Neutral Citation Number: [2017] EWCA Civ 194

Case No: C3/2015/4104 PJ and C3/2016/0561 MM

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE UPPER TRIBUNAL (ADMINISTRATIVE APPEALS CHAMBER)
CHARLES J
HM/2133/2015 & HM/1518/2015

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 29/03/2017

Before:

THE PRESIDENT OF THE FAMILY DIVISION
LADY JUSTICE GLOSTER
Vice-President of the Court of Appeal (Civil Division)
and
THE SENIOR PRESIDENT OF TRIBUNALS

- -

Between:

The Secretary of State for Justice	**Appellant**
-and-	
MM	**Respondent**

And Between:

Welsh Ministers	**Appellant**
- and -	
PJ	**Respondent**

- -
- -

Mr James Eadie QC and Mr David Lowe (instructed by **Government Legal Department**) for the **Appellant Secretary of State for Justice**
Mr Michael Paget and Ms Zoe Whittington (instructed by **Bison Solicitors**) for the **Respondent MM**

Mr Richard Gordon QC and Ms Amy Street (instructed by **Blake Morgan LLP**) for the **Appellant Welsh Ministers**

Mr Peter Mant (instructed by **GHP Legal**) for the **Respondent PJ**

Hearing dates: 8 and 9 June 2016

- -

Approved Judgment

Sir James Munby, President, Lady Justice Gloster, Vice-President, and Sir Ernest Ryder, Senior President:

Introduction:

1. This is the judgment of the court. We heard the appeals of MM and PJ together because they raise the issue of deprivation of liberty in two contexts a) where a mental health patient who is detained by a criminal court seeks to be conditionally discharged into circumstances that deprive him of his liberty (MM) and b) where a mental health patient who is detained in a non-criminal context seeks to be moved from hospital under a community treatment order which has the effect of depriving him of his liberty (PJ). Both appeals are allowed.

2. The appeals raise questions about the nature and extent of the powers of the First-tier Tribunal [FtT] in England and the Mental Health Review Tribunal for Wales [MHRTW] which hear appeals from mental health patients. For the avoidance of doubt, there is no distinction between the FtT and the MHRTW that is relevant to an issue in these proceedings. All of the relevant sections of the Mental Health Act 1983 [MHA] are set out in a schedule to this judgment.

Part One – MM:

3. MM is a patient who has a diagnosis of mild learning disability and autistic spectrum disorder, whose behaviours are described as including pathological fire starting. He was convicted of arson on 27 April 2001 and a criminal court imposed a hospital order upon him under section 37 MHA and a restriction order under section 41 MHA. In 2006 he was conditionally discharged under section 73 MHA but his behaviour deteriorated and, in April 2007, he was recalled to hospital.

4. MM has capacity in respect of the question whether his liberty should be deprived and has expressed his wish to agree to a lesser form of restriction than detention in hospital.

5. MM applied to the FtT for a conditional discharge which was refused on 18 May 2015. MM's responsible clinician and treating team opposed discharge but were of the opinion that his transfer to another low security unit would be appropriate. Two external experts considered that MM could be safely managed in the community under a conditional discharge provided that a care plan with a suitable care package was in place. It was common ground that any care plan would involve an objective deprivation of his liberty having regard to the principles explained by the Supreme Court in *Cheshire West and Cheshire Council v P* [2014] AC 896.

6. It is MM's case that any deprivation of liberty would be lawful *if* he consented to it and that although any care plan would include terms that would necessarily deprive him of his liberty, that should not prevent a FtT imposing a general condition that MM must comply with his care plan that is, a condition that does not of itself deprive MM of his liberty even though the terms of the care plan would. That would of course be no more

than a stylistic circumvention of any jurisdictional limitation on a FtT, something that the FtT in its judgment overtly recognised and declined to permit. They reminded themselves that the jurisdiction of the FtT to impose conditions that deprived a patient of his liberty had been considered and rejected by this court in *RB v Secretary of State for Justice* [2012] 1 WLR 2043.

7. The Upper Tribunal [UT] allowed MM's appeal from the FtT and remitted the matter to the FtT for a new determination. In so doing, the President of the Administrative Appeals Chamber of the UT, Charles J, followed his earlier decision in *Secretary of State for Justice v KC & Anor* [2015] UKUT 0376 (AAC) and held that an FtT has jurisdiction to impose conditions on a conditional discharge that involve a deprivation of liberty and that a capacitated patient could give valid consent to such conditions.

8. The Secretary of State appeals to this court and submits that it is not lawful for a FtT to direct the conditional discharge of a patient detained under part III of the MHA where:
    a. the conditions imposed would necessarily involve a deprivation of liberty;
    b. the patient has capacity; and
    c. the patient purports to consent to the conditions.

9. On the facts it is arguable whether MM could give valid and effective consent, that is, his consent would have to be unequivocal, voluntary and untainted by constraint. He has Hobson's choice in the circumstance in which he finds himself and he has changed his mind more than once. The FtT made a finding of fact that his consent was neither true and unfettered nor was it 'genuine, properly considered and reliable'. Given the way the appeal is framed by the Secretary of State, it has not been necessary for us to re-determine whether MM's purported consent was valid and effective; it is sufficient to consider the hypothetical possibility of valid consent and its effect.

10. The question in this appeal turns on the construction of the relevant statutory provisions. The following issues were canvassed in submissions:

    a. The powers of the tribunal;
    b. The effect of consent.

