THE UPPER TRIBUNAL (ADMINISTRATIVE APPEALS CHAMBER)

UPPER TRIBUNAL CASE NO: UA-2023-000193-HM
[2023] UKUT 195 (AAC)
PQR v Derbyshire Healthcare NHS Foundation Trust

Decided following an oral hearing on 7 August 2023

Representatives

PQR	Stephen Simblet KC and Ollie Persey of counsel, instructed by Deborah Robinson of Cartwright King solicitors, all acting pro bono
The Trust	Fenella Morris KC, instructed by Browne Jacobson solicitors
Secretary of State for Health and Social Care	Karl Laird (written submission only), instructed by the Government Legal Department

DECISION OF UPPER TRIBUNAL JUDGE JACOBS

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

Reference:	MP/2022/15869
Decision date:	9 December 2022 as reviewed on 23 January 2023

The decision of the First-tier Tribunal did not involve the making of an error on a point of law under section 12 of the Tribunals, Courts and Enforcement Act 2007.

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

REASONS FOR DECISION

A. Introduction

1. PQR was the applicant before the First-tier Tribunal and is the appellant in these proceedings. He is also involved in Part 8 proceedings in the High Court, in which he is known by the same initials. The parties in the Upper Tribunal agreed that he should be known by the same initials in these proceedings also.

2. The High Court proceedings seek a declaration on the meaning of 'examination' in various provisions of the Mental Health Act 1983. One of those provisions is section 20A(4)(a), which deals with extensions of community treatment orders (CTOs). The issue is whether that examination has to be carried out in the presence of the patient. This issue might also arise in the tribunal proceedings, depending on the jurisdiction of the First-tier Tribunal. In the event, I have decided that the First-tier Tribunal has no jurisdiction to rule on the validity of a CTO. As the issue cannot arise within the First-tier Tribunal's jurisdiction, it would not be permissible for the Upper Tribunal to deal with it as an academic issue: *Secretary of State for Work and Pensions v Robertson* [2015] CSIH 82 at [42]-[45].

B. The tribunal proceedings

3. PQR was born in 1966 and was diagnosed with schizophrenia in 1996. The First-tier Tribunal described the current nature of his condition as 'a chronic, relapsing and remitting mental illness characterised by psychotic symptoms (particularly auditory hallucinations), thought disorder and associated disturbed behaviour. The patient has a lengthy and well recorded history of exhibiting violent behaviour at times of relapse.'

4. Since he was diagnosed, PQR has had frequent and regular involvement with the mental health services, involving both admissions to hospital (ten by my count) and intermittent discharges subject to CTOs. He was subject a CTO that was due to expire in 2020. In order to decide whether the CTO should be extended, his responsible clinician examined him but, on account of the pandemic, did so by telephone. There were further examinations in 2021 and 2022, both of which were carried out in the presence of PQR. Following all three examinations, the responsible clinician reported that PQR appeared to satisfy the conditions for the CTO to be extended.

5. In June 2022, PQR applied to the First-tier Tribunal. His solicitor argued that an examination necessary for a CTO to be extended had to be conducted in the presence of the patient. As the 2020 examination of PQR had been conducted by telephone, it did not comply with the requirements of the Mental Health Act 1983 and the CTO had not been extended. The Trust's solicitor argued that that issue was outside the tribunal's jurisdiction. The tribunal decided: (a) it did not have jurisdiction to consider the validity of the CTO (the jurisdiction issue); but (b) if it had jurisdiction, it would find that the examination did comply with the Act (the construction issue). It concluded: (c) PQR satisfied the conditions for a CTO to be extended.

6. PQR applied to the First-tier Tribunal for permission to appeal to the Upper Tribunal. The tribunal refused permission. In doing so, the tribunal carried out a review under section 9 of the Tribunals, Courts and Enforcement Act 2007 and set aside the decision on the construction issue on the ground that the tribunal should not have decided it. I gave PQR permission to appeal and the appeal was considered at an oral hearing on 7 August 2023.

7. The Secretary of State for Health and Social Care, who is a party to the High Court proceedings, applied to be made a party to the Upper Tribunal proceedings. I refused on the ground that this would not add value to the Upper Tribunal proceedings. I did, however, allow the Secretary of State to make submissions in the case. This was done in writing by Mr Laird. I am grateful to him and to counsel who appeared before me for their submissions. I am also grateful to PQR's solicitor and counsel, all of whom are representing him pro bono.

