IN THE UPPER TRIBUNAL **Case No: HM/1518/2015**
ADMINISTRATIVE APPEALS CHAMBER

Before: Mr Justice Charles

Secretary of State for Justice

Appellant

and

(2) KC

First Respondent

(3) C Partnership NHS Foundation Trust

Second Respondent

Attendances:

For the Appellant:	Peter Mant, instructed by the Government Legal Department
For the First Respondent:	David Lock QC, instructed Southerns
The Second Respondent:	Not represented

Save for the cover sheet this decision may be made public. That sheet is not part of the decision.

DECISION

1. **This appeal is dismissed.**
2. **In view of the change in circumstances since the matter was before the FTT the Secretary of State should invite the FTT to reconsider its decision.**

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REASONS

Introduction

1. KC is a restricted patient.

2. This appeal was triggered by proceedings in the Court of Protection (the COP proceedings) which were brought by the relevant local authority (the local authority) for an order under the Mental Capacity Act 2005 (the MCA). The local authority was seeking a personal welfare order on the basis that it would be in KC's best interests for him to move to a proposed placement (the Placement) on the terms of a care plan for his care, supervision and management at that community placement.

3. The COP proceedings were brought as a result of the decision of the FTT made on 25 July 2014 (the FTT Decision) that is the subject of this appeal. It was described by the FTT as a "provisional decision" and was in the following terms:

> The tribunal is currently of the view that a conditional discharge should be directed but it is not satisfied that the condition(s) now proposed (set out below) can be implemented immediately. ---------
>
> Conditions
>
> 1. The patient (KC) will reside at ---------- (the Placement) and will not leave the premises unless accompanied and supervised at all times by an appropriate member of staff.
>
> 2. He will comply with all aspects of the care package which is devised for him by the NF organisation, and accept supervision and support from their staff.
>
> 3. He will accept psychiatric and social supervision from his community RC - ----------
>
> 4. He will refrain from taking any alcohol and submit to any routine testing which may be required of him.

4. The grounds for the decision set out in the FTT Decision are as follows:

> 1. The tribunal is not satisfied that the patient is suffering from mental disorder or from mental disorder of a nature or degree that makes it appropriate for the patient to be liable to be detained in a hospital for medical treatment
>
> 2. The tribunal is not satisfied that it is necessary for the health or safety of the patient or for the protection of other persons that the patient should receive such treatment.
>
> 3. The tribunal is satisfied that appropriate medical treatment is available for the patient.
>
> 4. The tribunal considers that it is appropriate for the patient to remain liable to be recalled to hospital for further treatment.
>
> 5. The tribunal considers that conditions are required.

5. These grounds reflect the conclusions of the FTT on the tests set by s. 73 of the Mental Health Act 1983 (the MHA). There was no challenge to those conclusions including the conclusion that KC should remain liable for recall to

hospital. As appears later, matters have now moved on and further factors need to be taken into account.

6. The FTT made a "provisional" decision. In *DC v Nottinghamshire Healthcare NHS Trust and the Secretary of State for Justice* [2012] UKUT 92 (AAC) Upper Tribunal Judge Jacobs discusses the earlier cases and gives guidance on when the FTT should adjourn, make a decision under s. 73(7) of the MHA or a provisional decision as *R(H) v SSHD* [2003] QB 320 and [2004] 2 AC 253 indicates is possible. It seems to me that the FTT made such a provisional decision because it was confident enough to formulate conditions and defer a direction with a view to reconsideration if it was necessary. In my view, that was a permissible approach and one that should be supported by the Upper Tribunal (see paragraph 32 of the Decision in the *DC* case). I add that in my view if the FTT had decided to adjourn that too would have been a permissible decision that should have been supported.

7. In my view correctly, it was common ground that the regime of care, supervision and management that was necessary for KC and would be provided pursuant to the care plan at the Placement and outside it (when he would be under constant supervision) by the NF organisation would amount to a deprivation of his liberty on the application of the approach set out by the majority in *Cheshire West and Cheshire Council v P* [2014] UKSC 19 (*Cheshire West*).

8. The Placement is not at a care home or a hospital and so the provisions of Schedules A1 and 1A of the MCA (its DOLS) do not apply to it. So the application of the local authority in the COP proceedings was for a welfare order under s. 16(2)(a) of the MCA in respect of that regime of care, supervision and management at the Placement and the authorisation of that deprivation of liberty pursuant to s. 4A(3) of the MCA.

9. In particular in respect of a deprivation of liberty, the relationship between the MHA and the MCA is not straightforward and the Court of Protection cannot include in a welfare order a provision which authorises a deprivation of liberty of the relevant person if he is "*ineligible to be deprived of liberty by the MCA*". The definition of that ineligibility is found in Schedule 1A.

10. At the directions hearing in the COP proceedings, the Appellant (the Secretary of State) indicated that he was considering seeking permission to appeal the FTT Decision out of time and I directed that, if he did so, I would list that application with the COP proceedings on the basis that, if I gave permission to appeal out of time, I would go on to deal with the substantive appeal. I gave permission.

11. The Secretary of State bases that appeal on the decision of the Court of Appeal reported as *RB v Secretary of State for Justice* [2010] UKUT 454 (AAC) and *B v Justice Secretary* [2012] 1 WLR 2043 (the *RB* case). He argues that the ratio of the decision in the *RB* case means that the FTT had no power to make the FTT Decision because it is binding authority to the effect that no FTT can direct a conditional discharge of a restricted patient on

conditions that, if they are put into effect, would result in a deprivation of liberty of the patient outside hospital.

12. If that is right, issues obviously arise as to whether, and if so how, a restricted patient, with or without capacity to consent to the terms of a care regime that provides his care, support and control outside hospital can be conditionally discharged to a placement on terms that would objectively amount to a deprivation of liberty.

13. The Secretary of State opposed an absolute discharge because he agreed with the FTT that he should retain his power to recall KC to hospital for further treatment (see paragraph 4 of the FTT's grounds of decision).

14. The Secretary of State argues that although on his interpretation of the *RB* case it is jurisdictionally impossible for the FTT to impose the conditions that it did, it is nonetheless possible to achieve the result that KC is conditionally discharged to live at the Placement pursuant to a care plan that:

    (1) deprives KC of his liberty, but which (and as was effective common ground)

    (2) is the least restrictive option available for KC that is consistent with the promotion of his best interests and the protection of the public and KC.

15. The Secretary of State argues that the jurisdictional route to achieving this result is for the FTT to direct a conditional discharge (on conditions that do not amount to a deprivation of liberty) on the basis that the deprivation of liberty can be authorised and put in place under the MCA. However, and understandably given his view that an absolute discharge would not be appropriate, the Secretary of State acknowledges that, as the test applied under the MCA (a best interests test) is different to those under the MHA, it is possible that the Court of Protection might refuse to continue to authorise a care plan that contained a degree of supervision and control (and thus a deprivation or degree of deprivation of liberty) which would cause the Secretary of State to consider exercising the power of recall of KC to hospital. Accordingly, the Secretary of State invited the Court of Protection to include in the care plan it approves:

    (1) the protective conditions identified by the FTT as being needed to protect the public and which, when they are implemented, will result in KC being deprived of his liberty, and

    (2) provisions to alert him to circumstances that might found grounds for such a recall.

    And he reserved his position to oppose in the COP proceedings any care plan that does not contain such conditions or provisions.

16. If the Secretary of State's argument on the binding effect of the *RB* case is correct, his jurisdictional route to the result supported by him, the FTT and KC is dependent on:

(1) that route representing a proper exercise of the jurisdictions of respectively the FTT under the MHA and the Court of Protection under the MCA, and

(2) KC not being ineligible to be deprived of his liberty by the MCA.

17. In my view, the second of those conditions is satisfied but the first of them is not.

18. It follows that the lynch pin to the determination of whether:

(1) the FTT erred in law, and

(2) the result supported by the FTT, the Secretary of State and KC can be achieved

is the identification of the binding ratio of the *RB* case to a case (unlike *RB* itself) where the restricted patient lacks the capacity on a conditional discharge to consent to his care plan and the deprivation of liberty its implementation will cause.

19. As appears later, I do not accept the argument of the Secretary of State and in my view, the ratio of the *RB* case is that it:

(1) prevents the FTT (or the Secretary of State) from imposing or requiring conditions which when implemented would result in a deprivation of liberty that would be in breach of Article 5 and so be unlawful,

but it does not prevent

(2) the FTT (or the Secretary of State) from imposing (and so directing a conditional discharge on) conditions that when implemented will, on an objective assessment, give rise to a deprivation of liberty that is lawful because it has been authorised by the Court of Protection under the MCA or pursuant to the DOLS contained in the MCA and so complies with Article 5.

