procedure before, at and following the hearing.

15. Prior to the hearing the Tribunal and the patient's nominated legal representative will be provided with written reports from the patient's Responsible Medical Officer and from the patient's Social Worker for consideration and this evidence will supplemented by means of oral evidence given by these witnesses at the hearing.

16. The RMO's report should contain information to enable the Tribunal to ascertain the following matters, always subject to oral evidence to be adduced at the hearing.

17. The first issue which the report should address is the RMO's diagnosis of the mental disorder presently suffered by the patient. The relevance of this is that unless the patient (other than a patient is subject

to guardianship) suffers from a “mental illness” or suffers from “severe mental impairment” as defined in Article 3 (1), the Tribunal must discharge the patient. Article 77 (1) (a).

18. The second issue which the report should address is whether the nature or degree of the mental illness or severe mental impairment is such that it warrants the patient’s detention in hospital for treatment. If the nature or degree of either of these forms of mental disorder are not such as to warrant detention in hospital for treatment, the Tribunal must discharge the patient. Article 77 (1) (a). In relation to this issue, one must consider whether treatment could effectively and safely be given as an outpatient. See Re DH [2004] a decision of Weatherup J. The Tribunal must consider the question of whether the patient would remain as a voluntary patient. See the decision of Horner J in MH v MHRT given on 24th June, 2014. Further, in the context of a person diagnosed with an eating disorder, the decision of Weatherup J in JR 18 delivered on 23rd November, 2007, contains the following guidance is set out in paragraph 16:

“In my judgment medical treatment for mental disorder may include the provision of nourishment, when the need for the provision of such nourishment is brought about as a consequence of the mental disorder. It would be somewhat incongruent if this patient could be detained in hospital without her consent for a mental disorder that involved the patient in self-harming and having suicidal ideation and that once detained she could continue to manifest self-harm by resorting to hunger strike, thereby putting her life at risk, but could not be treated for that consequence of her mental disorder without her consent.”

19. The third issue which the report should address is whether discharge of the patient would create a substantial likelihood of serious physical harm to the patient and/or to other persons. If there is not a substantial likelihood of serious physical harm to the patient and/or to others upon the discharge of the patient, the patient must be discharged.

Article 77 (1) (b). In this context Article 2 (4) of the Order is of crucial importance. It states:

"(4) In determining for the purposes of this Order whether the failure to detain a patient or the discharge of a patient would create a substantial likelihood of serious physical harm—

(a)to himself, regard shall be had only to evidence—

(i)that the patient has inflicted, or threatened or attempted to inflict, serious physical harm on himself; or

(ii)that the patient's judgment is so affected that he is, or would soon be, unable to protect himself against serious physical harm and that reasonable provision for his protection is not available in the community;

(b)to other persons, regard shall be had only to evidence—

(i)that the patient has behaved violently towards other persons; or

(ii)that the patient has so behaved himself that other persons were placed in reasonable fear of serious physical harm to themselves."

20. I have to stress again that if the Tribunal is not satisfied on the balance of probabilities on solely on the basis of evidence of matters set out in Article 2 (4) that discharge would create a substantial likelihood of serious physical harm to the patient and/or others, the Tribunal must order the discharge of the patient even if detention in hospital for treatment of the patient's mental illness or severe mental impairment is considered by all concerned to be in the patient's best interests.

21. The Courts have been asked to consider the meaning of the phrase substantial likelihood of serious physical harm" and it is worthwhile taking some time to consider the guidance given by the Courts.

22. In JR 45, McCloskey J delivered a decision on 3rd March, 2011 in which he stated at paragraph 13 that a "substantial likelihood connotes a real probability…" He went on to state in the same paragraph:

"Accordingly, in simple terms, Article 77(1)(b) is concerned with the formation by the Tribunal of an evaluative, predictive and rational judgment, applying the civil standard of the balance of probabilities, that the discharge of the patient would create *a real probability of serious*

physical harm to the patient or some other person, with the burden resting on the detaining authority.*"*

23. He then gave the following guidance in respect of Article 2 (4) and I quote from paragraph 14 of the Judgment:

"I consider that Article 2(4) has two central features. The first is that the harm to which the Tribunal must direct its mind is of the *serious physical* variety. The second is that in making the determination required, the Tribunal must have regard *only* to a certain kind of evidence viz. *evidence that the patient has behaved violently towards other persons* or *evidence that the patient has so behaved himself that other persons were placed in reasonable fear of serious physical harm to themselves.* Thus, the Tribunal must cast its gaze both backwards and forwards. In short, by virtue of Article 2(4), duly analysed:

(a) The violence or apprehended harm belonging to the past must be *physical* in nature.

(b) The apprehended harm, as regards the future, must also be *physical* in nature.

(c) The apprehended physical harm as regards both the past and, by prediction, the future must be *serious* in nature: I construe this as harm which is more than trivial or minor.

(d) Psychological harm or a state of mental anxiety or foreboding or a feeling of harassment on the part of a third party – as regards both the past and the future, as predicted - will not suffice.

(e) The evidence relating to the patient's past conduct must establish not only that this engendered a fear of serious physical harm to some third party but that such fear was *reasonable*. In my view, this imports an objective element, which is designed to protect the patient from unfounded, irrational or ill motivated assertions of fear by some third party.

This analysis of Article 2(4) serves to highlight the exacting and intellectually challenging nature of the Tribunal's decision making under Article 77."

24. However, I issue a major caveat at this stage in respect of undue reliance on JR 45. The guidance provided by McCloskey J must be considered in the light of the Northern Ireland Court of Appeal's decision in the case of R v Sean Hackett (judgment delivered on 14th September, 2015). The relevant passage of the Lord Chief Justice's judgment is contained at paragraphs 43 to 45:

"[43] It is apparent from the wording of Article 77 that the statute imposes a burden upon the detaining authority to satisfy the statutory test. Where a statutory test depends upon past or present fact there is no dispute that the Tribunal must be satisfied on the balance of probabilities about that fact. It is also clear from the authorities that the same approach follows in relation to the determination of whether the applicant to the Tribunal is suffering from mental illness. If there is a dispute about that the task of the Tribunal is to resolve the dispute.