11. Section 37 MHA empowers the Crown Court and the Magistrates Court on conviction of an offence punishable with imprisonment to authorise that a person be admitted and detained in a hospital (a 'hospital order'). Section 41 MHA empowers the court, where it has made a hospital order and where it considers it necessary for the protection of the public, to make a 'restriction order'.

12. The Secretary of State has powers conferred upon her by the statutory scheme. She may direct that the restriction order shall cease to have effect if she is satisfied that it is no longer required for the protection of the public from serious harm (section 42(1)), she may discharge the patient from hospital either absolutely or subject to conditions (section 42(2)) and while a restriction order remains in force she may recall a patient to hospital who has been conditionally discharged (section 42(3)). If the Secretary of State directs the absolute discharge of a patient, the patient ceases to be liable to be detained and the restriction order ceases to have effect so that there can be no recall (section 42(2)).

13. The FtT has a power set out in section 72 MHA to discharge a patient who is liable to be detained in hospital and who is not a restricted patient where one or more of the qualifying conditions for detention are no longer satisfied, that is, where it is no longer satisfied that (i) he is 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) it is necessary for the health and safety of the patient or for the protection of other persons that he should receive such treatment; or (iii) appropriate medical treatment is available for him.

14. The power in the FtT to discharge restricted patients is set out in section 73 MHA. It is exercisable where one or more of the qualifying conditions in section 72 are no longer satisfied and the tribunal is also satisfied that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment. In addition the tribunal has the power to direct a conditional discharge where one or more of the qualifying conditions are no longer satisfied but the tribunal is not satisfied that it is not appropriate for the patient to remain liable to be recalled to hospital (section 73(2)). The tribunal may defer a conditional discharge to abide the event of necessary arrangements being made to the tribunal's satisfaction (section 73(7)).

15. Section 37 MHA provides the authority to detain a patient in hospital and 'hospital' is a defined term. Section 41 MHA provides for a restricted regime for the discharge of patients subject to section 37 orders. Save where a patient is absolutely discharged from detention in hospital, only the Secretary of State can lift the restrictions imposed by section 41.

16. The authority to detain in hospital remains when a conditional discharge is ordered. The liability to detention is reflected in the Secretary of State's power of recall and the section 75 power of 'ancillary' detention and the section 136 holding provision. In our judgment, none of that is sufficient to give rise to a necessary implication of an umbrella power that authorises any deprivation of liberty outside detention in hospital. On the contrary, there is a critical distinction to be drawn between detention in hospital, liability to detention in hospital where a patient is subject to conditional discharge and any other objective deprivation of liberty. There is nothing in the terms of sections 37, 41 and 42 MHA which provides a power in either the Secretary of State or a tribunal to detain or otherwise deprive a patient of his liberty outside a hospital.

17. The construction of the statutory provisions which provide the powers of the FtT was considered in *RB*. In language that is clear, the Court held that the right to liberty of the person is a fundamental right and that a person cannot have his right to liberty taken away unless that is the clear effect of a statute. There is no statutory authority in the MHA which permits an FtT to direct a deprivation of liberty as a condition or consequence of a direction that a patient be conditionally discharged. Such a power has to be prescribed by law and it is not. As Arden LJ said in *RB* at [27], [48], [53] and [57]:

> "[27] … Sections 42 and 73 make no reference to detention otherwise than in a hospital, and this would indicate that Parliament did not contemplate that on discharge a patient should be detained in an institution which was not a hospital. Had it been intended that there should be detention in an institution other than a hospital (as defined), the proper inference from the

statutory scheme and its background is that Parliament would have ensured that the *Winterwerp* conditions were satisfied in relation to that detention also.

[…]

[48]. In my judgment, the core issue 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 shall call this "the 'prescribed by law' issue".

[…]

[53] At the end of the day, however, I accept the submission of Mr Chamberlain that the original order made against RB authorised, and authorised only, detention in a hospital: see section 37 and section 41(3)(a) of the 1983 Act set out above. That conclusion seems to me to be the starting point. The consequence of that conclusion is that Mr Burrows is driven to rely for the authority to deprive RB of his liberty on the wording of section 73(2), which is wholly silent on that important point. The right to liberty of the person is a fundamental right. It has been so regarded since at least the time of the well known provisions of clause 39 of Magna Carta, which in due course found its reflection in article 9 of the Universal Declaration of Human Rights and article 5 of the Convention. A person cannot have his right to liberty taken away unless that is the clear effect of a statute: see Lord Hoffman in *R v Secretary of State for the Home Department, Ex p Simms* [2000] 2 AC 115, 131:

'Fundamental rights cannot be overridden by general or ambiguous words. This is because it is too great a risk that the full implications of their unqualified meaning may have passed unnoticed in the democratic process. In the absence of express language or necessary implication to the contrary, the courts therefore presume that even the most general words were intended to be subject to the basic rights of the individual. In this way the courts of the United Kingdom, though acknowledging the sovereignty of Parliament, apply principles of constitutionality little different from those which exist in countries where the power of the legislature is expressly limited by a constitutional document.'