C. The Mental Health Act 1983

8. These are the relevant provisions of the Act:

17A Community treatment orders

(7) In this Act–

'community patient' means a patient in respect of whom a community treatment order is in force;

'the community treatment order', in relation to such a patient, means the community treatment order in force in respect of him; …

20A Community treatment period

(1) Subject to the provisions of this Part of this Act, a community treatment order shall cease to be in force on expiry of the period of six months beginning with the day on which it was made.

(2) That period is referred to in this Act as "the community treatment period".

(3) The community treatment period may, unless the order has previously ceased to be in force, be extended—

(a) from its expiration for a period of six months;

(b) from the expiration of any period of extension under paragraph (a) above for a further period of one year,

and so on for periods of one year at a time.

(4) Within the period of two months ending on the day on which the order would cease to be in force in default of an extension under this section, it shall be the duty of the responsible clinician—

(a) to examine the patient; and

(b) if it appears to him that the conditions set out in subsection (6) below are satisfied and if a statement under subsection (8) below is made, to furnish to the managers of the responsible hospital a report to that effect in the prescribed form.

(5) Where such a report is furnished in respect of the patient, the managers shall, unless they discharge him under section 23 below, cause him to be informed.

(6) The conditions referred to in subsection (4) above are that—

(a) the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;

(b) it is necessary for his health or safety or for the protection of other persons that he should receive such treatment;

(c) subject to his continuing to be liable to be recalled as mentioned in paragraph (d) below, such treatment can be provided without his being detained in a hospital;

(d) it is necessary that the responsible clinician should continue to be able to exercise the power under section 17E(1) above to recall the patient to hospital; and

(e) appropriate medical treatment is available for him.

(7) In determining whether the criterion in subsection (6)(d) above is met, the responsible clinician shall, in particular, consider, having regard to the patient's history of mental disorder and any other relevant factors, what risk there would be of a deterioration of the patient's condition if he were to continue not to be detained in a hospital (as a result, for example, of his refusing or neglecting to receive the medical treatment he requires for his mental disorder).

(8) The statement referred to in subsection (4) above is a statement in writing by an approved mental health professional—

(a) that it appears to him that the conditions set out in subsection (6) above are satisfied; and

(b) that it is appropriate to extend the community treatment period.

(9) Before furnishing a report under subsection (4) above the responsible clinician shall consult one or more other persons who have been professionally concerned with the patient's medical treatment.

(10) Where a report is duly furnished under subsection (4) above, the community treatment period shall be thereby extended for the period prescribed in that case by subsection (3) above.

20B Effect of expiry of community treatment order

(1) A community patient shall be deemed to be discharged absolutely from liability to recall under this Part of this Act, and the application for admission for treatment cease to have effect, on expiry of the community treatment order, if the order has not previously ceased to be in force.

(2) For the purposes of subsection (1) above, a community treatment order expires on expiry of the community treatment period as extended under this Part of this Act, but this is subject to sections 21 and 22 below.

23 Discharge of patients

…

(1A) Subject to the provisions of this section and section 25 below, a community patient shall cease to be liable to recall under this Part of this Act, and the application for admission for treatment cease to have effect, if an order in writing discharging him from such liability is made in accordance with this section.

(1B) An order under subsection (1) or (1A) above shall be referred to in this Act as ‘an order for discharge’.

(2) An order for discharge may be made in respect of a patient—

…

(c) where the patient is a community patient, by the responsible clinician, by the managers of the responsible hospital or by the nearest relative of the patient.

66 Applications to tribunals

(1) Where-

…

(fza) a report is furnished under section 20A above in respect of a patient and the patient is not discharged under section 23 above;

…

an application may be made to the appropriate tribunal within the relevant period-

(i) by the patient …

(2) In subsection (1) above the 'relevant period' means-

…

(fza) in the cases mentioned in paragraph (fza) and (faa) of that subsection, the period or periods for which the community treatment period is extended by virtue of that report; …

72 Powers of tribunals

(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—

…

(c) the tribunal shall direct the discharge of a community patient if it is not satisfied–

(i) that he is then suffering from mental disorder or mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment; or

(ii) that it is necessary for his health or safety or for the protection of other persons that he should receive such treatment; or

(iii) that it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) above to recall the patient to hospital; or

(iv) that appropriate medical treatment is available for him; or

(v) in the case of an application by virtue of paragraph (g) of section 66(1) above, that the patient, if discharged, would be likely to act in a manner dangerous to other persons or to himself.