[44] The task faced by the Tribunal in Article 77 (1) (b) is different. It is required to make an evaluative judgment and assessment about future events. The judgment is to be made in the context of evaluating risk. At paragraph 35 of R v Vowles the court accepted the submission that the concept of burden of proof was not relevant in risk evaluation. A slightly different approach was taken in R(N) v Mental Health Review Tribunal (Northern Region) [2006] QB 468. The court sought to resolve the difficulty of imposing a standard of proof on an evaluative judgment in this context at paragraph 99:

"99. We would accept that the concept of a standard of proof is "not *particularly* helpful" (per Lord Hoffmann, at para 56, in Secretary of State for the Home Department v Rehman , with emphasis added) in relation to such a process. But we would not go so far as to hold that there is no room for its application at all. An opinion on the appropriateness or necessity of continuing detention may in principle be held with different degrees of certainty, and it may be important for the tribunal to know what degree of certainty is called for. Under sections 72 and 73 the tribunal has to be "satisfied" as to the relevant matters. As Lord Lloyd of Berwick observed in In re H (Minors) (Sexual Abuse: Standard of Proof) [1996] AC 563 , 576 d – g), "is satisfied" is an expression with a range of meanings covering the criminal standard of proof ("satisfied so as to be sure"), through the civil standard ("satisfied on a balance of probabilities") to being a synonym for "concludes" or "determines" and therefore having an entirely neutral function. We see no absurdity in a tribunal having some doubt as to the appropriateness or necessity of continuing detention, yet being satisfied on the balance of probabilities that it is appropriate and necessary. Accordingly, as it seems to us, the standard of proof has a potential part to play in the decision-making process even in relation to issues that are the subject of judgment and evaluation. In practice, we would expect the tribunal generally either to form the requisite judgment or not to form it, without needing to have specific regard to any standard of proof. But the standard of proof provides a backdrop to the decision-making process and may have an important role in some cases."

[45] We consider that the approach espoused in JR 45 unduly fetters the evaluative judgement which Article 77 (1) (b) of the 1986 Order requires. That approach is also out of kilter with the case law to which we have referred in the preceding paragraph. When considering this test the Tribunal should examine the nature and extent of the risk and the consequences if the event were to occur. It should then as a matter of judgement assess whether the likelihood of serious physical injury is substantial. Likelihood is not to be interpreted as requiring a probability of serious physical injury. The context is one of risk assessment. Where the risk is of an injury that is very serious or life-threatening a real possibility may well be sufficient to satisfy the test."

25. It is clear that the Court of Appeal has rejected McCloskey J strict test and has recommended a much more flexible and apposite approach

which takes into account the severity of the harm which could occur if the patient were to be discharged.

26. The fourth issue which the RMO's report should address, as it is a matter which the Tribunal has to address in its decision, is whether, on the facts of the case, detention in hospital for the purposes of treatment is compatible with Articles 5 and 8 of the European Convention on Human Rights. I will spare you the recital of the text or Articles 5 and 8 of the ECHR and will simply refer you to two important decisions of the European Court of Human Rights which deal with the issue of detention of patients suffering from mental illness for the purpose of medical treatment. The two decisions are Winterwerp v Netherlands, a decision of the Court in 1979, and Pleso v Hungary, a decision of the Court in 2012. I apologise in advance for the length of the quote from the Pleso judgment starting at paragraph 55 but the following passage is of importance:

"55. The Court reiterates that the expressions "lawful" and "in accordance with a procedure prescribed by law" in Article 5 § 1 essentially refer back to domestic law; they state the need for compliance with the relevant procedure under that law. The notion underlying the term in question is one of fair and proper procedure, namely that any measure depriving a person of his liberty should issue from and be executed by an appropriate authority and should not be arbitrary (see *Winterwerp v. the Netherlands*, 24 October 1979, § 45, Series A no. 33; *Wassink v. the Netherlands*, 27 September 1990, § 24, Series A no. 185-A; and more recently, *Bik v. Russia*, no. 26321/03, § 30, 22 April 2010).

56. It is in the first place for the national authorities, notably the courts, to interpret and apply domestic law. However, since under Article 5 § 1 failure to comply with domestic law entails a breach of the Convention, it follows that the Court can, and should, exercise a certain power of review of such compliance (see *Benham v. the United Kingdom*, 10 June 1996, § 41, *Reports of Judgments and Decisions* 1996-III, and *Bik v. Russia,* cited above, § 31).

57. While the Court has not previously formulated a global definition of what types of conduct on the part of the authorities might constitute "arbitrariness" for the purposes of Article 5 § 1, key principles have been developed on a case-by-case basis. It is moreover clear from the case-law that the notion of arbitrariness in the context of Article 5 varies to a certain extent depending on the type of detention involved (see *Saadi v. the United Kingdom* [GC], no. 13229/03, § 68, ECHR 2008).

58. One general principle established in the case-law is that detention will be "arbitrary" where, despite complying with the letter of national law, there has been an element of bad faith or deception on the part of the authorities. The condition that there be no arbitrariness further demands that both the order to detain and the execution of the detention must genuinely conform with the purpose of the restrictions permitted by the relevant sub-paragraph of Article 5 § 1. There must in addition be some relationship between the ground of permitted deprivation of liberty relied on and the place and conditions of detention (*ibid*, § 69 with further references).

59. The requirement of lawfulness laid down by Article 5 § 1 (e) ("lawful detention" ordered "in accordance with a procedure prescribed by law") is not satisfied merely by compliance with the relevant domestic law; domestic law must itself be in conformity with the Convention, including the general principles expressed or implied in it, particularly the principle of the rule of law, which is expressly mentioned in the Preamble to the Convention. The notion underlying the expression "in accordance with a procedure prescribed by law" requires the existence in domestic law of adequate legal protections and "fair and proper procedures" (see, among other authorities, *Winterwerp v. the Netherlands*, cited above, § 45).
60. Moreover, the Court has outlined three minimum conditions for the lawful detention of an individual on the basis of unsoundness of mind under Article 5 § 1 (e) of the Convention: he must reliably be shown to be of unsound mind, that is, a true mental disorder must be established before a competent authority on the basis of objective medical expertise; the mental disorder must be of a kind or degree warranting compulsory confinement; and the validity of continued confinement must depend upon the persistence of such a disorder (see *Winterwerp v. the Netherlands*, cited above, § 39; *Johnson v. the United Kingdom*, 24 October 1997, § 60, *Reports* 1997-VII; and more recently, *Stanev v. Bulgaria* [GC], no. 36760/06, § 145, 17 January 2012).
61. In deciding whether an individual should be detained as a "person of unsound mind", the national authorities have a certain margin of appreciation regarding the merits of clinical diagnoses since it is in the first place for them to evaluate the evidence in a particular case: the Court's task is to review under the Convention the decisions of those authorities (see *Winterwerp v. the Netherlands*, cited above, § 40, *Luberti v. Italy*, 23 February 1984, § 27, Series A no. 75, and more recently, *Witek v. Poland*, no. 13453/07, § 39, 21 December 2010). It is not the Court's task to reassess various medical opinions, which would fall primarily within the competence of national courts; however, it must ascertain for itself whether the domestic courts, when taking the contested decision, had at their disposal sufficient evidence to justify the detention (see *Herz v. Germany*, no. 44672/98, § 51, 12 June 2003). Deference is greater if it is a case of emergency detention (*ibid*, § 55).
62. The detention of an individual is such a serious measure that it is only justified where other, less severe, measures have been considered and found to be insufficient to safeguard the individual or public interest which might require that the person concerned be detained (see *Witold Litwa,* loc. cit.; *Varbanov v. Bulgaria*, no. 31365/96, § 46, ECHR 2000-X; and *Stanev v. Bulgaria,* cited above, § 143)."