[…]

[57]. The points made by Mr Chamberlain underline this point because they show that Parliament could not have intended to create, as he puts it, a new species of detention that is potentially more detrimental to personal liberty than the detention under the 1983 Act. This is because the 1983 Act does

not specify the circumstances in which a tribunal can order a conditional discharge on terms that there is a deprivation of liberty. Moreover, section 73 appears, on its face, to be wide enough, on the Upper Tribunal's interpretation, to authorise detention for the purposes of containment rather than treatment, which is contrary to the policy of the 1983 Act: see para 24 above."

18. Accordingly, as a matter of statutory construction, having regard to domestic law principles, the Act does not provide a power in the FtT / MHRTW to impose conditions on a conditional discharge that extend to the imposition of an objective deprivation of liberty. There is no other power in the FtT / MHRTW to impose conditions on a conditional discharge than that set out in section 73 MHA. The analysis of Convention jurisprudence in *RB* is to the same effect. We are of the view that *RB* is correct and it is binding on us. It cannot be said to be *per incuriam* but in any event that submission was not pursued and the Respondent's Notice asserting that it was *per incuriam* and/or wrongly decided was withdrawn with our leave.

19. In our judgment, the *per incuriam* argument had no prospects of success given that the court in *RB* expressly dealt with the legal framework in the MHA which prescribes the only basis for mental health detention in the criminal context and in particular the continuation of the patient's liability to detention when conditions are attached to a discharge (see the judgment in *RB* at [27]). In essence, the FtT cannot infer or claim for itself a power to detain which is subsidiary to that prescribed by law in a circumstance where the prescribed power of detention is not vested in the FtT and the legislation is otherwise silent in respect of 'criminal patients'. We do not accept that a power in the FtT can be inferred from the framework of the Act in the sense that it would be justified as being an inclusive component of the powers described in the Act but vested in others. There is no express language in the Act to support such a submission and it is not a necessary implication of the statutory scheme.

20. Even if it could be suggested that the power to deprive liberty is a necessary implication, there is no prescribed process in law and the generality of the implication suggested could give rise to conditions being imposed that are contrary to the purposes of the Act. Parliament has not by express words removed a fundamental right and there is no clear, that is, sufficient process. The power would be unconstrained, without criteria, time limits or analogous protections. If the power to deprive liberty were to be implied as submitted then the condition which directed the same could only be reviewed by an application to the FtT. The difference in protection between a restricted patient's annual right of review while detained in hospital and the time limit for applications by a restricted patient under section 75 MHA for variation or discharge of a condition or for a direction that a restriction order should cease to have effect is stark. In the latter case the time limit is two years. In our judgment it is appropriate to describe that as an inferior right of review. The difference in protection between the two circumstances would not be equivalent with the consequence that it would be incoherent and unjustified. That cannot be imputed to be the intention of Parliament. It would amount to discrimination within the meaning of article 14 ECHR. There can be no read-in of an extra-statutory scheme to achieve Convention compatibility in this circumstance.

21. In so far as it is submitted on behalf of MM that the *ratio* of *RB* is very narrow and limited to the proposition than that it is unlawful for the FtT / MHRTW to impose

conditions that are a deprivation of liberty only if they are in breach of article 5 ECHR, we disagree. In *RB* the court proceeded on the basis that the patient agreed to the imposition of conditions and nevertheless held that it was not permissible to impose conditions necessarily amounting to a deprivation of liberty. Accordingly, it follows that the court must have had in mind conditions that amounted to a deprivation of liberty in the objective sense. The *ratio* of *RB* is plain and is that there is no power to impose a condition of a conditional discharge that is an objective deprivation of the patient's liberty.

22. Finally, in respect of this aspect of the appeal, there is no necessary connection between the provisions of the statutory scheme so far as they affect patients detained in the criminal context and those detained in the non-criminal context. The function of the FtT/MHRTW is different in each context as is the function of the responsible clinician. There is no concept of continuing deprivation of liberty in the criminal context only continuing liability to detention. The one is not equivalent to the other.

The effect of consent:

23. There are three elements to a deprivation of liberty within the meaning of article 5 ECHR. They are: (i) an objective component of confinement in a particular restricted place for a non-negligible period of time; (ii) the subjective component of lack of valid consent; and (iii) the attribution of responsibility to the state: *Cheshire West* at [37] per Baroness Hale of Richmond. The 'acid test' for an objective deprivation of liberty is that the individual is subject to constant supervision and control and is not free to leave: [49] *supra*.

24. As the Mental Health Act Code of Practice reminds us, there is a danger in mental health specialist care that "the threat of detention must not be used to coerce a patient to consent to admission to hospital or to treatment". The Code goes on to suggest that the threat of coercion "is likely to invalidate any apparent consent" (see §14.17 of the Code): we agree.

25. In any event, even if the patient's consent is valid, what happens if the patient changes his or her mind? It would be contrary to public policy and the concept of autonomy to restrict the circumstances in which a patient who has capacity can change his mind is able to do so (see, for example: *HE v A Hospital Trust* [2003] EWHC 1017 (Fam) per Munby J at [37] to [39]). Furthermore, if it is open to the patient to withdraw consent at any time, the deprivation of liberty would then become unlawful, undermining the protective purpose of the Act's provisions.

26. Whether a patient has a free choice to leave is a question that goes not just to the objective component of confinement but also to the subjective validity of consent (see, for example: *Osypenko v Ukraine* Application No: 4634/04 at [48] to [49] and *I.I v Bulgaria* Application No: 44082/98 at [87]).

