A

Court of Appeal

*Regina (H) *v* Ashworth Special Hospital Authority

Regina (Ashworth Special Hospital Authority) *v* West Midlands and North West Region Mental Health Review Board

B

[2002] EWCA Civ 923

2002 May 20, 21 22; June 28

Simon Brown, Mummery and Dyson LJJ

Mental disorder — Admission for treatment — Compulsory detention — Mental health review tribunal ordering discharge of patient in absence of after-care provision — Hospital authority detaining patient in compliance with recommendations of doctors and application of approved social worker — Whether tribunal's decision unreasonable — Whether decisions of professionals and hospital authority lawful

C

H, who had a long history of violent conduct, had been detained for about six years in a special hospital pursuant to section 3 of the Mental Health Act 1983. D A mental health review tribunal ordered his discharge from detention, although a majority of doctors opposed the decision, no after-care arrangements were in place for him and his previous releases into the community had been unsuccessful. The tribunal did not fully address those issues in its reasons, although it stated that it preferred the minority medical opinion. Being without alternative accommodation, H remained in the hospital as a voluntary patient. Acting on recommendations of two registered medical practitioners and an application of an approved social E worker, the hospital authority detained H under section 3 of the Act. The judge stayed the tribunal's decision pending the hospital authority's application for judicial review of that decision. At a subsequent hearing the judge granted that application and refused H's application for judicial review of the decisions of the doctors, the social worker and the hospital authority.

On an appeal by H—

Held, (1) allowing the appeal in relation to the decisions of the professionals and F the hospital authority, that, since there were no material circumstances of which the tribunal was not aware when it ordered H's discharge and the order for discharge had not been quashed by a court, it was not open to the professionals and the hospital authority to detain H (post, paras 56, 64, 89, 102, 105, 108).

R (Von Brandenburg) v East London and The City Mental Health NHS Trust [2002] QB 235, CA applied.

(2) Dismissing the appeal in relation to the tribunal's decision, that no reasonable G tribunal could have made an order for the discharge of H without being satisfied that suitable after-care arrangements for him were in place; that, further, the tribunal had not, on the facts, given adequate reasons for its decision; and that, therefore, the decision was unlawful (post, paras 66–69, 80–82, 89, 108).

Flannery v Halifax Estate Agencies Ltd (trading as Colleys Professional Services) [2000] 1 WLR 377, CA applied.

Per Simon Brown and Dyson LJJ. It is not satisfactory that the only means of H challenge to mental health decisions is by judicial review (post, paras 88, 108)

Per Mummery and Dyson LJJ. The court has jurisdiction to stay the decision of a tribunal which is subject to a judicial review challenge, even where the decision has been fully implemented (post, paras 46, 48, 89).

Per Simon Brown LJ. If, before the judicial review challenge can be brought before the court, the patient has already been discharged, then, in the absence of any

relevant change of circumstances, it would not be right for the judge granting permission to make any order with a view to the patient's forcible return to hospital (post, para 106).

Decision of Stanley Burnton J [2001] EWHC Admin 901 affirmed.

The following cases are referred to in the judgments:

Associated Provincial Picture Houses Ltd v Wednesbury Corpn [1948] 1 KB 223; [1947] 2 All ER 680, CA

English v Emery Reimbold & Strick Ltd (Practice Note) [2002] EWCA Civ 605; [2002] 1 WLR 2409; [2002] 3 All ER 385, CA

Flannery v Halifax Estate Agencies Ltd (trading as Colleys Professional Services) [2000] 1 WLR 377; [2000] 1 All ER 373, CA

Minister of Foreign Affairs, Trade and Industry v Vehicle and Supplies Ltd [1991] 1 WLR 550; [1991] 4 All ER 65, PC

R v Mental Health Review Tribunal, Ex p Booth (unreported) 22 September 1997, Laws J

R v Oxford Regional Mental Health Review Tribunal, Ex p Secretary of State for the Home Department [1988] AC 120; [1987] 3 WLR 522; [1987] 3 All ER 8, HL(E)

R v Secretary of State for Education and Science, Ex p Avon County Council [1991] 1 QB 558; [1991] 2 WLR 702; [1991] 1 All ER 282, CA

R (Epsom and St Helier NHS Trust) v Mental Health Review Tribunal [2001] EWHC Admin 101