27. The key points are that in order to be convention compliant, detention must only take place and be maintained within a strict legal framework. A patient must reliably be shown to be of unsound mind, that is, a true mental disorder must be established before a competent authority on the basis of objective medical expertise. The mental disorder must be of a kind or degree warranting compulsory confinement. The validity of continued confinement must depend upon the persistence of such a disorder. Finally, detention is only justified where other, less severe, measures have been considered and found to be insufficient to

safeguard the individual or public interest which might require that the person concerned be detained.

28. In dealing with the contents of the RMO's report I have also dealt with issues to be determined by the Tribunal when considering whether detention for treatment is justified. I will now briefly describe what should be contained in the Approved Social Worker's Report.

29. The Social Worker is required to provide to the Tribunal and the legal representative of the patient an up-to-date social circumstances report on specified matters to be considered by the Tribunal before a decision is reached on whether the patient should be discharged following the application of the foregoing statutory criteria. The matters to be considered include the patient's home and family circumstances, the views and wishes of the patient's nearest relative or the person so acting, the patient's financial circumstances, the patient's opportunities for education, training, employment or occupation, and the accommodation, community support and medical care and therapy facilities which the patient would be able to avail of if discharged.

30. This, usually, is the extent of the evidence which will be presented by the Trust to the Tribunal. The formal requirement for the Trust to provide such information to the Tribunal is set out in Rule 6 and the schedule to the 1986 Rules. Part A of the schedule sets out the information relating to the patient that is required and part B sets out the reports relating to the patient that are required. If the Trust is of the opinion that any information should be withheld from the patient on the ground that disclosure would adversely affect the health or welfare of the patient or others, this information must be set out in a separate document in which shall be set out the reasons for believing that its disclosure would have that effect. Parts A and B of the schedule do not include the entirety of the patient's medical, therapeutic or nursing notes and records. Although

these are not included in Parts A and B, the practice is that requests by patient's representatives for access to the notes and records will usually be granted, especially if required to enable an independent expert to be instructed on the patient's behalf.

31. The combined effect of Rule 6 and Rule 12 and Parts A and B of the schedule to the rules is that all the information that the Tribunal receives apart from information which it is requested to withhold from the patient on the ground that disclosure would adversely affect the health or welfare of the patient or others has to be provided to the patient or the applicant. The Tribunal in advance of the hearing must consider whether any objection to disclosure has merit and if it determines that the objection to disclosure is justified it must record its decision in writing not to disclose the documentation. However, if the patient is represented by a barrister or solicitor or registered medical practitioner or "other suitable person by virtue of his experience or professional qualification", the material withheld from the patient or applicant must be disclosed to that representative "provided that no information which is disclosed only to the representative is thereby disclosed either directly or indirectly to the patient or the applicant.

32. Once the patient's legal representative has received the information to which there is an entitlement under the legislation, it is usual for the representative to consult with the patient, if that is possible and to give consideration to the need for an independent expert report, taking into account the presentation of the patient and the patient's instructions. The instruction of an independent expert Psychiatrist on behalf of the patient can in appropriate cases provide the Tribunal with valuable additional evidence to aid it in its determination of the question of whether the statutory tests for detention are met. However, the instruction of such an expert does inevitably introduce an element of delay into the process.

33. Procedure at the hearing is regulated by Article 83 of the Order and by the 1986 Rules. The Tribunal will usually have the relevant Notes and Records and a copy of the most recent previous decision of the Tribunal, is any. The hearings are usually listed for the afternoon. The reason for this is that the Psychiatrist member of the Tribunal usually interviews the patient on the morning of the hearing, reads through the notes and records and interviews staff who are assigned to the patient. See Rule 11. It is unusual for the Tribunal to interview the patient, unless the patient requests this. See Rule 22 (2). The Tribunal may conduct the hearing in such a manner as it considers most suitable bearing in mind the health and best interests of the patient. See Rule 22 (1). The Tribunal sits with a member of the secretariat who notes the proceedings.

34. At the outset, before the parties are brought into the Tribunal room, the Psychiatrist member orally reports to the two other members of the Tribunal the interview with the patient and staff and the review of the notes. The psychiatric member then orally states whether he or she is in agreement with the diagnosis put forward in the report of the RMO. It is at this stage that the legal representatives are asked into the Tribunal room and are informed of the preliminary views of the psychiatric member of the Tribunal in relation to the issue of diagnosis. The representatives are then asked if there are any issues arising out of this preliminary view and whether there are any other issues that they wish to raise and those issues are then dealt with at that stage. See the decisions of Re DH [2004] Weatherup J and Re MW [2008] Weatherup J. The representatives then leave the Tribunal room to discuss the preliminary views with their respective clients and once a reasonable time has been given for this to take place, the hearing of the application or referral is resumed with the Trust witnesses giving evidence.