27. Further, both domestic and Convention jurisprudence strongly doubt the hypothesis that valid consent can prevent a compulsory confinement from being a deprivation of liberty. In *R (G) v Mental Health Review Tribunal* [2004] EWHC 2193 (Admin) Collins J held at [23] that:

> "I do not think that consent to continuing deprivation of liberty can confer jurisdiction on a tribunal. A deprivation remains since the consent cannot convert [it] into something else."

28. We agree with that principle which is equally firmly described in Strasbourg jurisprudence. Where conditions amounting to a deprivation of liberty are compulsorily imposed by law, the agreement of an individual cannot prevent that compulsory confinement from constituting a deprivation of liberty: *De Wilde and Ors v Belgium* (1979-80) 1 EHRR 373 at [64] and [65]. We need go no further than to express our respectful agreement with the analysis of Convention jurisprudence set out in *RB*, in particular at [3] to [14], inclusive.

29. In any event, conditions have to be considered by reference to their real not technical effect. What is the concrete situation of the patient? The question of enforceability, which was raised in submissions by reference to the decision of Charles J in *KC*, does not assist in that analysis. A condition of residence in itself is not a deprivation of liberty. The most common condition that might be a deprivation of liberty is continuous supervision including the lack of availability of any unescorted leave. Even if the question of consent were to be hypothetically relevant, the patient cannot consent in any irrevocable way. He cannot be taken to have waived or have had his right to withdraw his consent removed. There is no scope for consent in a case such as this.

30. Accordingly, whether a capacitated patient can consent to a deprivation of liberty is not a decisive issue. A purported consent, even if valid, could arguably go no further than to provide for the subjective element of the article 5 test, it cannot create in the FtT / MHRTW a jurisdiction it does not possess to impose a condition that is an objective deprivation of liberty. Article 5 ECHR does not provide any free standing jurisdiction in a tribunal to impose conditions that have the effect of authorising a deprivation of liberty. A purported consent would also be ineffective in fact. It cannot be an irrevocable consent and it could not act to bind the patient or waive his right to withdraw or rely on, *inter alia*, articles 5 and 6 ECHR at any time thereafter. A deprivation of liberty is an imposition by the state so that examples of enforceable agreements in other contexts are not analogous.

31. If the FtT/MHRTW is satisfied that a patient will validly consent to supervision in the community and that will protect both the patient and the public then it is open to the tribunal to grant an absolute discharge or a conditional discharge on conditions that do not involve an objective deprivation of liberty. The tribunal is well used to identifying cases where there will or will not be compliance with a necessary regime of treatment.

32. A FtT and the MHRTW are inferior tribunals. Unlike the UT, they are not a superior court of record (see section 3(5) Tribunals Courts Enforcement Act 2007 [TCEA]) nor do they possess the powers, rights, privileges and authority of the High Court granted to the UT by section 25(1)(a) TCEA. The FtT and the MHRTW cannot make binding declarations or exercise the judicial review jurisdiction of the High Court or the UT. Neither the FtT/MHRTW nor the UT is able to exercise the jurisdiction of the Court of Protection, although this should not be taken to suggest that a judge authorised in a tribunal jurisdiction cannot also sit in the Court of Protection and vice versa so that in an appropriate circumstance the judge might exercise both jurisdictions concurrently or separately on the facts of a particular case.

33. No application was made to the UT in these proceedings to exercise any power of the High Court or the limited statutory jurisdiction of the UT in judicial review and no application was made that invoked the jurisdiction of the Court of Protection. Accordingly, the UT cannot on appeal exercise any of those powers without a party making an application to it to invoke one of those jurisdictions or the tribunal giving notice of its intention to consider the same and asking for submissions.

34. In like manner to the analysis of the tribunals' powers under section 73 MHA, which we consider in the proceedings relating to PJ below, there is no 'umbrella' power that can be exercised by the tribunal to authorise a patient's deprivation of liberty outside hospital. It is accordingly inappropriate for a tribunal to do so, whether by direct or indirect means (for example, by the use of declarations to provide for an asserted lacuna in the statutory scheme). There is no lacuna in the scheme. However practicable and effective it may be to provide for a tribunal to have such a power, for example to improve access to justice to a specialist and procedurally appropriate adjudication, Parliament has not provided for the same.

35. The power of deferment to permit arrangements to be made for discharge could be used in an appropriate case to invoke the separate jurisdiction of the CoP to authorise a deprivation of liberty if the patient is incapacitated. That might provide free standing deprivation of liberty safeguards in certain factual circumstances but does not provide a basis for a condition of conditional discharge under section 73 that is outside the jurisdiction of the tribunal.

36. Accordingly, it cannot be said that it was Parliament's intention to authorise detention outside hospital when a patient is conditionally discharged. If that conclusion presents practical difficulty then it is a matter for Parliament to consider.

37. There is nothing in *Cheshire West* which suggests that the general principles there set out do not apply to a deprivation of liberty that is not authorised by a process prescribed by law.

Part Two: PJ:

38. PJ is a patient who has capacity to make decisions about the restriction of his liberty. He is diagnosed with a mild learning disability, an autism spectrum disorder and what is described as a significant impairment in his behaviour. He was detained in a hospital between 1999 and 2007 following a conviction for actual bodily harm and threats to kill. In 2009 he was detained again under section 3 MHA. He has spent almost all of his adult life detained in hospital.