This means that the FTT did not err in law as argued by the Secretary of State. Also, it means that as envisaged by the FTT, the result supported by the Secretary of State, the FTT and KC could have been achieved in the circumstances that prevailed when the FTT made its decision, and can be achieved in light of existing circumstances if the MHA decision maker concludes that KC should be conditionally discharged on conditions that, when implemented would objectively create a deprivation of KC's liberty. As explained below (see paragraphs 42 to 44) a deprivation of liberty for the purposes of Article 5 has an objective and a subjective component or element.

Some background facts

20. KC was convicted of indecent assault on a female under the age of 16 in 2004. As a result he was made the subject of a hospital order and became a

restricted patient pursuant to ss. 37 and 41 of the MHA. He was made the subject of a conditional discharge by a FTT in November 2010 but was recalled in April 2011.

21. At the hearing before the FTT in July 2014 all parties accepted that applying the tests set by the MHA the conditions that would have to be imposed to protect the public in the event that KC was discharged would inevitably amount to a deprivation of KC's liberty.

22. In their reasons, having referred to the history, the then recent judgment of the Supreme Court in *Cheshire West,* the *RB* case and to difficulties that KC had encountered concerning the funding of an application to the Court of Protection, the FTT said:

> 6. The tribunal were anxious not in any way to prejudge or influence the application but were encouraged by all parties to consider KC's application for conditional discharge at this stage, rather than simply adjourning the case again, so that if we were satisfied that he continues to warrant detention in hospital for treatment there would be no point in making an application to the Court of Protection.
>
> 7. The evidence on this occasion reflected that which the tribunal had heard in January. KC's new RC ---------- informed the tribunal about her extensive experience as a consultant psychologist in the field of sexual offenders and their risks. Her opinion is that, although KC obviously has very limited cognitive abilities, he did at least manage to participate to a degree in the Sexual Offences Treatment Programme which had taught him strategies to minimise this risk, and if continually supervised would comply with the plans devised for him without posing any problem for his own health and safety or the safety of others.
>
> 8. The unanimous opinion of all those members of the care team present who gave evidence has consistently been that, whilst KC plainly requires continual supervision at all times when he is out in the community because without it he will continue to pose a high risk of offending, neither the nature or degree of his mental disorder any longer warrant detention in a hospital setting because he has achieved as much as he is capable of achieving from a therapeutic point of view.
>
> 11.The tribunal were well aware of the importance of ensuring in particular that KC does not in the future have any opportunity to offend sexually as he has done in the past but all the evidence presented to us led to the conclusion that he can no longer be said to require detention in hospital for treatment, as opposed to mere containment, and that he would therefore be entitled to be discharged provided the strict conditions set out are in place. He himself expresses his full support for the plan but as he lacks capacity it will need to be approved by the Court of Protection as being in his best interests. The parties are hopeful that such a declaration may be made within the 16 weeks which the tribunal have allowed for the arrangements to be made to implement the conditional discharge sought. In the meantime KC will remain detained as before and will in any event, if discharged, remain liable to recall to hospital in the future.

23. Apart from the point that in the *RB* case everyone proceeded on the basis that the patient (*RB*) had capacity to make decisions relating to (a) his residence, (b) the care plan relating to the supervision and control of his day-to-day living

at such residence and in the community, and (c) the deprivation of liberty caused by the implementation of that care plan, the respective positions of *RB* and *KC* are for present purposes effectively the same.

24. The Court of Appeal record in the *RB* case (at paragraph 47 of the judgment of Arden LJ) that *RB*'s counsel did not suggest that RB's consent could confer on the FTT jurisdiction that it did not have.

25. Following the first hearing before me I invited the parties to address, or further address, legal issues that I had identified. By the time of the second hearing (on 4 June) an incident in which KC was alleged to have committed an act of sexual assault had taken place. It was agreed that further investigation of that incident was needed and it was effective common ground that:

    (1) the COP proceedings should be adjourned, and

    (2) the question whether KC should now be conditionally discharged should be returned to the FTT for further consideration by it. (In my view that should be done by the Secretary of State pursuant to *R(H)* or by analogy to the approach approved in that case (and see paragraph 1-922 of the Mental Health Act Manual 17th edition)).

The most relevant provisions in the MHA

26. Section 37 provides that:

> (1) Where a person is convicted before the Crown Court of an offence punishable with imprisonment other than an offence the sentence for which is fixed by law, or is convicted by a magistrates' court of an offence punishable on summary conviction with imprisonment, and the conditions mentioned in subsection (2) below are satisfied, the court may by order authorise his admission to and detention in such hospital as may be specified in the order or, as the case may be, place him under the guardianship of a local social services authority or of such other person approved by a local social services authority as may be so specified.
>
> ...
>
> (2) The conditions referred to in subsection (1) above are that—
>
> (a) the court is satisfied, on the written or oral evidence of two registered medical practitioners, that the offender is suffering from mental disorder and that either—
>
> (i) the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and appropriate medical treatment is available for him; or
>
> (ii) in the case of an offender who has attained the age of 16 years, the mental disorder is of a nature or degree which warrants his reception into guardianship under this Act; and
>
> (b) the court is of the opinion, having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with him, that the most suitable method of disposing of the case is by means of an order under this section.

27. Where a hospital order is made in respect of an offender by the Crown Court, and it appears to the court, having regard to the nature of the offence, the antecedents of the offender and the risk of his committing further offences if set at large, that it is necessary for the protection of the public to do so, the court may further order that the offender be subject to a restriction order under s. 41. It provides:

> (1) Where a hospital order is made in respect of an offender by the Crown Court, and it appears to the court, having regard to the nature of the offence, the antecedents of the offender and the risk of his committing further offences if set at large, that it is necessary for the protection of the public from serious harm so to do, the court may, subject to the provisions of this section, further order that the offender shall be subject to the special restrictions set out in this section . . ; and an order under this section shall be known as "a restriction order".
>
> (2) --
>
> (3) The special restrictions applicable to a patient in respect of whom a restriction order is in force are as follows—
>
> (a) none of the provisions of Part II of this Act relating to the duration, renewal and expiration of authority for the detention of patients shall apply, and the patient shall continue to be liable to be detained by virtue of the relevant hospital order until he is duly discharged under the said Part II or absolutely discharged under section 42, 73, 74 or 75 below;
>
> (aa) none of the provisions of Part II of this Act relating to community treatment orders and community patients] shall apply;
>
> (b) no application shall be made to [the appropriate tribunal] in respect of a patient under section 66 or 69(1) below;
>
> (c) the following powers shall be exercisable only with the consent of the Secretary of State, namely—
>
> (i) power to grant leave of absence to the patient under section 17 above;
>
> (ii) power to transfer the patient in pursuance of regulations under section 19 above or in pursuance of subsection 3 of that section; and
>
> (iii) power to order the discharge of the patient under section 23 above;
>
> and if leave of absence is granted under the said section 17 power to recall the patient under that section shall vest in the Secretary of State as well as the responsible clinician; and
>
> (d) the power of the Secretary of State to recall the patient under the said section 17 and power to take the patient into custody and return him under section 18 above may be exercised at any time;
>
> and in relation to any such patient section 40(4) above shall have effect as if it referred to Part II of Schedule 1 to this Act instead of Part I of that Schedule.
>
> (4) A hospital order shall not cease to have effect under section 40(5) above if a restriction order in respect of the patient is in force at the material time.
>
> (5) Where a restriction order in respect of a patient ceases to have effect while the relevant hospital order continues in force, the provisions of section 40 above and Part I of Schedule 1 to this Act shall apply to the patient as if he had been admitted to the hospital in pursuance of a hospital order (without a restriction order) made on the date on which the restriction order ceased to have effect.
>
> (6) While a person is subject to a restriction order the responsible clinician shall at such intervals (not exceeding one year) as the Secretary of State may direct examine and report to the Secretary of State on that person; and every report shall contain such particulars as the Secretary of State may require.

28. As appears therefrom:

(1) special restrictions applicable to a patient in respect of whom a restriction order is in force are set out in section 41(3), and

(2) the Secretary of State is given an important continuing role directed to promoting the protection of the public.