R (K) v Camden and Islington Health Authority [2001] EWCA Civ 240; [2002] QB 198; [2001] 3 WLR 553, Burton J and CA

R (Von Brandenburg) v East London and The City Mental Health NHS Trust [2001] EWCA Civ 239; [2002] QB 235; [2001] 3 WLR 588, CA

R (Wirral Health Authority) v Finnegan [2001] EWHC Admin 312; [2001] EWCA Civ 1901, CA

Winterwerp v The Netherlands (1979) 2 EHRR 387

The following additional cases were cited in argument:

C (Detention: Medical Treatment), In re [1997] 2 FLR 180

Clunis v Camden and Islington Health Authority [1998] QB 978; [1998] 2 WLR 902; [1998] 3 All ER 180, CA

Eagil Trust Co Ltd v Pigott-Brown [1985] 3 All ER 119, CA

Edinburgh Council (City of) v Secretary of State for Scotland [1997] 1 WLR 1447; [1998] 1 All ER 174, HL(Sc)

Gomess, Ex p (1890) 6 TLR 147

Gouriet v Union of Post Office Workers [1978] AC 435; [1977] 3 WLR 300; [1977] 3 All ER 70, HL(E)

M v Home Office [1994] 1 AC 377; [1993] 3 WLR 433; [1993] 3 All ER 537, HL(E)

O and J (Paternity: Blood Tests), In re [2000] 1 FLR 418

Ohio v Nuclear Regulatory Commission (1987) 812 F 2d 288

Overseers of the Poor of Walsall v London and North Western Railway Co (1878) 4 App Cas 30, HL(E)

R v Chancellor of St Edmundsbury and Ipswich Diocese, Ex p White [1948] 1 KB 195; [1947] 2 All ER 170, CA

R v Managers of South Western Hospital, Ex p M [1993] QB 683; [1993] 3 WLR 376; [1994] 1 All ER 161

R v Mental Health Review Tribunal, Ex p Hall [2000] 1 WLR 1323; [1999] 4 All ER 883, CA

R v Mental Health Review Tribunal, Ex p Pickering [1986] 1 All ER 99

R v Richmond upon Thames London Borough Council, Ex p Watson [2001] QB 370; [2000] 3 WLR 1127, [2001] 1 All ER 436, CA

R (IH) v Nottinghamshire Healthcare NHS Trust [2001] EWHC Admin 1037

R (Warren) v Mental Health Review Tribunal [2002] EWHC 811 (Admin)
R (Wooder) v Feggetter [2002] EWCA Civ 554, CA

APPEAL from Stanley Burnton J

By a claim form filed on 29 March 2001 Ashworth Special Hospital Authority applied for judicial review of an order made on 22 March 2001 by the Mental Health Review Board for the West Midlands and the North West Region discharging H, a mental patient, from detention at Ashworth Special Hospital under section 3 of the Mental Health Act 1983.

By a claim form filed on 4 May 2001 H applied for judicial review of the decisions of Ashworth Special Hospital Authority, Lorraine Berry (an approved social worker) and Edward Silva and Melanie Croy (registered medical practitioners) relating to his detention on 29 March 2001 at Ashworth Special Hospital under section 3 of the 1983 Act.

On 9 November 2001 the judge granted the application of the hospital authority and refused that of H. H appealed against both decisions.

The facts are stated in the judgment of Dyson LJ

Paul Walker QC and *Jonathan Butler* for H.

Nigel Pleming QC and *Alison Foster QC* for the hospital authority.

Stephen Knafler for the social worker (interested party).

Fenella Morris for Hammersmith and Fulham London Borough Council and Ealing, Hammersmith and Hounslow Health Authority (interested parties).

Cur adv vult

28 June. The following judgments were handed down.

DYSON LJ

Outline of the case

1 H has been a patient in Ashworth Special Hospital ("Ashworth") since 1994. Until 22 March 2001 he was detained there under section 3 of the Mental Health Act 1983. On that date the Mental Health Review Tribunal for West Midlands and North West Region discharged him from detention. He did not leave hospital because he had nowhere to go. Instead, he remained as a voluntary patient. On 26 March Dr Croy, H's responsible medical officer ("RMO") signed a report on him for the purposes of section 5(2) of the Act. On 28 March, two registered medical practitioners, Dr Croy and Dr Silva, made written recommendations for the admission of H for treatment pursuant to section 3 of the Act. On 29 March, Ms Berry, an approved social worker ("ASW") for the purposes of the Act, made an application for the admission and detention of H pursuant to sections 3 and 13. At 16.40 on the same day, the managers of Ashworth acted on that application, and since that date have detained him for treatment under the Act.