39. PJ was made the subject of a community treatment order [CTO] by his responsible clinician on 30 September 2011. The order discharged him from hospital into the care of a residential specialist facility for men with moderate to borderline learning disabilities and challenging or offending behaviour. The order had the effect of significantly restricting his liberty by providing for near continuous supervision and only very limited unescorted leave from his residential placement. The conditions included the following:

i) PJ was to reside at a care home with nursing and adhere to the rules of residence at the home.

ii) PJ was to abide by the section 117 MHA care plan drawn up by the multi-disciplinary team.

iii) PJ was to abide by the risk mitigation plan for community access which specified the nature and extent of the supervision of him.

40. The reasoning of the responsible clinician was that PJ required treatment for his safety and the protection of others. Before this court it was not argued that the CTO conditions together with the rules, care and associated plans were an objective deprivation of his liberty. To the extent that the MHRTW decided that the CTO did not have the effect of an objective deprivation of liberty, no-one sought to argue before this court that such a conclusion was open to the tribunal on the facts although we heard argument about what was a deprivation of liberty in the circumstances of the case.

41. PJ applied under section 72 MHA to the Mental Health Review Tribunal for Wales for his discharge. The MHRTW refused the application on 2 May 2014. On appeal to the Upper Tribunal (Administrative Appeals Chamber), PJ was successful. The decision is reported at [2015] UKUT 0480 (AAC). On 4 September 2015 the President of the UT (AAC), Charles J, made the following declarations:

> "(1) The MHRT erred in law in their application of the majority decision of the Supreme Court in *Cheshire West and Cheshire Council v P* [2014] UKSC 19 and so in their approach to whether the implementation of the conditions of the Community Treatment Order did or did not, on an objective assessment, deprive PJ of his liberty.
>
> (2) The MHRT erred in law in concluding in the alternative that if PJ was deprived of his liberty in breach of article 5 that the CTO framework must take precedence over any human rights issues."

42. The purported effect of the declarations was that the FtT and the MHRTW must, when exercising their discretion under section 72(1) MHA and also in respect of their conduct of and any adjournment of the hearing, take into account whether the implementation of the conditions of a CTO will or may create a breach of article 5 or any other Convention right. If they conclude that there is such a breach, they must exercise their powers with the aim of bringing the breach to an end.

43. By the time PJ's appeal came to be heard by the UT, he was no longer subject to a CTO. That led to the consequence that despite the fact that the appeal was allowed, Charles J did not remit the case to the MHRTW for a re-hearing. In truth, the appeal was academic before it was heard by the UT. The declarations left the status quo intact, namely that PJ was not then subject to the restrictions of the MHA. This appeal is made against the decision of the UT by Welsh Ministers.

44. The grounds of appeal are that:

i) The judge erred in law in determining that the UT had jurisdiction to revise conditions under a CTO and/or to adjourn proceedings for such conditions to be

revised and/or to take into account article 5 ECHR when exercising its powers of discharge under section 72 MHA in respect of CTOs; and

ii) The judge erred in law in holding that the MHRTW erred in its approach to the question of whether PJ was deprived of his liberty.

45. Like the case of MM, the case turns on the construction of the relevant statutory provisions. For the purposes of this appeal, these can be found in sections 17 and 72 MHA.

46. The following issues were canvassed in submissions:

i) The nature and extent of the power to make CTO conditions;

ii) Whether the statutory framework provides effective and practical safeguards;

iii) The powers of the tribunal; and

iv) What is a deprivation of liberty?

The power to make CTO conditions:

47. The CTO scheme is set out in sections 17A to 17E, inclusive, of the MHA. The powers of tribunals in respect of patients under the scheme are set out in section 72. The scheme is separate from that in section 73 for the conditional discharge of restricted patients who are subject to section 37 and 41 (hospital and restricted patient) orders. As can be seen from the language of the sections, the statutory purpose of the CTO scheme is different. It is necessary to appreciate the roles and responsibilities of those involved in the CTO scheme in the context of the overall statutory framework in order to interpret that framework in a way that is consistent with the fundamental features of the legislation.

48. A restricted patient remains liable to be detained in hospital during a conditional discharge until he is absolutely discharged in accordance with section 42(2) MHA, whereas the authority for the detention of a patient who is subject to a CTO ('a community patient') is suspended during the CTO by reason of section 17D(2)(a). A community patient is not liable to be detained in hospital although he may be recalled for treatment under section 17E. The exercise of the power of recall, which rests solely with the responsible clinician, is not dependent upon any compliance with or alleged breach of the CTO conditions. The consequence is that the power to deprive a community patient of his liberty during the imposition of a CTO comes not from the powers arising out of a compulsory admission for treatment under section 3 MHA but from the statutory scheme that provides for the CTO.

49. Sections 17A and 17B MHA provide the lawful authority for a responsible clinician to make a CTO. Section 17B(2) is the source of the power for the responsible clinician to make conditions that are necessary and appropriate for one or more of three defined purposes: a) ensuring that the patient receives medical treatment, b) preventing risk of harm to the patient's health or safety, and c) protecting other persons. Those purposes have to be read in conjunction with the power granted to the responsible clinician to make a CTO. That power is constrained so that a CTO may not be made unless the relevant criteria are met. The criteria are set out in section 17A(5). They include the

continuing necessity for medical treatment for the patient's health and safety or the protection of other persons, the necessity of the retention of the power of recall to hospital and that appropriate medical treatment is available and can be provided for the patient without his continuing detention in a hospital.