29. Under s. 42 the Secretary of State is granted powers over restricted patients. That section provides:

> (1) If the Secretary of State is satisfied that in the case of any patient a restriction order is no longer required for the protection of the public from serious harm, he may direct that the patient shall cease to be subject to the special restrictions set out in section 41(3) above; and where the Secretary of State so directs, the restriction order shall cease to have effect, and section 41(5) above shall apply accordingly.
>
> (2) At any time while a restriction order is in force in respect of a patient, the Secretary of State may, if he thinks fit, by warrant discharge the patient from hospital, either absolutely or subject to conditions; and where a person is absolutely discharged under this subsection, he shall thereupon cease to be liable to be detained by virtue of the relevant hospital order, and the restriction order shall cease to have effect accordingly.
>
> (3) The Secretary of State may at any time during the continuance in force of a restriction order in respect of a patient who has been conditionally discharged under subsection (2) above by warrant recall the patient to such hospital as may be specified in the warrant.
>
> (4) Where a patient is recalled as mentioned in subsection (3) above—
>
> (a) if the hospital specified in the warrant is not the hospital from which the patient was conditionally discharged, the hospital order and the restriction order shall have effect as if the hospital specified in the warrant were substituted for the hospital specified in the hospital order;
>
> (b) in any case, the patient shall be treated for the purposes of section 18 above as if he had absented himself without leave from the hospital specified in the warrant.
>
> (5) If a restriction order in respect of a patient ceases to have effect after the patient has been conditionally discharged under this section, the patient shall, unless previously recalled under subsection (3) above, be deemed to be absolutely discharged on the date when the order ceases to have effect, and shall cease to be liable to be detained by virtue of the relevant hospital order accordingly.
>
> (6) The Secretary of State may, if satisfied that the attendance at any place in Great Britain of a patient who is subject to a restriction order is desirable in the interests of justice or for the purposes of any public inquiry, direct him to be taken to that place; and where a patient is directed under this subsection to be taken to any place he shall, unless the Secretary of State otherwise directs, be kept in custody while being so taken, while at that place and while being taken back to the hospital in which he is liable to be detained.

These powers, and so the role of the Secretary of State, are again directed to the need for continuing protection of the public and include the power, by warrant, to discharge a patient absolutely or subject to conditions (s. 42(2)) and the power to recall a patient who has been conditionally discharged (s. 42(3)).

30. The FTT's general power of discharge is set out in s. 72 which provides that:

> (1) Where application is made to the appropriate tribunal by or in respect of a patient who is liable to be detained under this Act or is a community patient, the tribunal may in any case direct that the patient be discharged, and—
> ...
> (b) the tribunal shall direct the discharge of a patient liable to be detained otherwise than under section 2 above if it is not satisfied—
> (i) that he is then suffering from mental disorder or from mental disorder of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or
> (ii) that it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment; or
> (iia) that appropriate medical treatment is available for him.

31. The powers of the FTT in respect of restricted patients are set out in s. 73 which states:

> (1) Where an application to the appropriate tribunal is made by a restricted patient who is subject to a restriction order, or where the case of such a patient is referred to the appropriate tribunal, the tribunal shall direct the absolute discharge of the patient if—
> (a) the tribunal is not satisfied as to the matters mentioned in paragraph (b)(i), (ii) or (iia) of section 72(1) above; and
> (b) the tribunal is satisfied that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment.
>
> (2) Where in the case of any such patient as is mentioned in subsection (1) above—
> (a) paragraph (a) of that subsection applies; but
> (b) paragraph (b) of that subsection does not apply,
> the tribunal shall direct the conditional discharge of the patient.
>
> (3) Where a patient is absolutely discharged under this section he shall thereupon cease to be liable to be detained by virtue of the relevant hospital order, and the restriction order shall cease to have effect accordingly.
>
> (4) Where a patient is conditionally discharged under this section—
> (a) he may be recalled by the Secretary of State under subsection (3) of section 42 above as if he had been conditionally discharged under subsection (2) of that section; and
> (b) the patient shall comply with such conditions (if any) as may be imposed at the time of discharge by the tribunal or at any subsequent time by the Secretary of State.
>
> (5) The Secretary of State may from time to time vary any condition imposed (whether by the tribunal or by him) under subsection (4) above.
>
> (6) Where a restriction order in respect of a patient ceases to have effect after he has been conditionally discharged under this section the patient shall, unless previously recalled, be deemed to be absolutely discharged on the date when the order ceases to have effect and shall cease to be liable to be detained by virtue of the relevant hospital order.
>
> (7) A tribunal may defer a direction for the conditional discharge of a patient until such arrangements as appear to the tribunal to be necessary for that purpose have been made to its satisfaction; and where by virtue of any such deferment no direction has been given on an application or reference before the time when the patient's case comes before the tribunal on a subsequent application or reference, the previous application or reference shall be treated as one on which no direction under this section can be given.
>
> (8) This section is without prejudice to section 42 above.

32. Section 75 make provision for applications by a restricted patient to the FTT to vary or discharge any condition on a conditional discharge or for a direction that the restriction order should cease to have effect. As is pointed out in paragraph 28 of the judgment of Arden LJ in the *RB* case the time limits for such applications (2 years) is longer than that for the right of review of a restricted patient who is detained in a hospital which is one year. Arden LJ there described that as an inferior right of review.

The most relevant provisions of the MCA

33. Sections 1, 2, 3, 4, 4A, 16, 21A provide:

> 1. The principles
>
> (1) The following principles apply for the purposes of this Act.
>
> (2) A person must be assumed to have capacity unless it is established that he lacks capacity.
>
> (3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
>
> (4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
>
> (5) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
>
> (6) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.
>
> 2. People who lack capacity
>
> (1) For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.
>
> (2) It does not matter whether the impairment or disturbance is permanent or temporary.
>
> 3 Inability to make decisions
>
> (1) For the purposes of section 2, a person is unable to make a decision for himself if he is unable—
>
> (a) to understand the information relevant to the decision,
>
> (b) to retain that information,
>
> (c) to use or weigh that information as part of the process of making the decision, or
>
> (d) to communicate his decision (whether by talking, using sign language or any other means).
>
> 4 Best interests
>
> (1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of—

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

(b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.

(2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.

(3) He must consider—

(a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and

(b) if it appears likely that he will, when that is likely to be. ----------

(6) He must consider, so far as is reasonably ascertainable—

(a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),

(b) the beliefs and values that would be likely to influence his decision if he had capacity, and

(c) the other factors that he would be likely to consider if he were able to do so.

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.

(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).

16 Powers to make decisions and appoint deputies: general

(1) This section applies if a person ("P") lacks capacity in relation to a matter or matters concerning—

(a) P's personal welfare, or

(b) P's property and affairs.

(2) The court may—

(a) by making an order, make the decision or decisions on P's behalf in relation to the matter or matters, or

(b) appoint a person (a "deputy") to make decisions on P's behalf in relation to the matter or matters.

(3) The powers of the court under this section are subject to the provisions of this Act and, in particular, to sections 1 (the principles) and 4 (best interests).

(7) An order of the court may be varied or discharged by a subsequent order.

21A Powers of court in relation to Schedule A1

(1) This section applies if either of the following has been given under Schedule A1—

(a) a standard authorisation;

(b) an urgent authorisation.

(2) Where a standard authorisation has been given, the court may determine any question relating to any of the following matters—

(a) whether the relevant person meets one or more of the qualifying requirements;

(b) the period during which the standard authorisation is to be in force;

(c) the purpose for which the standard authorisation is given;

(d) the conditions subject to which the standard authorisation is given.

(3) If the court determines any question under subsection (2), the court may make an order—

(a) varying or terminating the standard authorisation, or

(b) directing the supervisory body to vary or terminate the standard authorisation.

(4) Where an urgent authorisation has been given, the court may determine any question relating to any of the following matters—

(a) whether the urgent authorisation should have been given;

(b) the period during which the urgent authorisation is to be in force;

(c) the purpose for which the urgent authorisation is given.

(5) Where the court determines any question under subsection (4), the court may make an order—

(a) varying or terminating the urgent authorisation, or

(b) directing the managing authority of the relevant hospital or care home to vary or terminate the urgent authorisation.

(6) Where the court makes an order under subsection (3) or (5), the court may make an order about a person's liability for any act done in connection with the standard or urgent authorisation before its variation or termination.

(7) An order under subsection (6) may, in particular, exclude a person from liability.

34. Section 16A provides that if a person is ineligible to be deprived of liberty by the MCA the Court of Protection may not include within a welfare order a provision that authorises him to be deprived of his liberty.

35. The way in which ss. 4A(3), 16(2)(a) and 16A work together founds the making of an order to the effect that the relevant person is to live at a certain place pursuant to a defined care plan on the basis that the (or any) deprivation of liberty that is thereby created is authorised. That authorisation is provided by s. 4A(3).

36. The underlying approach of s. 16 is, as it states, that by making the order the Court of Protection is making the decision which P lacks the capacity to make on behalf of P. This is reflected in:

(1) paragraph 18 of the judgment of Lady Hale in *Aintree University Hospitals NHS Trust v James* [2013] UKSC 67, [2014] AC 591 where she says that the MCA:

> is concerned with doing for the patient what he could do for himself if of full capacity but it goes no further,

and

(2) the Court of Protection can only choose between available options (see *ACCG and Another v MN and Another* [2013] EWHC 3895 (CoP) and in the Court of Appeal [2015] EWCA Civ 411). At paragraph 46, of his judgment Munby LJ said:

> It is easy to fall into the trap of thinking that, because, typically, both the court and some other public authority are concerned with the welfare or well-being of a child or incapacitated adult, they are viewing the matter from the same perspective and applying the same principles. Neither is so. The perspective of the court – the Court of Protection or the family court – is a narrow focus on the welfare of the individual child or adult. The perspective of the public authority is necessarily different and much wider. Often, the public authority, as with the authorities involved in the present case, will have to have regard to the interests of a very wide group of service users who are, in the nature of things, competing with each other for the allocation of often scarce resources. Sometimes, as in the case of the Secretary of State in an immigration case, the public authority has to balance an individual's private interest against a wider public interest, in the immigration context the public interest in a proper system of immigration control. Flowing from this, the principles that have to be applied by the court and the public authority will almost inevitably differ.