2 On 29 March Ashworth started judicial review proceedings against the tribunal in which they contended that the decision of 22 March was legally flawed. On the same day Stanley Burnton J gave permission to apply for judicial review and made an order staying the carrying into effect of the decision, and granted an injunction prohibiting the release of H pursuant to it.

3 On 4 May 2001 H started judicial review proceedings in which he sought to challenge as unlawful the recommendations of Dr Croy and Dr Silva of 28 March, the application of Ms Berry of 29 March as well as the decision of the managers of Ashworth to admit H on that date.

4 The two proceedings were heard at the same time by Stanley Burnton J. In a clear and comprehensive judgment given on 9 November 2001 he upheld the challenge by Ashworth and quashed the decision of the tribunal, and he dismissed the challenge by H to the acts of the doctors, the ASW and the hospital managers.

5 H now appeals against both decisions. So far as H is concerned, the outcome of these appeals is of no interest whatsoever. This is because, following his readmission to Ashworth on 29 March 2001, he applied to another tribunal for a discharge. On 4 April 2002 the tribunal decided that he should not be discharged. Nevertheless, the appeals raise issues of considerable importance in the field of mental health law. It is common ground that, if the judge was right to quash the decision of the tribunal, then H was lawfully detained at the hospital under the procedures put in place prior to that decision, and that H's challenge to the decisions of Doctors Croy and Silva, Ms Berry and the managers of Ashworth fall away. That challenge is based on the premise that the tribunal's decision was lawful. If the tribunal's decision was lawful, the question whether he was lawfully detained remains, and that depends on the lawfulness of the decisions which led to his readmission on 29 March.

The background and events leading to the tribunal's decision of 22 March

6 The admission of H to Ashworth was precipitated by an incident in July 1994, when he gained access to his ex-partner's house, chasing her with a knife. He punched and kicked her and placed his son in an arm-lock. Once admitted to a medium secure unit ("MSU") a few days later, he kicked down a door, assaulted the social worker and gained access to another ward, where he attacked a junior doctor, striking him about 20 times with blows to the head. Following an assault on a secretary, he was transferred from the MSU to Ashworth.

7 H has a long history of violence going back to the early 1980s. He was convicted of criminal offences a number of times. On one occasion in 1984, he was transferred from prison to a mental hospital, having assaulted prison officers with an iron bar, and having set fire to his bedding. In the late 1980s he was admitted to Broadmoor. He was released by a mental health review tribunal in 1991. There were subsequent relapses and several further in-patient episodes until the incident in 1994 to which I have already referred. In 1993 he attacked a fellow patient, and at about the same time he decided that the baby his wife was carrying was connected to the devil and not his own and should be killed. This provoked the attack that led to his detention in Ashworth.

8 Between 1994 and 1997 there were many examples of aggressive behaviour at Ashworth, including assaults on staff and patients. In 1998 his medication was substantially increased. Thereafter, his aggression continued, but at a reduced level: in particular, there were no further acts of physical violence.

9 Dr Williams was his RMO between September 1994 and April 1997. In January 1998 Dr Croy became his RMO. From time to time he applied to

A a tribunal for discharge, but until 22 March 2001 all his applications were unsuccessful.

The documents before the tribunal at the hearing on 22 March

10 There were before the tribunal no fewer than nine medical reports from six doctors, namely, Drs Williams, Croy, Duncan, Cole, Lomax and
B Heads. Dr Duncan and Dr Lomax were psychiatrists who had been instructed by H's solicitors and were independent of Ashworth. Dr Heads, of the Ealing Hammersmith and Fulham Mental Health Trust, wrote a report dated 2 October 2000 in which she said that H continued to require care and treatment in conditions of maximum security, and that he had not made enough progress to move to a long-term medium secure unit. In his report of 30 October 2000 Dr Lomax recommended that H be transferred to
C a MSU.