77 General provisions concerning tribunal applications.

(1) No application shall be made to the appropriate tribunal by or in respect of a patient under this Act except in such cases and at such times as are expressly provided by this Act.

145 Interpretation

(1) In this Act, unless the context otherwise requires-

…

'community patient' has the meaning given in section 17A above;

'community treatment order' and 'the community treatment order' have the meanings given in section 17A above;

'the community treatment period' has the meaning given in section 20A above; …

D. Logic and jurisdiction

9. I have decided this appeal on the assumption that the examination in 2020 did not comply with section 20A(4)(a). At the hearing, we discussed two ways of analysing the consequences. I call them the logical approach and the pragmatic approach. For both, the issue for me is what jurisdiction would the First-tier Tribunal have?

10. Mr Simblet began with the logical approach. On this analysis:

- an examination under section 20A had to be conducted in the presence of the patient;
- as it had been conducted by telephone, the examination in 2020 was not carried out properly;
- the result was that the CTO was not extended in that year;
- at the end of the community treatment period for the CTO, the patient was discharged under section 20B; and
- in 2021 and 2022, there was no longer a CTO that could be extended.

11. Even if all of that is correct, it does not help PQR in the tribunal proceedings. In order to commence proceedings, PQR would have to show that there had been a report to the managers (section 66(1)(fza)) and that the application was made within the relevant period as defined by section 66(2)(fza). He could satisfy the former. But he could not satisfy the latter because, on the logical approach, there had been no extension and, therefore, there was no relevant period within which to make an application.

12. Even if section 66(2) were satisfied, the First-tier Tribunal would have no powers under section 72(1). The tribunal is only given power to discharge, but on the logical approach, the patient would already have been discharged by operation of law under section 20B. Moreover, the power only exists in respect of a community patient, which is defined by section 17A(7) as someone in respect of whom a CTO 'is in force'. But if there had been no extension, there would be no CTO in force. The logical approach prevents the First-tier Tribunal having any power to discharge.

13. In short, the logical approach is self-defeating in so far as the First-tier Tribunal's jurisdiction is concerned. Whatever rights or remedies a patient may have, they are not to be found in the First-tier Tribunal. PQR in effect would be applying for a declaration that he was not subject to a CTO, but the logical analysis prevents the First-tier Tribunal having any power to deal with the application, let alone to give him the declaration he wants.

E. The pragmatic approach and jurisdiction

14. The law has recognised the dangers in following logic and takes an approach that recognises the 'important values underpinning the court's supervisory jurisdiction, such as the public interest in legal certainty, orderly administration, and respect for the rule

of law.' Those words come from the Supreme Court in *R (Majera (formerly SM (Rwanda))) v Secretary of State for the Home Department* [2022] AC 461 at [32].

15. As Lord Slynn put it in *Boddington v British Transport Police* [1999] 2 AC 143 at 165, 'courts have had to grapple with the problem of reconciling the logical result with the reality that much may have been done on the basis that an administrative act or a byelaw was valid. The unscrambling may produce more serious difficulties than the invalidity. … [T]he law in this area has developed in a pragmatic way on a case by case basis.'

16. The leading authority is now the decision of the Supreme Court in *Majera*. The case involved a judicial decision, but the Court devoted a section of its judgment to administrative acts that had not been properly made in some way. I have taken account of the whole of the section, which runs from [27]-[42], but will limit myself to these quotations:

> 27. … Although judges have commonly used expressions such as 'null' and 'void' to describe unlawful administrative acts and decisions, it has nevertheless been recognised that the notion that such acts and decisions are utterly destitute of legal effect, as if they had never existed at all, is subject to important qualifications.
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> …
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> 28. Accordingly, if an unlawful administrative act or decision is not challenged before a court of competent jurisdiction, or if permission to bring an application for judicial review is refused, the act or decision will remain in effect. Equally, even if an unlawful act or decision is challenged before a court of competent jurisdiction, the court may decline to grant relief in the exercise of its discretion, or for a reason unrelated to the validity of the act or decision, such as a lack of standing (as in *Durayappah v Fernando* [1967] 2 AC 337) or an ouster clause (as in *Smith v East Elloe*). In that event, the act or decision will again remain in effect. An unlawful act or decision cannot therefore be described as void independently of, or prior to, the court's intervention.