And so it is the case that:

(3) when, for example, the decision on where a person should live is vested in a guardian appointed under the MHA the Court of Protection cannot in that person's best interests make an order that he is to live somewhere else (see *C v Blackburn and Darwen Borough Council* [2011] EWHC 3321 (COP) and to similar effect *ReT (A child: murdered parent)* [2011] EWHC B4 (Fam), [2011] MHLR 133),

(4) a local authority or health authority can seek to rule out an option by not offering it and assert (correctly) that its decision can only be challenged on administrative law grounds and the Court of Protection cannot deal with a challenge on those grounds (see *KD v A Borough Council, the Department of Health and Others* [2015] UTUK 0251 (AAC) in particular at paragraphs 44 to 54).

37. In the case of a regime of care, whether or not it involves a deprivation of liberty, the decision of the Court of Protection is effectively to give consent to that regime on behalf of P, and the same applies, for example, in respect of medical treatment that the Court of Protection concludes is in P's best interests. All substantive decisions of the Court of Protection are governed by the best interests test.

38. The deprivation of liberty safeguards (the DOLS) work differently. Schedules 1A and A1 to the MCA and in relevant codes of practice (which relate both to DOLS and orders made by the Court of Protection relating to deprivation of liberty) are lengthy, in parts complicated and contain the provisions for determining whether a person is ineligible to be deprived of his liberty by the MCA.

39. In short, Schedule A1 provides that the managing authority of a hospital or care home is authorised to deprive P of his liberty if he is detained there for the purpose of being given care or treatment if a standard (or urgent – which is not relevant here) authorisation is in place (see paragraphs 1 and 2 of Schedule A1). A standard authorisation is given at the request of the managing authority by the supervisory body. Paragraph 3 of schedule A1 reverts to the concept of what P could have consented to if he or she had the relevant capacity by providing that any person (D) does not incur liability for any act which he does for the purpose of detaining (P) pursuant to paragraph 2 thereof if he would not have incurred liability for that act if P had the capacity to consent to it and had consented to it.

40. Before a standard authorisation can be given positive assessments of the qualifying requirements must be made (see paragraph 12 of Schedule A1). This means that, amongst other things, the best interests test has to be satisfied and the relevant person has to be eligible to be deprived of his liberty by the MCA. It should also be noted that there is a mental health requirement and a mental capacity requirement.

41. It follows that in contrast to the MHA, the MCA does not contain express statutory powers to detain a person for defined purposes, rather its approach is to authorise a deprivation of liberty if it is in the best interests of the relevant person (and so is the least restrictive available option to provide the relevant care and treatment in the best interests of that person).

Article 5 of the ECHR – Deprivation of Liberty

42. Article 5 of the ECHR provides:

> 1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
>
> (a) the lawful detention of a person after conviction by a competent court; -----
>
> (e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants; ------
>
> 4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

43. In *Cheshire West* Lady Hale starts her judgment by stating that what that case was about is the criteria for judging whether the living arrangements made for a mentally incapacitated person amount to a deprivation of liberty. All of the Justices address this by reference to Article 5 and the Strasbourg and other cases relating to it (e.g. Lady Hale from paragraph 19 onwards). At paragraph 37, Lady Hale sets out the well established and accepted proposition that the essential character of a deprivation of liberty has three components namely:

(1) the objective component of confinement in a particular restricted place for a not negligible length of time;

(2) the subjective component of lack of valid consent; and

(3) the attribution of responsibility to the state.

She added that component (1) and not components (2) and (3) were in issue. The point that valid consent to the confinement in question has the result that there is not a deprivation of liberty for the purposes of Article 5 (and so the objective deprivation of liberty is lawful) is also made by the quotation in paragraph 22 of Lady Hale's judgment from *Stanev v Bulgaria* (2012) 55 EHRR 696 which is in the following terms:

> 117. Furthermore, in relation to the placement of mentally disordered persons in an institution, the Court has held that the notion of deprivation of liberty does not only comprise *the objective element* of a person's confinement in a particular restricted space for a not negligible length of time. A person can only be considered to have been deprived of his liberty if, as *an additional subjective element*, he has not validly consented to the confinement in question. (Emphasis supplied)

44. It is important to remember that for the purposes of Article 5 and so its breach a deprivation of liberty has these two components. Regularly, and for example in the MCA (see the definition in s. 64(5)), the term deprivation of liberty is used or effectively used to describe only the objective element or component because, for example, the relevant person lacks the capacity to supply the subjective element or the context so requires. When I use that term or description without qualification in this Decision I am referring to that objective element or component.

45. As I have said, in this case, I am concerned with a person who does not have capacity to make the relevant decisions relating to where he should live and the regime of care, control and supervision involved in relation to that placement, and so any deprivation of liberty it creates. Further, it is only in those circumstances that the jurisdiction of the Court of Protection and its DOLS are engaged.

46. What about a restricted patient who has the capacity to make the relevant decisions on those matters? In the *RB* case the Upper Tribunal expressed the view that *RB* could not validly consent to his deprivation of liberty on his conditional discharge. In my view it was correctly common ground before me that that conclusion is obiter. I shall return to it.

Conditions under ss.42 and 73 of the MHA

47. The most important provisions are s. 42(2) to (4) and s. 73(2), (4)(b) and (5). Section 42 does not have an equivalent to s. 73(4)(b), which creates in mandatory terms a statutory duty on the patient to comply with conditions imposed at the time of discharge by the FTT or at any subsequent time by the Secretary of State, who may vary them (the statutory duty).

48. The patient can seek changes in or the discharge of any such conditions and so of that statutory duty from the Secretary of State or the FTT (see for example *R v Merseyside MHRT ex parte K* [1990] 1All ER 694). At 699g to 670a in that case Butler –Sloss LJ said:

> The 1983 Act lays down a framework for the admission and detention, inter alia, of those convicted of crimes who are suffering from mental disorder and capable of being treated. There is thereafter a procedure designed to give them the opportunity of discharge into the community by application to an independent body, the mental health review tribunal. At the time the offender is detained under a hospital order he is a patient within the interpretation in s 145. By s 41(3)(a) a restricted patient continues to be liable to be detained until discharged under s 73 and, in my judgement, remains a patient until he is discharged absolutely, if at all, by the tribunal. Any other interpretation of the word "patient" makes a nonsense of the framework of the 1983 Act and the hoped-for progression to discharge of the treatable patient, treatable being a pre-requisite of his original admission.
>
> Section 73 gives to the tribunal power to impose a conditional discharge and retain residual control over patients not then suffering from mental disorder or not to a degree requiring continued detention in hospital. This would appear to be a provision designed both for the support of the patient in the community and the protection of the public, and is an important discretionary power vested in an independent tribunal, one not likely to be set aside in the absence of clear words.

49. This is a helpful confirmation and reminder of the following:

(1) the MHA sets a framework for the admission and detention of those convicted of crimes who are suffering from a treatable mental disorder,

(2) the MHA also contains provisions that involve the Secretary of State and an independent body (the FTT) that is designed to give those patients an opportunity to be discharged into the community either absolutely or conditionally (when they remain a patient),

(3) a conditional discharge enables the FTT and the Secretary of State to have residual control for defined purposes over patients who are not then suffering from a mental disorder or who do not need to remain in hospital for its treatment,

(4) central purposes of a conditional discharge are (a) to support the patient in the community, and (b) the protection of the public and the patient,

(5) the discretion to impose the statutory duty flowing from a conditional discharge arises under the MHA and it is exercised by applying the

tests set by the MHA and so by having regard to its underlying purpose of treatment and not detention,

(6) that statutory duty is based on the decision of an independent tribunal, and

(7) often that statutory duty to comply with conditions will be founded on the possibility of relapse that would trigger a renewed need for treatment and detention in a hospital.

50. The statutory duty is on the patient. In *R(H) v SSHD* [2004] 2 AC 253, at paragraph 26, it was stated that the FTT has no power to secure compliance with the conditions by a public authority. But it was confirmed that the imposition of conditions by the FTT creates a public law duty on a public body charged with giving effect to them. Section 73(7) has the general result that the conditional discharge will not take place until the arrangements are made to give effect to the conditions.