50. The terms of the power are wide. It is clear from the nature and extent of the CTO scheme that the object of the power is to provide a balance between the protection of the patient and the public and the receipt by him of medical treatment without his continuing detention in hospital, where that is appropriate. Objection is taken on behalf of PJ that the lack of an express power to use the conditions to restrict a patient's freedom of movement to the extent of objectively depriving him of his liberty is fatal to an interpretation of section 17B(2) to that effect. Given that a community patient remains liable to recall to hospital by the responsible clinician and if recalled the suspension of the authority to detain him in hospital falls away, the responsible clinician has the ultimate power of detention. To restrict the responsible clinician so that s/he can only restrict freedom of movement and thereby both protect the patient and the public and facilitate appropriate medical treatment by recall to hospital rather than by a gradual integration of the patient into the community conflicts with the purposes of the legislation.

51. Further, as a matter of language and logic, rather than interpretation, the nature and extent of the power in section 17B(2) must by necessary implication be that which follows from the express provisions of the statute considered in their context, namely a power to provide for a lesser restriction of movement than detention in hospital which may nevertheless be an objective deprivation of liberty provided it is used for the specific purposes set out in the CTO scheme. Necessary implication is a strict test but where it is based on the language of the statute itself and where the statutory purpose would otherwise be frustrated it may be justified: *R (Morgan Grenfell & Co Ltd) v Special Commissioners of Income Tax & Anor* [2002] UKHL 2, [2003] 1 AC 563 at [45] per Lord Hoffman:

> "It is accepted that the statute does not contain any express words that abrogate the taxpayer's common law right to rely upon legal professional privilege. The question therefore becomes whether there is a necessary implication to that effect. A necessary implication is not the same as a reasonable implication as was pointed out by Lord Hutton in *B (A Minor) v Director of Public Prosecutions* [2000] 2 AC 428, 481. A necessary implication is one which necessarily follows from the express provisions of the statute construed in their context. It distinguishes between what it would have been sensible or reasonable for Parliament to have included or what Parliament would, if it had thought about it, probably have included and what it is clear that the express language of the statute shows that the statute must have included. A necessary implication is a matter of express language and logic not interpretation."

52. There are limits to what can be provided for in a CTO, for example, it would be wrong in principle for the responsible clinician to make a CTO which has the effect of increasing the levels of restriction to which a patient is subject beyond those applicable in hospital detention. Deprivation of liberty under a CTO is intended to be a lesser restriction on freedom of movement than detention for treatment in hospital.

53. Accordingly, the power to restrict the freedom of movement of a patient to the extent of objectively depriving him of his liberty by the conditions attached to a CTO is part of a statutory framework within which a CTO is intended to be a lesser restriction on freedom of movement than detention in hospital for medical treatment. This reflects an appropriate balance between safety and freedom of movement in conformity with the statutory purpose which is to achieve integration of a patient into the community with the minimum interference with the patient's freedom of movement commensurate with the protection of the patient and the public.

The safeguards:

54. The CTO scheme is provided for in a statutory framework that is a procedure prescribed by law. The criteria for the imposition of conditions that may deprive a patient of his liberty are specified in sections 17A(4) to (5) and 17B(2) MHA. They are limited to the purposes of the legislation, for example, for medical treatment. They are time limited by section 17C and they are subject to regular rights of review by sections 20A and 66 which are equivalent to the rights enjoyed by a patient detained in hospital so that there is no incoherence or lack of equivalence in the safeguards provided by the scheme. The conditions in a CTO have to be in writing: see, for example sections 17A(1) and 17B(4). The responsible clinician has the power of recall (sections 17E(1) and (2)) and the powers of suspension and variation (sections 17B(4) and (5)). Accordingly, in our judgment, the framework provides both practical and effective protection of a patient's Convention rights.

The powers of the tribunal:

55. The tribunal has a distinct and separate power: that of discharge if the statutory criteria for detention are not met. The statutory framework does not provide for the intervention of a tribunal to regulate the conditions made by the responsible clinician. In particular, there is no power in the CTO scheme for a tribunal to consider the terms of a CTO or to change those terms. The power vested in the tribunal is to discharge the patient if the circumstances described in section 72 MHA permit or to leave the CTO in place subject to the conditions made by the responsible clinician. The power exercisable by the tribunal is to discharge the patient from detention not to 'discharge the CTO'. There is no power to revise the conditions or examine the legality of the CTO including the proportionality of the interference with the patient's article 5 or other ECHR rights. Likewise, the tribunal does not have power to defer discharge on an application for discharge of a community patient. There is no analogous provision to that contained in section 73(7) which confers a power on the tribunal to defer a direction for the conditional discharge of a restricted patient "until such arrangements as appear to the tribunal to be necessary for that purpose have been made to its satisfaction".

56. The remedy for any illegality, including any Convention illegality, is to challenge the CTO by judicial review. The absence of a power in the tribunal does not create a Convention incompatibility if the statutory scheme has effective and practical safeguards. Furthermore, a tribunal which exercises a jurisdiction which is itself Convention compatible i.e. possessing effective and practical safeguards for the patient is not as a public authority acting unlawfully in not assuming what would have to be an inherent jurisdiction to scrutinise the Convention compatibility of the CTO.