35. The role of the Psychiatric member has been the subject of a number of challenges in the High Court. Kerr J in the case of Re G [2003] addressed the issue of whether Rule 11 was compatible with the European Convention. He stressed that the role of the Psychiatrist member was to arrive at a provisional view of the patient's mental condition and not a final view. The substance of the views should be communicated. The parties should be given the opportunity to comment on any significant findings and any factual differences with the RMO. This summary should normally be given by the President. Cross-examination of the Psychiatrist member was not permitted but all differences or additional information should be fairly laid out. These views were reiterated by Weatherup J in the case of Re DH [2004] and by the same judge in Re MW [2008] in which the learned judge considered whether Rule 11 was compatible with Article 6 of the Convention. The issue was whether procedural fairness was compromised and apparent bias was demonstrated by the Psychiatric member expressing her opinion on the issue of diagnosis. The judge held that the purpose of the examination was to form an opinion on the patient's mental condition and not on the issue of whether detention was merited. The opinion should be a provisional one. If the opinion differed from the RMO's or was otherwise adverse to the patient's interests, that provisional view should be disclosed at the hearing and representations on this issue should be received.

36. I should just say at this stage that it is highly desirable that the patient be appropriately represented at the hearing and the rules empower the Tribunal to appoint a person to act for a patient who does not want to conduct their own case or to appoint a representative.

37. The patient is entitled to be present throughout the hearing but the issue as to whether the patient should be excluded from the hearing or

any part thereof often arises. The Tribunal will make such a decision only after considering the views expressed by the parties and their representatives and the views of the Psychiatrist member. Exclusion of patients against their will is only permitted when his or her presence during the hearing or any part of the hearing would be contrary to the best interests of their health. The Tribunal cannot exclude legal or other qualified representatives of the patient or applicant as defined in Rule 12 (3). Other representatives can be excluded but to do so it must inform the person excluded of its reasons and must record those reasons in writing. Rule 21 (4).

38. The Tribunal sits in private unless the patient requests otherwise and the Tribunal is satisfied that admission of members of the public including relatives and friends of the patient would not be contrary to the interests of the patient. Rule 21 (1). The patient must be informed of the reasons for the refusal of a request to have the matter heard in public and the Tribunal must record the reasons in writing. Rule 21 (2). Even where the Tribunal sits in private it may admit such persons on such terms and conditions as it considers appropriate. Rule 212 (3).

39. The Tribunal must seek to avoid formality in the proceedings as far as is appropriate and the President must explain the manner of proceedings that the Tribunal proposes to adopt. Rule 22 (3).

40. The RMO and Social Worker will give oral evidence additional to and in support of the evidence contained in their reports, and then will be subject to cross-examination on behalf of the patient. Strict rules of evidence do not apply. Rule 14 (2). Although evidence can be given on oath it is unusual for witnesses to be sworn before giving their evidence.

41. The patient is then given the opportunity to give or call evidence. The patient should always be given the opportunity to speak. Any additional evidence can follow from other sources. See Rule 22 (4). After

all the evidence is given the applicant and, where the patient is not the applicant, the patient must be given a further opportunity to address the Tribunal. Rule 22 (5). Throughout the proceedings attempts should be made to reduce the stress experienced by the patient. Every reasonable accommodation should be made to enable the patient to understand and engage in the proceedings. See the recent Galo decision. The RMO will be present throughout the hearing unless the patient requests an interview in the absence of any other persons including the RMO. See Rule 22 (2).

42. The decision of the Tribunal must be in accordance with the evidence. The options are:

(a) In every case, there is the discretion to discharge even where the statutory criteria for detention or continuance of guardianship have been satisfied. See Article 77 (1).

(b) The Tribunal may order detention or guardianship to continue when all the relevant criteria have been satisfied. This order may be accompanied with a recommendation to leave of absence or to transfer into hospital or to transfer into guardianship with a view to facilitating discharge at a future date. See Article 77 (2) (a) of the Order. If such a recommendation is not complied with the Tribunal can further reconsider the case. Article 77 (2) (b).

(c) The Tribunal must order the discharge of the patient if one or more of the criteria for detention have not been met. In the case of a discretionary as opposed to a mandatory discharge, such discharge may be delayed to a certain date to facilitate setting up alternative accommodation or supervisory facilities. However, a mandatory discharge cannot be delayed for any reason and certainly not to facilitate setting up alternative accommodation or supervisory facilities as is clear from the judgment of Stephens J in Re X (No 2) [2009].

(d) In the case of a restricted patient, the Tribunal may order a conditional discharge. See Article 77 (3) of the Order.

(e) In the case of a patient subject to guardianship, the tribunal may order the continuation or the discharge of guardianship. See Article 77 (3) of the Order.

(f) In any case, the tribunal may adjourn the hearing for the purpose of obtaining further information or for other appropriate purposes. See Rule 16 of the 1986 Rules. This provision requires further consideration.

43. Rule 16 states as follows:

"(1) The tribunal may at any time adjourn a hearing for the purpose of obtaining further information or for such other purposes as it may think appropriate.

(2) Before adjourning any hearing, the tribunal may give such directions as it thinks fit for ensuring the prompt consideration of the application at an adjourned hearing.

(3) Where the applicant or the patient (where he is not the applicant) or the responsible authority or in the case of a restricted patient or a conditionally discharged patient, the Secretary of State requests that a hearing adjourned in accordance with this rule be resumed, the hearing shall be resumed provided that the tribunal is satisfied that resumption would be in the interests of the patient.

(4) Before the tribunal resumes any hearing which has been adjourned without a further hearing date being fixed it shall give to all parties and, in the case of a restricted patient or a conditionally discharged patient, the Secretary of State not less than 14 days' notice (or such shorter notice as all parties may consent to) of the date, time and place of the resumed hearing."

44. At first sight Rule 16 of the above Rules appears to give the Tribunal a wide discretionary power to grant adjournments in appropriate cases. Sub-paragraph (1) specifically states that the Tribunal may at any time adjourn a hearing for the purpose of obtaining further information or for such other purposes as it may think appropriate. It is difficult to envisage how an enabling provision such as this could have been more widely drafted. On the face of it, there is nothing in the provision to limit the type of "further information" which might be obtained during the proposed adjournment and there does not appear to be any specific limitation or

restriction on the “other appropriate purposes” which might justify an adjournment.

45. It is permissible for a Tribunal to adjourn a hearing for many reasons. These include obtaining further evidence, allowing the attendance of a particular witness, instructing an independent expert, appointing a legal representative or facilitating the attendance of an existing representative. In restricted cases, the need for an adjournment would arise if the Secretary of State has not been notified of the hearing or had not had an opportunity of commenting on all the reports. The decision in relation to whether or not to adjourn involves the Tribunal exercising its discretion and it is clear from the authorities that this exercise of judicial discretion can be reviewed if there is an error of law.