Enforceability of the statutory duty created by s. 73(4) of the MHA and thus the conditions

51. The MHA does not contain enforcement provisions.

52. Rather it provides a power of recall. The exercise of that power is not directly linked to a breach of a condition. The position is summarised in paragraph 36 of the judgment of Holman J in *R (SH) v MHRT* [2007] EWHC (Admin), [2007] MHLR 234 in the following terms:

> 36... section 73 does not attach, or empower the attachment of, any sanction for failure to comply with a condition and the tribunal did not attach or purport to attach any sanction. The Secretary of State has a general power of recall under section 73(4)(a), but there is nothing to make recall an automatic sanction for non-compliance as such with a specific condition. As the decision of the European Commission of Human Rights in *Kay v United Kingdom*, 1st March 1994, 40 BMLR 20 at paragraph 50, made clear, the Secretary of State cannot (save in an emergency) exercise the power of recall without up to date medical evidence. This has now been confirmed by Scott Baker J in *B v Mental Health Review Tribunal and Secretary of State for the Home Department [2002] EWHC 1553* (Admin), where he said, at paragraph 11:
>
> > "Since *Kay v United Kingdom* 40 BMLR 20 it has been necessary for the Secretary of State, in order to justify recall, to have up to date medical evidence showing that the criteria for detention are met."
>
> Accordingly, the Secretary of State could not lawfully recall simply because of, or as a sanction for, non-compliance with a condition. He could only recall on the basis of up-to-date medical evidence as to risk to the patient or others. I agree with Ms Lieven QC in paragraph 23 of her skeleton argument, where she said:
>
> > "The fact that the patient did not comply with the condition would not itself warrant a recall to hospital. It is possible to imagine many breaches of condition which would be most unlikely to lead to a recall. Equally, on the facts of this case it may be quite possible that if the claimant ceased to take his medication he would be recalled. But that would not be because he had broken a condition of discharge. It would be because there was clear medical evidence that if he ceased to take his medication he would pose a serious risk to the safety of others."

53. This links the power of recall to the underlying purposes of the MHA (i.e. treatment not detention or punishment). However, in a number of cases breach of the conditions (and so the statutory duty) may well be powerful evidence of, for example, relapse and the need for a recall.

54. It is also the case that the existence of the power of recall is a powerful incentive for the patient to comply with conditions if he or she appreciates the risk that non-compliance will be likely to lead to a consideration of whether the power of recall should be exercised and so to its exercise.

A comparison between a conditionally discharged patient who is not deprived of his liberty in the community and a person who needs social care and is placed by a local or other public authority in pursuance of its duties and powers

55. Unsurprisingly there is a considerable overlap because on a conditional discharge the Secretary of State and/or the FTT will not provide the relevant care package and it will be offered by someone else (see s. 117 of the MHA). So in both cases the care package is provided pursuant to the exercise of statutory functions and sometimes by agreement with a provider (e.g. a care home or a placement such as that envisaged for KC).

56. An equivalent position exists in respect of adults in need of social care. When they have capacity their placement is with their consent and, when they do not, it can be provided in reliance on s. 5 of the MCA or a welfare order of the Court of Protection.

57. In my view, both regimes could be supported by injunction (see for example *Re P (Care Orders: Injunctive Relief)* [2000] 1 FLR 385) but it is likely that this relief would only be of any practical utility against third parties and the consequences of breach of the terms of the care plan is best avoided and dealt with by the prospect and implementation of a change in placement.

The roles of (i) the FTT, and (ii) the Court of Protection

58. They are governed by different statutory regimes. Different tests apply under them which have differing purposes. The FTT has no jurisdiction under the MCA and the Court of Protection has no jurisdiction under the MHA. Both the Secretary of State and the FTT have important roles and powers under the MHA in respect of restricted patients that are directed to promoting the result that the public is properly protected from the serious harm referred to in s. 41(1) of the MHA, namely if the convicted person committed further offences.

59. It follows that decision makers under the MHA and the MCA are applying different tests and making decisions from different perspectives. But a feature common to them both is that they make choices between available options. So when decisions fall to be made under both statutory regimes an issue arises as to which of the regimes sets the choices that are available.

60. In my view it was correctly accepted before me by the Secretary of State that neither he nor the FTT can make a decision that a restricted patient is to be

conditionally discharged without taking into account the detail of the arrangements relating to his accommodation, care and supervision that will exist in the community. This is an acceptance that to properly exercise their MHA decision making powers they must:

(1) take into account the arrangements and thus the conditions that are needed to protect the public and the patient (the protective conditions), and

(2) if those arrangements and protective conditions are not in, or going to be, in place they cannot support and direct a conditional discharge.

This is reflected in the stance taken by the Secretary of State in the COP proceedings (see paragraph 15 above) and it means that the FTT (and the Secretary of State) need to know that the relevant arrangements and protective conditions are in place when the conditional discharge comes into effect.

61. It was also in my view correctly asserted before me that a best interests decision, and so a decision under the MCA, could found a different conclusion on the arrangements and protective conditions that are required to one made under the MHA that has to have regard to the protection of the public and the patient.

62. In my view the points made in the last two paragraphs confirm that:

(1) the Court of Protection and the DOLS decision makers are ill equipped to make and should not make decisions on the arrangements and thus the protective conditions required to provide appropriate protection to the public and the patient as and when the patient moves from hospital into the community,

(2) the statutory responsibility for making the decision on what the protective conditions should be is placed on the MHA decision maker (and so the Secretary of State or the FTT), and so

(3) the decision under the MHA on what the protective conditions should be limits the choices available to the Court of Protection or the DOLS decision makers, with the result that

(4) the Court of Protection and the DOLS decision makers have to determine whether a regime of care, supervision and control that includes the protective conditions is in the patient's best interests and in doing so they cannot choose a regime that does not include the protective and other conditions decided on by the MHA decision maker (see paragraph 36 hereof).

63. An alternative route to the same result is that it would be a waste of time and money for the Court of Protection and the DOLS decision makers to consider the care arrangements for a conditionally discharged restricted patient without knowing what the protective conditions decided on by the MHA decision

maker are because the patient will not be, and indeed should not be, discharged into any care arrangements that do not include them.

64. *Conclusion.* The FTT (and the Secretary of State) cannot lawfully pass responsibility for deciding what the protective conditions are to be to the Court of Protection or the DOLS decision makers. This is so even though breach of the statutory duty created by s. 73(4)(b) of the MHA does not of itself trigger a recall to hospital.

The impact of my conclusion on the proper exercise of their powers by the decision makers under the MHA

65. The Secretary of State's argument on the ratio of the *RB* case gives rise to the problem that, although in making their decisions under the MHA the FTT (and the Secretary of State) must consider and be satisfied that appropriate conditions will be in place on a conditional discharge, they have no jurisdiction to impose protective conditions which, if implemented, would result in a deprivation of the liberty of the restricted patient in the community.

66. A part of the Secretary of State's argument is that the conditions are "imposed" and so protective conditions are not and cannot be consented to. If correct, this applies both to a restricted patient who has capacity to consent to protective conditions and to one who does not. But his argument was not dependent on this interpretation of "imposed".

67. It follows that if the Secretary of State is right Parliament did not confer jurisdiction on a MHA decision maker to conditionally discharge any restricted patient on protective conditions that if implemented would objectively create a deprivation of liberty, applying the *Cheshire West* test.

68. As one of the purposes of s. 73 of the MHA is to promote a supported move to the community whilst retaining the residual control based on the power of recall for the purpose of supporting the patient and protecting the public and the patient (see paragraphs 48 and 49 hereof) it would be surprising if Parliament intended this result in respect of either a restricted patient who had capacity to consent to the relevant conditions, or one who did not.

69. The jurisdictional solution suggested by the Secretary of State recognises the difficulties placed in the way of achieving the underlying purpose of s. 73 MHA by his submission on the ratio of the *RB* case. But his correct acceptance that the MHA decision maker has to consider what protective conditions are needed and be satisfied that they will be in place on a conditional discharge mean that his jurisdictional solution for a restricted patient who lacks capacity to consent to protective conditions seeks to achieve a result which, on his submission, cannot be achieved under the MHA "through the front door".

70. Accordingly this jurisdictional suggestion seeks to utilise a "back door".

71. In my view, if the Secretary of State is right about the ratio of the *RB* case his "back door" jurisdictional suggestion is not a permissible solution because:

(1) the MHA decision maker has to consider what the protective conditions should be,

(2) if the MHA decision maker concludes that they are required to protect the public or the patient (or for any other reason applying the MHA tests) he cannot direct or support a conditional discharge of the restricted patient without them being in place,

(3) the suggestion that the MHA decision maker can effectively require the imposition of the protective conditions but leave them out of the conditions he imposes and so the s. 73(4) statutory duty on the basis that they are or are to be included in a care plan approved by the Court of Protection (or authorised under the DOLS provided by the MCA) does not reflect the reality of the position,

(4) that reality is that the MHA decision maker is making the choice on what the protective conditions are to be and is thereby limiting the choices open to the Court of Protection (or under the DOLS) and so imposing those protective conditions of the conditional discharge, and

(5) the MCA does not fill the jurisdictional gap by providing an alternative regime that serves the same purpose as the MHA or creates the s. 73(4) statutory duty

72. If I am right, the jurisdictional solution suggested by the Secretary of State to achieve the result that he, the FTT and KC supported has to be founded on a conclusion that the ratio of the *RB* case is not that suggested by Secretary of State but is that the MHA decision maker cannot choose and impose conditions that when they are implemented would be in breach of Article 5 and so unlawful.