57. It is accordingly inappropriate for the tribunal to create an extra-statutory checklist which might lead to the discharge of a patient because of an alleged Convention incompatibility, in particular an objective deprivation of liberty. There is a statutory test for discharge in section 72(1) MHA the criteria for which mirror the criteria for making a CTO under section 17A(5). The criteria are part of the safeguards provided for in the statutory scheme. There is no mandate to alter them. To do so involves the assumption of a jurisdiction that the tribunal does not possess with the unintended consequence that tribunals engaged in a straightforward specialist task would become diverted into time consuming and procedurally irrelevant exercises.

58. The MHRTW analysed the CTO scheme as taking precedence over human rights issues. It would have been better to reason that the statutory framework contains all the safeguards that are required and that the safeguards can be read compatibly with human rights jurisprudence. Individual decisions of responsible clinicians that breach those safeguards can be remedied in judicial review.

59. Neither the Convention nor the Human Rights Act 1998 confer jurisdiction on a tribunal. There is nothing in the general role and function of a tribunal that permits it to exercise a function that it does not have by statute. The positive obligations inherent in article 5 ECHR are not in any way diminished by the functions to which the Convention jurisprudence would apply being held by another body i.e. the responsible clinician. It is accordingly neither necessary nor appropriate for the FtT / MHRTW to investigate or determine whether there is an objective deprivation of liberty as a consequence of a CTO.

60. As we observed at [33] above, the FtT and the MHRTW are inferior tribunals, they are not a superior court of record nor do they possess the powers, rights, privileges and authority of the High Court. The FtT and the MHRTW cannot make binding declarations nor exercise the judicial review jurisdiction of the High Court or the UT. Neither the FtT/MHRTW nor the UT is able to exercise the jurisdiction of the Court of Protection without application to an appropriately authorised judge. In the case of PJ, the UT should not have exercised the power to make declarations given that neither the default power of the UT to use the powers of the High Court nor the power of the High Court itself were invoked by any party making an application nor were they invoked by the tribunal giving notice and asking for representations on the use of those powers.

61. In like manner to the analysis of the tribunals' powers under section 73 MHA, there is no 'umbrella' power that can be exercised by the tribunal to authorise a patient's deprivation of liberty outside hospital. It is accordingly inappropriate for a tribunal to do so, whether by direct or indirect means (for example, by the use of declarations to provide for an asserted lacuna in the statutory scheme). There is no lacuna in the scheme. However practicable and effective it may be to provide for a tribunal to have such a power, for example to improve access to justice to a specialist and procedurally appropriate adjudication, Parliament has not provided for the same. For the purposes of the CTO scheme, the relevant powers are vested in the responsible clinician.

62. The power to discharge a patient in the circumstances provided for in section 72 MHA does not extend to a power exercisable by a tribunal to scrutinise the lawfulness of the conditions imposed by the responsible clinician. That challenge must go to the High Court in judicial review where the court can take steps to remedy an unlawful condition

without risking discharge of a patient in respect of whom the criteria for discharge are not made out.

63. The logical conclusion of the UT's analysis is that a patient may have to be discharged under section 72 MHA if a Convention non-compliance is made out despite the criteria for discharge not being satisfied i.e. at a time when the statutory criteria for the power of recall to be exercised still exist. That could be dangerous both for the patient and the public because if the need for treatment and/or protection has been identified (and it must be for the tribunal not to exercise its mandatory power to discharge) then the need also has to be provided for: any other circumstance is contradictory and in terms of the statutory purpose, perverse. The power of discretionary discharge in section 72 is limited to the defined statutory purposes. The UT's analysis involves an exercise in interpretation of the statutory framework that is inconsistent with a fundamental feature of the legislation which is impermissible. As to which, see for example: *Ghaidan v Godin-Mendoza* [2004] UKHL 30, [2004] 2 AC 557 at [33]:

> "Parliament, however, cannot have intended that in the discharge of this extended interpretative function the courts should adopt a meaning inconsistent with a fundamental feature of legislation. That would be to cross the constitutional boundary section 3 seeks to demarcate and preserve. Parliament has retained the right to enact legislation in terms which are not Convention-compliant. The meaning imported by application of section 3 must be compatible with the underlying thrust of the legislation being construed. Words implied must, in the phrase of my noble and learned friend, Lord Rodger of Earlsferry, "go with the grain of the legislation". Nor can Parliament have intended that section 3 should require courts to make decisions for which they are not equipped. There may be several ways of making a provision Convention-compliant, and the choice may involve issues calling for legislative deliberation."

Deprivation of liberty:

64. In so far as it is necessary to deal with the second ground of appeal, we agree that it necessarily follows from this court's interpretation of the statutory framework in the non-criminal context that there is a distinction to be drawn between deprivation of liberty consequent upon compulsory detention in hospital for treatment and a lesser restriction on a patient's freedom of movement that nevertheless amounts to an objective deprivation of liberty. The latter circumstance is a statutory alternative to compulsory detention for a clear purpose as long as the patient is not exposed to a greater restriction than would be the case if s/he were to be compulsorily detained in hospital.

65. It is unnecessary in our judgment to distinguish the acid test in *Cheshire West* when that test can perfectly satisfactorily be applied to the circumstances in these cases. The CTO scheme does not exist outside the scheme of fundamental rights nor does it override them.