46. On the face of it, it would appear that Rule 16 permits the Tribunal to approach cases which came before it with a valuable degree of flexibility with the aim of ensuring a just result. For instance, in cases where there is evidence of improvement in the Patient’s condition and further sustained improvement is anticipated in the short-term, but continued detention is warranted at the hearing date because the statutory tests for detention are then met, an adjournment might be appropriate in order to see whether such improvement does materialise in the hope that at the adjourned hearing the Patient’s discharge could be ordered or the Patient could be re-graded before the date of the adjourned hearing. If the Tribunal were compelled to deal with such a case on the first hearing date, the Patient’s detention would be confirmed and the Patient could not apply to the Tribunal again for a further set period of time, thus giving rise to the risk that his or her period of detention might be longer than was justified. In the past, I have considered that the use of Rule 16 to facilitate an adjournment in the circumstances described above was an appropriate use of this Rule as the “further information” was information as to the

condition of the Patient in a number of weeks' time and the "appropriate purpose" was to ensure that the detention of the Patient was not extended beyond a period which was strictly necessary and legally justified.

47. It would appear that this interpretation of Rule 16 does not accord with the English Court of Appeal's (E+W) interpretation of a similar provision contained in the Welsh Rules. There is a specific provision in the Welsh Rules (Rule 21 of the MHRT Wales Rules 2008) which confers a discretion on the Welsh Tribunal to adjourn a hearing in order to obtain further information or for such other reason as it thinks appropriate and the MHRT Wales will normally grant a request for adjournment by a representative if there are reasonable grounds for it. It has been decided by the Court of Appeal (E+W) that although Rule 21 of the Welsh Rules allows an adjournment for such other purposes as the Tribunal may think necessary, the Tribunal has no power to adjourn to give the Patient's condition an opportunity to improve or to see an improvement already made sustained. The Court of Appeal (E+W) stated that the purpose of the rule to adjourn is primarily to obtain information about the Patient's *current* condition. Where the Tribunal is satisfied that the criteria for discharge are not met at the time of the hearing, it has no power to adjourn to give the Patient's condition an opportunity to improve. See *R v The Nottingham Mental Health Review Tribunal Ex p Secretary of State for the Home Department and R v The Trent Mental Health Review Tribunal Ex p Secretary of State for the Home Department* Court of Appeal (E+W) Civil Division 15th September, 1988.

48. These two cases involved restricted patients and it is clear that the Court of Appeal, relying on the earlier Court of Appeal decision of *R v Oxford Regional Mental Health Review Tribunal Ex p Secretary of State for the Home Department* [1986] 1 WLR 1180, based its decision on the

premise that the statutory role of the Tribunal at a hearing in the case of restricted Patients was restricted to granting an absolute discharge, granting a conditional discharge or refusing any discharge. The Court of Appeal held that the power to adjourn the hearing must be interpreted in light of the limits placed by statute on the role of the Tribunal. Balcome LJ stated:

"The Tribunal in such a case is, of course, exercising a judicial, as opposed to an administrative, function. A judicial function does not of itself preclude the possibility of an adjournment to see whether or not conditions which are not then met will be satisfied at some future date, if that is within the scope of the powers which the Act in question gives the Tribunal. In my judgment the Act does not give a mental health review tribunal any such powers. It has, as I have said, no general supervisory function over the progress of a restricted Patient….It has certain specific judicial powers to be exercised in relation to the application before it…"

49. It is clear that English Court of Appeal decisions are not binding in this Jurisdiction but they are certainly of persuasive authority and it might be possible to argue that if this decision is to be followed in this jurisdiction then it should be limited in effect to restricted Patients under Article 78 of the 1986 Order and not applied in the case of a non-restricted Patients under Art 77. However, such a distinction would be difficult to justify in law. Therefore, in light of this authority, it would appear that it would be unlawful for a Mental Health Review Tribunal in Northern Ireland to grant an adjournment in the circumstances described above.

50. Other issues relevant to adjournments of Tribunal hearings have received judicial attention in England and Wales. *In R (on the application of B) v Mental Health Review Tribunal* [2002] EWHC 1533 (Admin), Scott Baker J held that where there is an adjournment, the Tribunal should fix a time-limit within which the reconvened hearing will take place, with clear directions to ensure that any relevant expert evidence is obtained on time. He also directed that experts should meet to narrow any differences of opinion and that adjournments should not be granted without giving the Patient's representative an opportunity to be heard. An adjournment which

is not required by the Patient may interfere with the Patient's right to a speedy determination of the case. Brief reasons should be given for any decision to adjourn.

51. In *R (on the application of X) v Mental Health Review Tribunal* [2003] All ER (D) 160 (May), Collins J held that whilst the MHRT has the power of its own motion to adjourn to obtain information, it should not do so unless it regards it as necessary to do justice and reach the right result in the case. This required a balance to be struck between the need for any information and any delay which will occur in the determination of the case.

52. In *R (Secretary of State for the Home Department) v Mental Health Review Tribunal (MW and FO)* [2000] EWHC 638 (Admin), it was held to be unlawful in the case of a restricted Patient for the Tribunal to adjourn *solely* for the purpose of obtaining evidence in relation to the making of a recommendation although there was nothing to stop it gathering such information if it adjourns the hearing in order to obtain further information on a matter within its jurisdiction (discharge).

53. In *R (Ashworth) v Mental Health Review Tribunal and R (H) v Ashworth* [2002] EWCA (Civ) 923, an unrestricted case, the Court of Appeal held that where the availability of suitable community based services is pre-requisite for the discharge criteria to be met, but the Tribunal is in any doubt as to the availability of such services, the Tribunal should adjourn to obtain information as to the availability of those services. This case was specifically referred to by Stephens J in his judgment in *Re X (no 2)* [2009] NIQB 2. In that case he held that the Tribunal did not have power to defer discharge for six weeks while a care package was put in place because the Tribunal had found that it was not satisfied that discharge would create a substantial likelihood of serious physical harm

to himself or others. There is no power to direct discharge at a future date if the criteria for detention are not met at the time of the hearing.

54. In *DC v Notinghamshire Healthcare NHS Trust* UKUT 92 AAC at 28*,* a restricted case, it was decided that if the Tribunal has decided that a conditional discharge is appropriate but is not yet in a position to draft the necessary conditions, it should adjourn for further information rather than grant a deferred conditional discharge.