73. If that conclusion on the ratio of the *RB* case is correct it "opens the door" to any deprivation of liberty resulting from the protective conditions being authorised by the Court of Protection or under the DOLS and so rendered lawful (and not a deprivation of liberty under Article 5).

The ratio of the RB case

74. I agree with the Secretary of State that the approach of the Court of Appeal was one of statutory construction. However, simply starting with the words:

(1) there is no limit on the conditions that can be imposed provided that they promote the underlying purposes of the MHA and so (a) treatment not detention and (b) the protection of the public or the patient referred to in ss. 42 and 73 of the MHA, and

(2) "impose" does not exclude the creation of an obligation or statutory duty based on agreement. For example, this regularly occurs through undertakings to a court and by contract.

75. But the focus of the Court of Appeal's analysis is on the effect of the conditions and effectively asks and answers whether s. 73 (and so also s. 42) of the MHA give the FTT (and the Secretary of State) the power to impose or set conditions that result in the patient being deprived of his liberty.

76. This is demonstrated by, for example, the formulation of the core issue by the Court of Appeal at paragraph 48 where Arden LJ says:

> In my judgment, the core issue in this case is whether there is any statutory authority for a deprivation of liberty once an order for a conditional discharge has been made. The Strasbourg court has made it clear that such an important matter must be "prescribed by law" (the fourth *Winterwerp* condition), and that includes a requirement that the grounds on which a person may be deprived of his liberty when an order for conditional discharge is to be made and the grounds on which he is entitled to be released from the conditions imposing a deprivation of liberty must be found in legislation. I call this "the "prescribed by law" issue.

77. This relates back to her definitions in paragraph 14. It seems to me that:

(1) by those definitions and formulations Arden LJ is referring to both Article 5(1) (a procedure prescribed by law and lawful detention) and Article 5(4) (proceedings to challenge the lawfulness of the detention),

(2) her reasoning in paragraphs 52 to 57 focuses on Article 5(1), and whether s. 73 gives the FTT power to deprive a restricted patient of his liberty,

(3) this is confirmed by the start of paragraph 58 where Arden LJ refers to the interpretation of the power of conditional discharge,

(4) that reasoning is not on all fours with the argument of the Secretary of State described in paragraphs 39 and 40 of the judgment, but

(5) both lines of reasoning address the extent of the powers conferred by s. 73 of the MHA, and so

(6) the ratio of the *RB* case relates to the construction of s. 73 of the MHA and so the extent of the powers it confers.

78. It is important to remember that:

(1) Arden LJ's formulation and reasoning is founded on the premise that *RB* had capacity but could not give a valid consent to the proposed conditions that, when implemented, would deprive him of his liberty, and so

(2) the Court of Appeal did not consider the point that for Article 5 to be engaged, and so for there to be deprivation of liberty in breach of it, both the objective and subjective elements must be present and a person can only be regarded as being deprived of his liberty if he has not validly consented to the confinement in question.

79. Also, that premise had the results that the formulation of the core issue and the reasoning that followed:

(1) looks for the relevant statutory authority only within the MHA, and

(2) does not recognise that the "procedure prescribed by law" referred to in Article 5(1) and the proceedings referred to in Article 5(4) could be provided by legislation other than the MHA, and so the MCA and its DOLS in a case where the patient lacks capacity, or a combination of both the MHA and the MCA.

80. In my view, those effects of that underlying premise mean that the ratio of the *RB* case on the power conferred by s. 73 of the MHA :

(1) goes no wider than the proposition that the lawfulness requirements of Articles 5(1) and 5(4) relating to a deprivation of liberty resulting from conditions imposed on the conditional discharge of a restricted patient cannot be founded on the MHA alone, and so is that

(2) the FTT cannot when directing a conditional discharge impose conditions that when they are implemented would be a deprivation of liberty in breach of Article 5 and so unlawful.

81. This conclusion relates primarily to Article 5(1) because it is directed to the creation of a deprivation of liberty on a conditional discharge. I shall return to Article 5(4) (see paragraphs 115 to 123 hereof)

82. It also leads to different lines of argument and consequences when the patient does and does not have capacity to consent to the relevant conditions.

83. In this case I am concerned with a patient who lacks capacity. But at the end of this Decision I shall make some obiter comments on the position of a patient such as *RB* who has capacity.

84. Also, my conclusion on the ratio of the *RB* case avoids the objection raised on behalf of KC that the formulation of the core issue and decision is flawed because under Article 34 of the ECHR, as replicated in s. 7 of the Human Rights Act 1998, the only person who can complain about an alleged breach of their human rights by a public body is the victim of the breach.

Conditional discharge under s. 73 MHA

85. As is shown in the *RB* case in both the Upper Tribunal and the Court of Appeal issues have arisen concerning what constitutes a "discharge" in earlier cases (including the *PH case – R(SSHD) v Mental Health Review Tribunal, PH as an interested party* [2002] MHLR 241) and this issue underlay the argument of the Secretary of State referred to by Arden LJ at paragraphs 39 and 40 of her judgment.

86. The issue arises against the background of the point that the hospital order remains in being and so the relevant person remains liable to be detained

under it if and when he is recalled to hospital. It is the power of recall and any conditions put in place that distinguish a conditional discharge from an absolute discharge.

87. In my view what constitutes a discharge is not part of the ratio of the *RB* case and I agree with paragraph 47 of the decision of the Upper Tribunal in that case that I am not bound by the *PH* case. Also, in my view the earlier cases including the *PH* case need to be considered having regard to *Cheshire West* and in particular its conclusion that a wide range of circumstances and settings can give rise to the result that on an objective assessment a person is deprived of his liberty.

88. The language and the purpose of s. 73 indicate that the section is directed to a change from one situation (detention for treatment under ss. 37 and 41 of the MHA) to another situation brought about by an absolute or a conditional discharge.

89. A conclusion that a conditional discharge cannot be made to a placement where the objective element of a deprivation of his liberty would exist would not promote the underlying purposes of the MHA as a whole and in particular ss. 42 and 73. Those purposes are referred to in paragraphs 48 and 49 above.

90. The Secretary of State submitted that a conditional discharge under s. 73 MHA is a discharge from detention under the MHA regime whereas, on behalf of KC, it was submitted that it was discharge from one place to another. In many cases these descriptions will overlap. I do not wholly agree with either because what is meant by "the MHA regime" is not clear and I would not wish to rule out the possibility that in some cases the change of place would make no effective difference.

91. In my view, if and when a conditional discharge is to circumstances in which the objective element of a deprivation of liberty would exist the "discharge" is from a situation in which the person is detained or deprived of their liberty under provisions of the MHA (and so usually in hospital) to one where he is so deprived of his liberty in different circumstances arising from the regime put in place on his conditional discharge and thus its conditions (and so usually not in a hospital).

92. So here the "discharge" is from KC's detention in a hospital pursuant to ss. 37 and 41 of the MHA to a lawful or unlawful deprivation of liberty created by the conditions at the Placement which is not a hospital.

93. In my view this accords with the reasoning of the Upper Tribunal in the *RB* case at paragraphs 48 to 56 and the express disagreement with paragraph 53 in paragraph 65 of the judgment of Arden LJ is not directed to this issue.

The process under the MCA to render a deprivation of his liberty lawful if the conditionally discharged restricted patient lacks capacity to consent to the regime of his care and its effect. The eligibility of such a patient to be deprived of liberty by the MCA

94. I have already set out the approach taken under the MCA and its DOLS.

95. The difficulties in applying those provisions is demonstrated by the point that initially the Secretary of State and KC, by the Official Solicitor, argued that a restricted patient who was conditionally discharged was not ineligible and so could be deprived on his liberty by the MCA on different bases.

96. The Secretary of State based his argument on Case B and KC based his on Case E (see paragraph 2 of Schedule 1A of the MCA). KC, by the Official Solicitor, now accepts that the relevant case is Case B (and that Case E applies and only applies to a restricted patient when there is an absolute discharge).

97. Ineligibility under paragraph 2 of Schedule 1A is determined:

(1) by applying criteria identifying the status of the relevant person, and then

(2) by applying the paragraphs applicable to a person with that status to him.

The person is *ineligible* if he falls within one of the status descriptions and the paragraphs corresponding to it provide that he is ineligible.

98. I agree with what has become common ground that on a conditional discharge KC would be within the status of P described in Case B as he would remain subject to a hospital order (see paragraphs 8(1) and (4)).