66. For these reasons, we would set aside the declarations made by the UT. No other order is necessary in the circumstances of this case.

67. For these reasons we allow both appeals.

Schedule:

17A Community treatment orders

(1)The responsible clinician may by order in writing discharge a detained patient from hospital subject to his being liable to recall in accordance with section 17E below.

(2)A detained patient is a patient who is liable to be detained in a hospital in pursuance of an application for admission for treatment.

(3)An order under subsection (1) above is referred to in this Act as a “community treatment order”.

(4)The responsible clinician may not make a community treatment order unless—

(a)in his opinion, the relevant criteria are met; and

(b)an approved mental health professional states in writing—

(i)that he agrees with that opinion; and

(ii)that it is appropriate to make the order.

(5)The relevant criteria are—

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

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

(e)appropriate medical treatment is available for him.

(6)In determining whether the criterion in subsection (5)(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 not 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).

17B Conditions

(1)A community treatment order shall specify conditions to which the patient is to be subject while the order remains in force.

(2)But, subject to subsection (3) below, the order may specify conditions only if the responsible clinician, with the agreement of the approved mental health professional mentioned in section 17A(4)(b) above, thinks them necessary or appropriate for one or more of the following purposes—

> (a)ensuring that the patient receives medical treatment;
>
> (b)preventing risk of harm to the patient's health or safety;
>
> (c)protecting other persons.

(3)The order shall specify—

> (a)a condition that the patient make himself available for examination under section 20A below; and
>
> (b)a condition that, if it is proposed to give a certificate under Part 4A of this Act in his case, he make himself available for examination so as to enable the certificate to be given.

(4)The responsible clinician may from time to time by order in writing vary the conditions specified in a community treatment order.

(5)He may also suspend any conditions specified in a community treatment order.

(6)If a community patient fails to comply with a condition specified in the community treatment order by virtue of subsection (2) above, that fact may be taken into account for the purposes of exercising the power of recall under section 17E(1) below.

(7)But nothing in this section restricts the exercise of that power to cases where there is such a failure.]

17C Duration of community treatment order

A community treatment order shall remain in force until-

> (a)the period mentioned in section 20A(1) below (as extended under any provision of this Act) expires, but this is subject to sections 21 and 22 below;
>
> (b)the patient is discharged in pursuance of an order under section 23 below or a direction under section 72 below;

(c)the application for admission for treatment in respect of the patient otherwise ceases to have effect; or

(d)the order is revoked under section 17F below,

whichever occurs first.

17D Effect of community treatment order

(1)The application for admission for treatment in respect of a patient shall not cease to have effect by virtue of his becoming a community patient.

(2)But while he remains a community patient—

(a)the authority of the managers to detain him under section 6(2) above in pursuance of that application shall be suspended; and

(b)reference (however expressed) in this or any other Act, or in any subordinate legislation (within the meaning of the Interpretation Act 1978), to patients liable to be detained, or detained, under this Act shall not include him.

(3)And section 20 below shall not apply to him while he remains a community patient.

(4)Accordingly, authority for his detention shall not expire during any period in which that authority is suspended by virtue of subsection (2)(a) above.]

17E Power to recall to hospital

(1)The responsible clinician may recall a community patient to hospital if in his opinion—

(a)the patient requires medical treatment in hospital for his mental disorder; and

(b)there would be a risk of harm to the health or safety of the patient or to other persons if the patient were not recalled to hospital for that purpose.

(2)The responsible clinician may also recall a community patient to hospital if the patient fails to comply with a condition specified under section 17B(3) above.

(3)The hospital to which a patient is recalled need not be the responsible hospital.

(4)Nothing in this section prevents a patient from being recalled to a hospital even though he is already in the hospital at the time when the power of recall is exercised; references to recalling him shall be construed accordingly.

(5)The power of recall under subsections (1) and (2) above shall be exercisable by notice in writing to the patient.

(6)A notice under this section recalling a patient to hospital shall be sufficient authority for the managers of that hospital to detain the patient there in accordance with the provisions of this Act.]

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—

(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 ofr safety of the patient or for the protection of other persons that he should receive such treatment; or

(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 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 of safety of the patient 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.

(1A) In determining whether the criterion in subsection (1)(c)(iii) above is met, the tribunal 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).]

(2) [. . .]

(3)A tribunal may under subsection (1) above direct the discharge of a patient on a future date specified in the direction; and where a tribunal does not direct the discharge of a patient under that subsection the tribunal may—

(a)with a view to facilitating his discharge on a future date, recommend that he be granted leave of absence or transferred to another hospital or into guardianship; and

(b)further consider his case in the event of any such recommendation not being complied with.

(3A) Subsection (1) above does not require a tribunal to direct the discharge of a patient just because it thinks it might be appropriate for the patient to be discharged (subject to the possibility of recall) under a community treatment order; and a tribunal—

(a)may recommend that the responsible clinician consider whether to make a community treatment order; and

(b)may (but need not) further consider the patient's case if the responsible clinician does not make an order.

(4)Where application is made to the appropriate tribunal by or in respect of a patient who is subject to guardianship under this Act, the tribunal may in any case direct that the patient be discharged, and shall so direct if it is satisfied—

(a)that he is not then suffering from mental disorder; or

(b)that it is not necessary in the interests of the welfare of the patient, or for the protection of other persons, that the patient should remain under such guardianship.