55. So far I have concentrated on the statutory criteria for the detention of a patient suffering from mental illness or severe mental impairment in hospital for treatment. I will now briefly address the somewhat different statutory criteria which in cases of restricted patients and patients subject to guardianship.

56. In the case of a restricted patient, exactly the same considerations apply in relation to the evidence to be presented concerning a detained patient but with the added provision that conditional discharge orders are possible. The effect of the provisions (Articles 78 (1) and (2) of the 1986 Order), is that if the evidence does not at the time of the hearing satisfy the Tribunal that the restricted patient suffers from mental illness or severe mental impairment of a nature or degree to warrant detention in hospital for treatment, or does not satisfy the Tribunal that discharge would give rise to a substantial risk of serious physical harm to the patient or to others, the Tribunal must additionally consider whether it is nevertheless appropriate for the patient after discharge to remain liable to be recalled into hospital for treatment. If so, a conditional discharge can be ordered.

57. The terms of the Tribunal's order can require the patient to comply with such conditions as the Tribunal imposes at the time of making the order. The Minister for Justice can also impose or vary conditions for compliance at any time thereafter, and can recall the conditionally discharged restricted patient to hospital at any time. See Article 78 (4) of

the Order. The Tribunal is not empowered to make a conditional discharge order in respect of any patient who is not subject to a restriction order.

58. When a patient is subject to guardianship, the criteria, and, therefore, the evidence which is required to enable the Tribunal to reach a decision as to whether the guardianship order should continue, is somewhat different. See Article 77 (3) of the Order. The requirement is that the Tribunal must discharge the patient from guardianship if it is not established that the patient is suffering from mental illness or severe mental handicap of a nature or degree which warrant his remaining under guardianship or if it is not established that it is necessary in the interests of the welfare of the patient that he should remain under guardianship. It should be remembered that severe mental handicap is defined as meaning a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning. Therefore, the North and West Belfast Trust case is of central importance to the determination of this aspect of the criteria for the continuation of guardianship.

59. It is important to note that the existence of the likelihood of harm to self or others if guardianship were to be discharged, is not a prerequisite to the continuation of guardianship. However, such evidence of the likelihood of harm to self, would be relevant to the question of whether the continuation of guardianship is necessary in the interests of the patient.

60. It is important to note that guardianship will be done away with when the relevant provisions of the 2016 Act come into force. However, in the meanwhile it is important to have a good understanding of what guardianship entails and what is and is not permitted in terms of the imposition of restrictions and requirements on the patient when a guardianship order is in place.

61. Under Article 18 of the 1986 Order, an application for reception of patient into guardianship can be made in respect of a patient who is aged 16 or over on the grounds that he is suffering from mental illness or severe mental handicap of a nature or degree which warrants his reception into guardianship and it is necessary in the interests of the welfare of the patient that he is so received. A patient accepted into guardianship can only remain under guardianship for a period of 6 months although it is possible under Article 23 of the 1986 Order to make an application to renew guardianship. The application for guardianship has to be based on two medical recommendations and a recommendation by an approved social worker. The medical recommendations must deal with the issue of whether the patient is suffering from a mental illness or severe mental handicap of a nature or degree which warrants the patient's reception into guardianship. The medical recommendations must be based on very recent examinations of the patient. One of the clinicians should be a clinician treating the patient and the other should be approved under the Mental Health Order by the RQIA. Schedule 1 of the Order sets out provisions designed to ensure the objectivity of the clinical opinions. The approved social worker must deal with the issue of whether guardianship is necessary in the interests of the welfare of the patient.

62. As stated above, under Article 3 of the 1986 Order, "mental illness" is defined as meaning "a state of mind which affects a person's thinking, perceiving, emotion or judgment to the extent that he requires care or medical treatment in his own interests or the interests of other persons" and "severe mental handicap" is defined as meaning "a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning."

63. Article 19 of the 1986 Order lists the persons who can apply for a guardianship order, namely the nearest relative of the patient or an

approved social worker other than the approved social worker who has dealt with the issue of welfare under Article 18. If the application is made by an approved social worker, then there is a requirement for that person to consult in advance with the nearest relative of the patient unless there are good reasons for not doing so. In such circumstances, the nearest relative has a right to be informed of application for guardianship as soon as it is practicable thereafter. If the nearest relative objects to the reception of the patient into guardianship then the approved social worker making the application must consult with another approved social worker not being the approved social worker who has dealt with the issue of welfare under Article 18 and, following such consultation, if it is decided to proceed with the application for guardianship, the application must state that the nearest relative objects to the application.

64. The RQIA which has taken over the role and functions of the now abolished Mental Health Commission (see Section 25 of the Health and Social Care (Reform) Act (Northern Ireland) 2009) has a responsibility to oversee the operation of guardianship in any particular case in that under Article 22 (a) of the 1986 Order, this body must be provided with copies of the guardianship application and the medical and social work recommendations upon which the application is founded and under Article 86 of the 1986 Order, this body is under a duty to "keep under review the care and treatment of patients, including (without prejudice to the generality of the foregoing) the exercise of the powers and the discharge of the duties conferred or imposed by 1986 Order" and to make "inquiry into any case where it appears that there may be ill-treatment, deficiency in care or treatment, or improper detention in hospital or reception into guardianship of any patient, or where the property of any patient may, by reason of his mental disorder, be exposed to loss or damage." In relation to guardianship, the overview functions of the RQIA include the power to

make recommendations to the relevant Trust or the Department and to refer a case to the Mental Health Review Tribunal.

65. Article 24 makes provision for the discharge of guardianship by means of orders in writing. The responsible medical officer must make an order in writing discharging a patient from guardianship as soon as the medical requirement is not met. An authorised social worker must make an order in writing discharging a person from guardianship as soon as the welfare condition is not met. Under Article 24 of the 1986 Order, the nearest relative of a patient who is subject to guardianship can make an order in writing discharging him from guardianship. However, such an order cannot be made by his nearest relative unless he first gives at least 72 hours' notice in writing to the relevant Trust. If within that 72 hour period the responsible medical officer involved in the treatment of the patient provides a report in writing to the Trust to the effect that the patient is still suffering from mental illness or severe mental handicap of a nature or degree which warrants his reception into guardianship and an authorised social worker provides a report in writing to the Trust stating that guardianship is necessary in the interests of the welfare of the patient, then any order discharging guardianship made by the nearest relative shall have no effect but under Article 71 (4) of the 1986 Order, the nearest relative can then apply to the Mental Health Review Tribunal to have guardianship discharged.