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

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

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

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

103. So if *any course of action amounting to a deprivation of liberty* contained in the relevant care plan (and thus in or referred to in the court order or the

standard authorisation) *is not in accordance with a requirement imposed by the MHA* the conditionally discharged patient is *ineligible.*

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

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

106. I therefore invited further submissions on this issue.

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

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

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

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

> A person must also meet the eligibility requirement, which relates to cases where a person is, or might be made, subject to the 1983 Act. Grounds for ineligibility are set out in new Schedule 1A to the MCA (inserted by Schedule 8). In summary, a person is ineligible if they are already subject to the 1983 Act in one of the following circumstances:
>
> • they are actually detained in hospital under the main powers of detention in the 1983 Act (or treated as such).

> • they are on leave of absence from detention or subject to guardianship, SCT or conditional discharge and in connection with that are subject to a measure (such as a requirement to live in a particular place) which would be inconsistent with the authorisation if granted. This means that a person who is subject to the 1983 Act but who is not in hospital could be subject to an authorisation under these new provisions. This might be necessary for example if a person subject to guardianship who normally lived at home needed respite care in a care home.
> • they are on leave of absence from detention, or subject to SCT or conditional discharge and the authorisation, if given, would be for deprivation of liberty in a hospital for the purposes of treatment for mental disorder. This means that a authorisation cannot be used as an alternative to the procedures for recall in the 1983 Act.

Such Explanatory Notes are admissible as an aid to construction to cast light on the objective setting or contextual scene of the statute, and the mischief at which it is aimed (see Lord Steyn in *Westminster City Council v NASS* [2002] UKHL38 at paragraph 5).

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

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

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

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

111. The potential for such a lacuna arises because conditions imposed and decisions made under the MHA must be consistent with its purposes and so with the reception, care and treatment of patients with disorders. Thus, any condition of discharge (and any condition imposed on leave of absence or under guardianship or a community treatment order) must be linked to the underlying mental disorder which engages the MHA. It follows that there is no power under the MHA to require a patient to undergo treatment or to accept care which is not linked to a mental disorder. This is relevant both to physical

conditions or illnesses and to learning disabilities which are not associated with abnormally aggressive or seriously irresponsible conduct (pursuant to section 2(2B) such learning disabilities are not a "mental disorder" for the purpose of, inter alia, sections 3 (detention for treatment), 7 (guardianship), 17A (community treatment), 37 (hospital order) and 72(1)(b) and (c) and (4) (discharge)).

112. So, if paragraph 3 was construed as requiring the terms of any care plan amounting to a deprivation of liberty to be imposed under the MHA, care and treatment in respect of physical conditions or illnesses and most learning disabilities, where they amount to a deprivation of liberty, could not be authorised under the MCA in respect of any conditionally discharged patient (or any patient on leave of absence or under guardianship or a community treatment order). The following examples illustrate the problems that would arise:

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

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

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

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

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

Article 5(4) and Article 14

115. Article 5(4) requires the availability of proceedings to challenge the lawfulness of the detention.

116. Paragraph 58 of the judgment of Arden LJ in the *RB* case indicates that if she had concluded that s. 73 of the MHA gave the FTT power to direct a conditional discharge on conditions that resulted in a deprivation of liberty at the relevant placement she would not have found a breach of Article 5(4). But as (a) she does not analyse this issue, (b) there may be contrary indications in paragraphs 63 to 65 of her judgment and (c) my analysis introduces new points it would not be appropriate for me to found my conclusion on the indication in paragraph 58 of her judgment.

117. The MCA contains such provisions in respect of orders of the court and authorisations under the DOLS including the need for reviews. But on my analysis the Court of Protection and the DOLS decision makers could not change the protective conditions decided on by the FTT or the Secretary of State. Rather the continued authorisation of the deprivation of liberty would be considered by reference to the choices available that include such protective conditions and the application of a best interests test. As already mentioned the Court of Protection or the DOLS decision maker could refuse to authorise any such placement and if that happened the provider would be likely to refuse to continue to provide it.

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

119. Problems relating to the existence of two statutory schemes and decision makers can arise in other circumstances (see for example the discussion in *KD v A Borough Council, the Department of Health and Others* [2015] UTUK 0251 (AAC) in particular at paragraphs 44 to 54). Whereas here they involve public authorities exercising statutory powers and duties they are approached pragmatically and cooperatively. And, for example, the duties of the Secretary of State under the MHA would require him to address material changes in circumstances (including the non-availability of a placement or changes of view on protective conditions) and a high court judge sitting in both the Court of Protection and the Administrative Court could resolve a judicial review challenge to a decision of the Secretary of State on such issues.

120. Further, in my view the language of s. 73 permits a FTT to write into the conditions it imposes an ability to apply to it for a variation or discharge of protective (or other) conditions on the basis of a material change in circumstances (a) if a variation or discharge is refused by the Secretary of State or the FTT agree to consider the application, and (b) if the FTT is invited to consider such an application by the Court of Protection (or a DOLS

decision maker). Such a provision would be in line with the approach in *R(H) v SSHD* [2003] QB 320 and [2004] 2 AC 253 to the problem of a material change in circumstances after deferral of a direction until arrangements have been made. It seems to me that generally it would be sensible for the FTT to do this to provide a further alternative route of challenge to a continuing deprivation of liberty.

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

122. For the same reasons I consider that there is no breach of Article 14.

123. Further, in my view the ratio of the *RB* case in the Court of Appeal on what Arden LJ described as the justification issue does not preclude me from reaching this view.

A restricted patient who has the capacity to consent to the protective conditions that if implemented would result in his deprivation of liberty

124. In the *RB* case the Upper Tribunal expressed the following views at paragraphs 60 to 62 of their decision:

> 60. The tribunal raised a separate point that RB's "valid and meaningful consent to a move to [the care home] (a move which would manifestly be in his interests) would prevent the deprivation of his liberty amounting to a breach of Article 5. It relied on comments in *Stork*, para 73 that:
>
> " -- A person can only be considered to have been deprived of his liberty if, as an additional subjective element, he has not validly consented to the confinement in question -- "
>
> 61. We cannot accept this line of reasoning. (As already noted, a similar line of argument was rejected by Collins J in *G* [2004] EWHC 2193) --- ------
>
> 62. By contrast, in the present case it cannot be suggested that RB consented to his initial psychiatric detention. He has at all material times been detained by virtue of an order imposed by the Court under the Mental Health Act 1983. He has never been offered the option of absolute discharge nor is there any prospect of such an offer being made in the foreseeable future. The only alternative presented to RB is to agree to a condition of his detention within his present regime or to agree the alternative regime contemplated in the Tribunal's order. This very limited choice cannot be equated to a free and unfettered consent to psychiatric detention order the conditions proposed by the Tribunal. A person's consent to alternative conditions of his detention regime is not the same as his consent to the existence of the regime itself.

125. These views and my comments on them are obiter.

126. I disagree with the reasoning that founds those views and so also with the reasoning in the *G* case (*R(G) v Mental Health Review Tribunal* in particular at paragraph 23). In my view, that line of reasoning is flawed because:

(1) it places incorrect reliance on a continuation of a liability to be detained, the lack of consent to the original detention, the lack of an offer of an absolute discharge, the lack of any such offer being made in the foreseeable future and the point that the situation of a voluntary patient under s. 131 of the MHA is different because it only applies when there is no order or direction rendering the patient liable to be detained under the MHA,

(2) it is at odds with the nature of a conditional discharge under s. 73 of the MHA (see paragraphs 83 to 88 above),

(3) importantly, and in any event, it fails to recognise that the risk of recall, and so the liability to be detained in the same compulsory way as existed before a conditional discharge, does not mean that the nature and effect of a deprivation of liberty that will arise on a conditional discharge based on different considerations and powers does not give rise to a choice particularly when, as in the case of *RB* and here, the change would manifestly (a) be to a different regime of care, support and control, and (b) be in the best interests of the relevant patient,

(4) *RB* could have applied for an absolute discharge even though his prospects of getting it would have been low, and accordingly

(5) it proceeds on the mistaken premise that all detentions and deprivations of liberty within or related to a regime should be treated as being the same and so fails to recognise that (a) just as with a move to being a voluntary patient the offer of a conditional discharge gives rise to a real choice between alternatives including ones between more and less restrictive options and ones that in many cases will have a marked impact on the living conditions and the short, medium and long term best interests of the patient, and (b) the consent would not have been to the continued existence of the pre-existing regime of care, support and control.

127. The Secretary of State argued that the situation is analogous to that of a prisoner being transferred from high to low security or to hospital and such a prisoner cannot be said to consent to the underlying detention. I do not agree because there the source of the underlying detention remains the same and in any event I see no reason why, if it was necessary to found a lawful move, the prisoner could not give informed and valid consent to the implementation of the changes to the manner in which he was to be detained.