17. Recognising the problems with the logical approach, Mr Simblet accepted that the examination and report in 2020 had had some effect. He began by accepting that the purported extension had had a 'practical effect.' Later, he used other expressions: 'acting on it', 'treated as valid' and 'had effect'. He was right to use all those expressions. But on the authority of *Majera* and of authorities dating at least from the 1950s, what was done in 2020 also had 'legal effect' unless and until it was set aside in some lawful manner.

18. The 'legal effect' meant that the existing CTO was extended in 2020, even if the examination had not been properly conducted. And it had been further extended in 2021 and 2022. That would allow PQR to apply to the First-tier Tribunal under section 66 and the First-tier Tribunal would have power under section 72(1) to discharge him. But that would not mean that the First-tier Tribunal would have jurisdiction to rule on the validity of a CTO or its extension. There is no caselaw on this issue, but there is authority from the Court of Appeal and House of Lords on the same issue in respect of section 3 of the Mental Health Act 1983. The First-tier Tribunal relied on those cases in deciding the jurisdiction issue.

19. *Ex parte Waldron* [1986] QB 824 concerned the jurisdiction of the High Court to hear judicial review proceedings that challenged the validity of a recommendation that a patient be admitted for treatment under section 3. Ackner LJ rejected an argument that the proper remedy lay through (what is now) the First-tier Tribunal:

> … as the opening words of section 72 make clear, the jurisdiction given to the tribunal is limited to entertaining applications made by a person who is liable to be detained under the Act. The tribunal's powers are thus confined to granting or refusing relief to persons liable to be detained. It has no power to consider the validity of the admission which gave rise to the liability to be detained. The tribunal cannot, in my judgment, be used where it is sought to challenge the underlying validity of the admission, as a route to the High Court. Mr. Brooke seeks to rely upon section 66(l)(b) to get over this difficulty. That subsection provides that where a patient is admitted to a hospital in pursuance of an application for admission for treatment, an application may be made to a mental health review tribunal within the relevant period. However, section 77, which deals with general provisions concerning tribunal applications, provides by subsection (1) that no application shall be made to a mental health review tribunal by or in respect of a patient, except in such cases and at such times as are expressly provided by the Act. The section 66(l)(b) case must be a person who is liable to be detained under the Act because he has been admitted in pursuance of an application made under section 3 and that requires the fulfilment of the conditions specified in that section. Such an applicant being admitted to the hospital in pursuance of a section 3 application has thereby acquired the liability to be detained. That a section 66(l)(b) patient is necessarily a person liable to be detained is recognised by section 6(4) of the Act which deals with the effect of an application for admission and provides:
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>> 'Where a patient is admitted to a hospital in pursuance of an application for admission for treatment, any previous application under this part of this Act *by virtue of which he was liable to be detained* in a hospital or subject to guardianship shall cease to have effect.' (My emphasis).
>
> It follows that the applicant was not entitled to seek from the mental health review tribunal a decision as to the vires of her admission. It had no jurisdiction to entertain such an application.

20. The other members of the Court did not deal with this issue. Ackner LJ's conclusion was, though, approved by the House of Lords in *R (von Brandenburg) v East London and the City Mental Health NHS Trust* [2004] 2 AC 280. In that case, the patient had been readmitted under section 3 following an order by a tribunal that he be discharged. Lord Bingham gave the only judgment. He began by setting out what he called (in [6]) 'certain familiar overriding principles, not in themselves controversial.' Among those principles was this:

> 9(3). It is plain from the language of sub-paragraphs (a)(i) and (b)(i) of section 72(1), quoted above, that the focus of the tribunal's enquiry into the mental health of the patient is on whether he is not 'then suffering' from mental disorder or mental illness. 'Then' refers to the time of the tribunal's review and the tribunal has no power to consider the validity of the admission which gave rise to the liability to be detained: see *Ex parte Waldron* [1986] QB 824, 846. The tribunal will doubtless endeavour to assess a patient's condition in the round, and in

considering issues of health, safety and public protection under sub-paragraphs (a)(ii) and (b)(ii) of section 72(1) it cannot ignore the foreseeable future consequences of discharge, but the temporal reference of 'then' is clear and the tribunal is not called upon to make an assessment which will remain accurate indefinitely or for any given period of time.