66. Article 27 of the 1986 Order imposes a duty on the Trust to take such steps as are practicable to ensure that the patient is informed about the meaning and effect of the guardianship order and is also aware of his rights to seek review by applying to the Mental Health Review Tribunal and to make representations to the RQIA and the rights of his nearest relative to discharge guardianship and to apply to the Review Tribunal. The nearest relative also has a qualified right to receive copies of any

written information and advice given to the patient. This right to information is further emphasised by the provisions of the Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986.

67. Article 71 of the 1986 Order gives a patient who is subject to guardianship the right to apply to the Mental Health Review Tribunal to have guardianship discharged. Under Article 77, the Tribunal may in any case direct that guardianship be discharged and must do so if satisfied that that he is not then suffering from mental illness or severe mental handicap or from either of those forms of mental disorder of a nature or degree which warrants his remaining under guardianship or that it is not necessary in the interests of the welfare of the patient that he should remain under guardianship.

68. Before dealing with the issue of what guardianship actually empowers the guardian to do, it is clear from the above paragraphs that the legislation dealing with guardianship contains clear and detailed provisions setting out who can apply for guardianship, the circumstances which need to exist for an application to be made, and the duration of any guardianship order. The legislation sets out provisions for the supervision of the exercise of the powers of guardianship by the independent RQIA. It enables the patient to challenge guardianship before an independent Tribunal. It gives the patient a right to detailed information about guardianship and of his rights to challenge guardianship. It gives the patient's nearest relative rights in respect of discharging guardianship and also seeking discharge before an independent tribunal.

69. In relation to the issue of what guardianship actually empowers the guardian to do and whether it entitles he guardian to deprive a patient of his liberty within the meaning of Article 5 of the Convention, Article 22 sets out the powers conferred on the patient's guardian under the 1986 Order.

The guardian has the power (a) to require the patient to reside at a place specified by the guardian; (b) to require the patient to attend at places and times so specified for the purpose of medical treatment, occupation, education or training; and (c) to require access to the patient to be given at any place where the patient is residing to any medical practitioner, approved social worker or other person so specified. Article 29 (2) of the 1986 Order provides that where a patient who is for the time being subject to guardianship absents himself without the leave of his guardian from the place at which he is required by the guardian to reside, he may be taken into custody and returned to that place by any constable or approved social worker or by any person authorised in writing by the guardian or by the Trust.

70. The power contained in Article 29 (2) of the 1986 Order is supplemented by further powers contained in Articles 131 and 132 of the 1986 Order. Article 131 (2) authorises the use of reasonable force in the exercise of various powers under the 1986 Order including the power contained in Article 29 (2). Article 131 (1) states that: **"**Any person required or authorised by or by virtue of this Order to be conveyed to any place or to be kept in custody or detained in a place of safety ... shall, while being so conveyed, kept or detained, as the case may be, be deemed to be in legal custody." Article 132 provides that if a person being in legal custody by virtue of Article 131 escapes, he may be retaken: "(a) in any case, by the person who had his custody immediately before the escape, or by any constable or approved social worker; (b) if at the time of the escape he was liable to be detained in a hospital or subject to guardianship under this Order, by any other person who could take him into custody under Article 29 if he had absented himself without leave." Article 124 of the 1986 Order makes it a criminal offence for a person

induce or knowingly assist a patient subject to a guardianship order to absent himself without leave or escape from custody.

71. However, the provisions relating to the powers available under guardianship must, if at all possible, be interpreted in a manner which is compliant with the principles of natural justice and the relevant provisions of the European Convention on Human Rights. The Courts have looked at the powers afforded under guardianship on a number of occasions in recent years and it is worthwhile briefly considering those decisions.

72. In JR 50, Treacy J who delivered his judgment on 12th May, 2011, made the following observations about the powers afforded by guardianship.

"[17] It is clear on every page of this case that what existed here was a fraught conflict between two sets of well-motivated carers each of whom had different perspectives and different roles in the applicant's life and each of whom had strong convictions about how the applicant's needs could best be met. Both sets of carers had different but equally legitimate roles to play and each of those roles could and should have inured to the benefit of the applicant. Unfortunately, the two roles did not co-exist peacefully and productively in this case. Each side in its own way sought to have the dominant role in the patient's care and to restrict or marginalise the input of the other. This drive for exclusive control is not appropriate and ultimately is not beneficial to the patient. The patient is the focus of this Court's concern and the Court wishes to ensure that the patient is able to benefit from the accepted and respected input of everyone with a legitimate interest in his care.

[18] Ultimately the Trust sought to resolve this dispute by taking guardianship powers and using these to give itself an apparent legal "casting vote" in the dispute between itself and the patient's family.

[19] I am entirely satisfied that whatever else guardianship may or may not permit, it certainly does not permit one party to a dispute about the management of a vulnerable person to assert a borrowed primacy over any other party's legitimate but conflicting interest. The idea that guardianship might be used in such a way offends fundamental principles of law and common sense, for example, the principle that "no man shall be judge in his own cause". In effect, in the circumstances of this case, the Trust took on guardianship powers to give itself a determinative role in a dispute with a private family and clothe itself with powers which it alleged vested it with sufficient authority to defeat the family's interest. It is quite clear that this is not what guardianship is for and that the Trust was wrong in seeking to use guardianship for this purpose.

[20] It also appears to be accepted in both party's skeleton arguments that other methods exist to resolve disputes of this nature. For example, both parties agree that the High Court has an inherent power to issue guidance on how such conflicts should best be resolved. There was consensus between the parties that such an avenue for dispute resolution does exist and indeed has some legal pedigree as seen, for example, in the case of ***Re F (Mental Patient: Sterilisation)*** **[1990] 2 AC 1** and in ***Re PS (Incapacitated or Vulnerable Adult)*** **[2007] EWHC 623 (Fam)**, **[2007] 2 FLR 1008.** Where there is an entrenched dispute between parties

about the management of a vulnerable person, and where this dispute cannot be resolved by appropriate information sharing and genuine participative decision making, or if necessary by mediation, then the matter should be referred to the court for its guidance. Such disputes should certainly not be decided by one of the parties to the conflict."