128. Further, if this approach and conclusion of the Upper Tribunal in the *RB* case is right it creates difficulties in the way of the Court of Protection making the relevant choice on behalf of a patient who lacks capacity (which was an integral part of the Secretary of State's jurisdictional solution to the problems created by the *RB* case). This is because the underlying theme of the MCA

is that it enables things to be done on behalf of the patient that he could do himself if he had capacity and, as I have explained, the best interests jurisdiction of the Court of Protection is exercised by making choices between available options. To my mind correctly no-one suggested that the Court of Protection could not make the equivalent choice for KC that the Upper Tribunal concluded *RB* could not give a valid consent to.

129. Further, the conclusion of the Upper Tribunal in the *RB* case founds the surprising and arguably discriminatory result that a restricted patient over whom the Court of Protection has no jurisdiction, or who is not covered by the DOLS because he has the relevant capacity, is in a worse position than a patient who lacks that capacity. In my view, the point made by the Secretary of State that the powers of the FTT are the same for both types of patient is not an answer to this problem. This is because it is the result that matters and the relevant issue is not directed to the powers of the FTT but to whether consent to conditions can be given by or on behalf of the patient.

130. The choices presented to the Court of Protection and a patient with the relevant capacity can be limited or wide and easy or difficult. For example, they may have to make choices between whether to have unpleasant and risky surgery for a medical condition or not to have surgery knowing the underlying condition may lead to death. However the existence of only unpleasant choices does not prevent the individual patient having the right to choose or the Court of Protection from choosing on his behalf.

131. Having said that limitations on, or the existence of influence in respect of, the choice are relevant factors as is shown for example by *Freeman v Home Office (No 2)* [1984] QB 524. That case, at the appeal stage, turned on the issue whether a vulnerable prisoner could give valid consent for drugs to be administered to him when he had initially refused to provide consent. The trial Judge found for the Home Office on the facts but acknowledged that a person's consent must be voluntary. His approach, endorsed by Lord Donaldson at 557, was as follows:

> The right approach, in my judgment, is to say that where, in a prison setting, a doctor has power to influence a prisoner's situation and prospects a court must be alive to the risk that what may appear, on the face of it, to be a real consent is not in fact so.

132. So, in my view, the FTT (and other decision makers) need to be alive to the possibility that an expression of consent may not be "real", but if real consent is given to the relevant protective conditions there will be no deprivation of liberty under or in breach of Article 5. Given that many patients are legally represented before the FTT by panel solicitors , if a represented patient gives consent after discussing the matter with his lawyers then the FTT can usually be reassured that the consent is real.

133. Finally, the right to give or refuse consent to something is an expression of the autonomy of the individual and thus the state has a duty to respect that expression of autonomy under Article 8 ECHR. That right applies equally to a detained mental health patient who has capacity as it applies to any other

person, particularly in the context of a possible discharge. So it is at least arguable that a conclusion that a mental health patient does not have the right to give consent to abide by a set of conditions is not compatible with Article 8(2) ECHR.

The problems arising from the ability to withdraw consent.

134. This practical problem arises in the case of a voluntary patient where it is alleviated by the provisions of s. 5 of the MHA. But the underlying practical assessments of whether there will be continuous voluntary compliance are similar in the cases of a voluntary patient and a conditionally discharged patient.

135. A particular problem in respect of a deprivation of liberty (e.g. restraint or a restriction on leaving a place) is that, on the analysis of Holman J in *R (SH) v Mental Health Review Tribunal* [2007] EWHC 884 (Admin), which concerned medical treatment, the relevant consent is subject to a condition that it can be withdrawn at any time and so as and when it is the person exercising the restraint or restriction could not rely on the earlier consent as a defence to a claim that he or she acted in breach of Article 5. At paragraph 35 of his judgment Holman J said:

> The law with regard to consent to treatment is clear and I have already quoted extensively from *In re T.* An adult of full capacity has an absolute right to choose whether to consent to medical treatment. That applies to every aspect of treatment and every occasion of treatment. Thus in this case, on each occasion that SH attends, or should attend, for his fortnightly depot injection he has an absolute right to choose whether to consent to it or not. The treating doctor or nurse must, on each occasion, satisfy himself that the apparent consent is a real consent and that the independence of the patient's decision or his will has not been overborne (see the language of Lord Donaldson in *In re T*). As *Freeman* makes clear, that is in every case and on every occasion a question of fact for the doctor and, in the event of legal challenge, the court. That is the law and Parliament has not derogated from it save by such express provisions as section 58. The tribunal must be presumed to know the law and, in my view, condition 1 is intended to be, and should be, read as subject to the general law.

136. I am not convinced by that analysis and result. But unless and until it is challenged and tested it places a considerable obstacle in the way of a patient with capacity being able to benefit from steps designed to enable him or her to return to the community and which are in his or her best interests. This is because those providing the care and support in the community may not be prepared to take the risk that the patient will not withdraw his or her consent to the terms and conditions of the placement.

137. It seem to me that it may be appropriate to revisit the *SH* case on the basis that a person with capacity can and often does agree (a) to act in a certain way, and (b) that others can act in a certain way towards him or her for a set period of time or until the expiry of a reasonable notice. Someone who has capacity can do this in respect of a variety of important rights and matters and thereby restrict his or her freedom of action and autonomy in respect of them. In my view, it is arguable that this ability extends to fundamental human rights

whose purpose is to protect and benefit the individual. And, if that is so, it is arguable, in the context of s. 73 of the MHA, that a patient can agree to comply with the statutory duty it imposes (just as he or she could give an undertaking to a court) up to the expiry of a notice withdrawing his consent or further order of the FTT. Those providing the care and support could then look to the continuing statutory duty or consent to provide a defence to any claim against them.

138. I acknowledge that that direction of travel may also provide a starting point for an argument that contrary to the ratio of the *RB* case, the statement cited in paragraph 109(2) above and indications contained in the eligibility provisions in the MCA, that the MHA does provide a statutory basis for the process prescribed by law that is required by Article 5.

139. These are points for another day.

Judge Rowland's analysis in the RB case by reference to the definition of a hospital and the PH principle

140. I heard no argument on and have not addressed this point. The overall effect of it does not arise where as here the conditionally discharged restricted patient is not to be accommodated or detained in an establishment for treatment provided by it (see paragraphs 77 and 78 of his judgment). The impact of this analysis is also for another day.

Summary of my conclusions on the approach to be taken

141. These are:

(1) FTT did not err in law as asserted by the Secretary of State.

(2) The FTT has power to impose (and so direct a conditional discharge on) conditions that when implemented will, on an objective assessment, give rise to a deprivation of liberty that is lawful because it has been authorised by the Court of Protection under the MCA or pursuant to the DOLS contained in the MCA (the MCA authorisations) and so complies with Article 5.

(3) The FTT should consider and generally should include in the protective conditions it imposes an ability to apply to it for a variation or discharge of them on the basis of a material change in circumstances (a) if a variation or discharge is refused by the Secretary of State or the FTT agrees to consider the application, and (b) if the FTT is invited to consider such an application by the Court of Protection (or a DOLS decision maker).

(4) The MCA authorisations can only be given if the relevant restricted patient lacks capacity to consent to the relevant conditions and is not ineligible to be deprived of his or her liberty by the MCA. Provided that the terms and conditions that give rise to the deprivation of liberty do not conflict with conditions the FTT have decided are necessary and

have identified the restricted patient will not be ineligible and such authorisations can be given under the MCA applying the tests it sets out.

(5) Both of the MCA authorisations can be given to come into effect at a future date or on a future event but the MCA decision maker needs to know the conditions (including those that when implemented will objectively give rise to a deprivation of liberty) that the FTT considers necessary to satisfy the tests under the MHA, before the MCA decision maker can properly make the relevant MCA decision.

(6) So, the FTT needs to identify what conditions it considers need to be in place as and when the direction for the conditional discharge of the restricted patient takes effect so that the MCA decision maker knows what they are when applying the MCA tests.

(7) The FTT will need to be satisfied that the proposed placement on the relevant conditions (and so the relevant care plan) is sufficiently defined and an available option in practice and if it is not when it will be so available (see *KD v A Borough Council, the Department of Health and Others* [2015] UKUT 0251 (AAC) at paragraph 68).

(8) The parties will therefore need to provide the necessary evidence on this and any other factors that will need to be taken into account by the FTT.

(9) The FTT should apply the guidance given by Upper Tribunal Judge Jacobs in *DC v Nottinghamshire Healthcare NHS Trust and the Secretary of State for Justice* [2012] UKUT 92 (AAC) on when the FTT should adjourn, make a decision under s. 73(7) of the MHA or a provisional decision in reliance on *R(H) v SSHD* [2003] QB 320 and [2004] 2 AC 253).

(10) The Court of Protection and the DOLS decision makers cannot override the conditions identified by the FTT and so can only choose between alternatives that include them.

2 July 2015

Signed on the original

Mr Justice Charles

President of the UT(AAC)