21. Mr Simblet argued that I was not bound by those passages. As to *Waldron*, it was only the opinion of Ackner LJ. The other judges did not find it necessary to deal with the argument. As to *von Brandenburg*, it was built on *Waldron* and was not necessary for the issue before the House of Lords.

22. Mr Simblet's submissions may be technically correct as a matter of precedent. Nevertheless, I am going to apply *Waldron* and *von Brandenburg* for these reasons. (a) If they are not binding as precedent, they are statements by a Lord Justice of Appeal in the Court of Appeal and a unanimous House of Lords. (b) They have stood for decades; *Waldron* was decided not far short of 40 years ago and *von Brandenburg* was decided a few months short of 20 years ago. (c) The reasoning is compelling on the language of the legislation. Every point made by Ackner LJ is equally applicable to a CTO, as is the reasoning of the House of Lords. Read as a whole, the provisions allowing applications to be made to, and those conferring powers on, the First-tier Tribunal do not include power to deal with issues of validity.

F. If I am wrong

23. Suppose, though, that I am wrong and that the cases I have just discussed can be distinguished to give the First-tier Tribunal jurisdiction on PQR's application to rule on the validity of the continued existence of the CTO. Mr Simblet argued that the tribunal could give effect to its conclusion on the issue under its discretion in the opening words of section 72(1).

24. Section 72(1) confers a discretion to 'direct that the patient be discharged'. That language – the statutory language - seems inapposite for a ruling on validity. The essence of the argument is that the 2020 extension should be treated as invalid, thereby depriving subsequent extensions of their validity also. Once that initial invalidity was accepted, PQR would be discharged by operation of section 20B. So, as soon as the tribunal had decided on invalidity, there would no longer be any need to exercise the discretion in order to give effect to PQR's discharge. Perhaps this is too technical, pedantic even, for so serious a matter as the operation of the mental health legislation.

25. This does not mean that Mr Simblet's argument would succeed, because there are good reasons why the tribunal should not exercise the discretion to discharge PQR. I have seen no evidence that the examination in 2020 was inadequate in some way that undermined the decision that an extension should be authorised. Mr Simblet suggested some ways in which this might occur, which I accept could happen, but there is no evidence that any of them did. Moreover, the 2020 examination did not occur in isolation. It has to be set in the context of the nature of PQR's condition; I have already quoted the tribunal's description of that condition. It is also part of a history that dated back two decades and more with numerous admissions and intermittent CTOs. Since 2020, there had been two further examinations, both conducted in accordance with section 20A, that have led to extensions. And the tribunal found that at the time of the hearing that there was no duty to discharge PQR under section 72(1)(c).

26. Mr Simblet emphasised that this case involved the liberty of the subject, which should only be curtailed in accordance with the law. I accept that. It is certainly one of the 'important values underpinning' the law's approach to validity, to quote *Majera*. But it is not the only value. There are others, which are apparent in section 72(1)(c) and apply generally throughout the legislation. First, there is the 'health or safety' of the patients themselves. Second, there is 'the protection of other persons', family members, medical and nursing staff, and the public generally. All three factors – liberty, health and safety – have to be taken into account in the context of the case and the proper exercise of the tribunal's discretion.

27. In the combined circumstances I have set out, I go so far as to say that it would have been perverse for the First-tier Tribunal to exercise its discretion in favour of PQR. This is, though, theoretical, because I have decided that the tribunal had no jurisdiction to exercise its discretion.

28. I notice that Mr Simblet did not rely on regulation 72(1)(c). The word 'then' in paragraph (c)(i) (and in the equivalent provisions in paragraphs (a)(i) and (b)(i)) requires the tribunal to decide whether the conditions are satisfied at the time of the hearing. That focus on the present would have been inconsistent with the focus of his argument, which was on the past and what was not done properly in 2020.

G. Conclusion

29. The First-tier Tribunal was right to decide that it had no jurisdiction to rule on validity. Having come to that conclusion, after hearing argument from both parties, it was under a duty to strike out that part of the proceedings under rule 8(3)(a) of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 (SI No 2699). This does not deprive PQR of a remedy; it means that the remedy lies in the courts and not in the tribunal system.

Authorised for issue on 11 August 2023	**Edward Jacobs Upper Tribunal Judge**