73. Following this decision, Treacy J also heard another JR Application (JMcA's Application [2013] NIQB 77) in which the Applicant challenged the use of guardianship to require him to be accompanied by a carer when leaving his place of residence or the day centre that he attended. Treacy J held that the imposition of such conditions constitute a legitimate use of the powers of guardianship. After this decision was handed down, the Supreme Court gave judgment in the Cheshire West and Chester Council v P case [2014] UKSC 19. It should be remembered that the issue which had to be determined in that case was whether the placement of incapacitous individuals in specialist residential accommodation with the requirement that they reside there amounted to a deprivation of liberty. The Supreme Court held that the acid test for deprivation of liberty is whether the person is under continuous supervision and control and is not free to leave. A number of matters are not relevant:

(a) the person's compliance or lack of objection;

(b) the relevant normality of the placement (whatever the comparison made); and

(c) the reason or purpose behind the particular placement.

74. The Supreme Court also stated that because of the extreme vulnerability of the individuals concerned, decision makers should err on the side of caution in deciding what constitutes a deprivation of liberty.

75. Following the decision of the Supreme Court in the Cheshire West Case, the Court of Appeal dealt with an appeal in the JMcA case. Morgan LCJ gave the judgment of the Court and stated as follows:

"[6] Treacy J held that the supervision of this appellant was with legal authority and lawful and that the 1986 Order did authorise the guardian to take the impugned measures in the circumstances of this case. Subsequent to his decision the Supreme Court examined the

concepts of deprivation of liberty and restriction of liberty in the case of patients suffering from mental health difficulties in P and others v Chester West and Chester Council [2014] UKSC 19.

[7] It is unnecessary for us to set out the facts or reasoning in that decision. It is, however, now accepted by the Trust that the guardianship order did not provide any mechanism for the imposition of any restriction on the entitlement of the appellant to leave the home at which he was residing for incidental social or other purposes. That did not, however, prevent the appellant entering into agreed care plan arrangements designed to assist him in achieving independent living to the greatest extent possible.

[8] In respect of any arrangements concerning the entitlement of the appellant to leave his place of residence for incidental social purposes the learned trial judge correctly recognised that the guardianship arrangement was based upon consensus and cooperation. We wish to make it clear that such an order does not provide any legal power to impose restrictions on such activities.

[9] Mr Potter on behalf of the appellant in this case recognised that this left a lacuna in the law. That gap had been filled by Schedule 7 of the Mental Health Act 2007 in England and Wales which introduced deprivation of liberty legislation into the Mental Capacity Act 2005 providing a mechanism for the lawful restriction on or deprivation of liberty of a person such as the appellant. It is clear that urgent consideration should now be given to the implementation of similar legislation in this jurisdiction."

76. In the recent case of Re NS, judgment was delivered by Keegan J on 14th October, 2016. This was an application by the Trust for an Order of the Court under the Inherent Jurisdiction that it was in the patient's best interests that she reside in a particular care home. In the course of her judgment Keegan J made the following comments:

"[43] In England and Wales there is a structure under the Mental Capacity Act of 2005 to deal with these issues and there is a bespoke court of protection. In Northern Ireland the relevant provisions of the Mental Capacity Act have not come into force as yet. Consequently, the court's inherent jurisdiction must be invoked to deal with these issues when Article 5 is engaged. I did enquire whether or not guardianship under the Mental Health (Northern Ireland) Order 1986 would be a sufficient remedy. Mr Potter referred me to a Northern Ireland Court of Appeal decision of JMcA v Belfast Health & Social Care Trust [2014] NICA 37 whereby the court determined that guardianship did not satisfy the requirements of Article 5. In this case the application for a residential placement involves NS being placed in a locked ward and as such it was accepted by all parties that this constitutes a breach of Article 5."

77. It is clear, therefore, from a review of these decisions that the powers of guardianship do not enable the state to lawfully restrict the liberty of an incapacitous patient. The 2016 Act, when it comes into force, will provide a statutory mechanism for dealing with such cases but until that time the Inherent Jurisdiction of the Court must be invoked. The

Tribunal must be alive to this issue when considering any application for the continuance of a guardianship order. Unless the patient has capacity and agrees to the restrictions placed upon him by the guardianship order, guardianship is an inappropriate mechanism by which to impose restrictions on the liberty of the patient.

78. I complete my discussion of the role, powers, structure and procedures of the Mental Health Review Tribunal by briefly commenting on the duties incumbent upon the Tribunal when giving its decision on an application or referral made to it under the 1986 Order.

79. Rule 24 of the 1986 Rules has now been interpreted in a matter which ensures compliance with Article 5 of the Convention and this means that the President of the Tribunal must announce the decision to the parties and/or their representatives as soon as possible after the conclusion of the evidence and submissions and that usually means the same afternoon. The decision can be by way of a majority decision of 2 to 1, but it is usual to try to achieve unanimity. Thereafter, the President must prepare detailed written reasons for the decision and those reasons are circulated to the other Tribunal members for approval or for correction or suggested amendment. When the written decision is finalised it is provided to the parties and this must occur within 14 days of the oral decision.

80. The High Court has dealt with the adequacy or otherwise of the reasons emanating from Mental Health Review Tribunals on a number of occasions. These decisions include Re X [2008] Gillen J, JR 45 [2011] McCloskey J, Re SC [2014] Treacy J and Re MH [2013] Horner J.

81. In summary, the case law directs that it is advisable to set out the statutory criteria and to analyse systematically the facts and other matters which allow the Tribunal to conclude that the statutory criteria have been met. It is advisable to deal with the substantive points raised at the

hearing. The decision should be sufficiently detailed to inform someone who was not at the hearing of the findings. The reasons must be sufficient to enable the patient or applicant to know if an error of law has been made. Focused reasoning is required. There must be a reasoned evaluation and determination of each of the matters in Article 77 and Article 2(4). The Tribunal must grapple with the core issues, link these to the relevant statutory tests and articulate the Tribunal's evaluation and determination of these matters.

82. It should be noted that there is no power to amend the reasons once they are made public. See the decision of Re Clarence [2008] Weatherup J.

83. Finally, there is no automatic right of appeal from the Tribunal's decision. The Tribunal may state a special case for determination by the Court of Appeal of any question of law which may arise before it, and must state a case if so required by the Court of Appeal. See Article 83 (7) of the 1986 Order. As can be readily appreciated from the various cases cited in this paper, the decisions of Tribunals are clearly liable to be subject to Judicial Review by the High Court.

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22nd November, 2016.