11 In her report of 26 February 2001 Dr Croy said that H's illness required him to be detained in hospital for treatment, in the interests of his own health, his own safety and for the safety of others. His lack of insight and openness with staff, and the general level of his hostility, would make it very difficult to supervise him in the community. She concluded her
D report:

> "Should the long-term medium secure facility in H's home area agree that they could manage him in their unit, then I would support his transfer there. However, given their expressed concerns, it remains appropriate for him to be treated at Ashworth."

12 Dr Williams was of the opinion that H suffered from paranoid
E schizophrenia, but that the illness was no longer of a nature or degree that continued to require treatment in a hospital setting. In his report of 8 March 2001 he said:

> "The symptoms of the illness are well controlled and he has gained full insight into illness. He intends to continue with his treatment on discharge and appreciates that he would need professional help to resettle
F in the community."

13 He strongly disagreed with the view of Dr Cole that H required long-term medium secure facilities. He was of the opinion that it would be appropriate for H to be discharged and made subject to supervision under section 25A of the Act.

14 In short, only Dr Williams thought that H was ready for discharge,
G but, according to his report, even he thought that H should be subject to an application for supervision upon discharge, i e, liable to detention.

15 There were also reports by two social workers. Tita Ariola, a senior social worker employed by the London Borough of Hammersmith and Fulham ("LBH"), reported that if H were discharged the local authority would not be able to provide appropriate accommodation, since he still
H needed a high level of care and supervision. She continued:

> "The London Borough of Hammersmith and Fulham is hopeful that H will soon respond to treatment and rehabilitation. It seems, however, that an adequate and appropriate treatment management can still only be effected at Ashworth Hospital at this stage. Indeed, Dr Heads's report

suggested that H still requires care and treatment in conditions of maximum security. The view of the local authority is that H meets the criteria for section 3 of the Mental Health Act 1983. In view of this, social services feel that perhaps a transfer to a medium secure unit could be looked at again after reassessment at a later date by forensic psychiatrist at Three Bridges. If this is the decision of the tribunal, gradual re-introduction to the community can then be effected from the regional secure unit."

16 Tim Miles, a social worker at Ashworth, wrote that it was appropriate for H to remain detained in hospital for treatment, and that it would "seem advisable for his rehabilitation to be via an MSU where it could proceed by stages and where he and his potential community supervisors could establish a relationship prior to his eventual discharge".

The hearing on 22 March and the decision

17 Dr Croy presented the case for Ashworth. Both H and LBH were represented by counsel. The only doctors present were Dr Croy and Dr Williams. They both gave evidence orally. Other oral evidence was given by H and Mr Miles. The hearing lasted three hours. At the conclusion of the evidence and submissions, the tribunal asked the parties to retire. At about 13.55 the tribunal announced its decision, which was that H was to be discharged with effect from 14.00.

18 There was a dispute before the judge as to what, if anything, was said by the chairman (Mr Simms) as to why the tribunal had not adjourned the hearing until it knew what after-care arrangements were in place, or directed a deferred discharge under section 72(3). The judge accepted as accurate the contemporaneous notes made by Mr Lloyd, H's solicitor, which included the following:

"It became clear that the tribunal accepted the evidence of Dr Williams. They specifically stated that they did not accept the evidence of Dr Heads or of the other doctors in this case. They were therefore discharging H. Consideration had been given as to whether such discharge should be deferred in order to provide time for the appropriate section 117 after-care package to be put in place. On the basis of the experience of the tribunal, no matter how often matters were deferred in Ashworth Hospital nothing ever happened"

19 There is no challenge by H to this finding by the judge. The written decision of the tribunal was produced and given to the parties immediately after the announcement of its decision. The reasons given were:

"The tribunal accepted the medical evidence that the patient suffers from a mental illness namely schizophrenia which manifested itself in the 1980s in assaultative behaviour, paranoid ideas and auditory hallucinations. This behaviour extended to the 1990 [sic]. Since 1997 there have been no further episodes of violence. The patient accepts that he has a mental illness and complies with medication—he states he will continue to do so. He presented well to the tribunal and responded appropriately to questions. Dr Williams has known the patient for some years and we accept his evidence of: an assurance of compliance; the

A recent three-year non-violent history; the level of insight; a period of recent stability and the maintenance of a job."

Events following the tribunal's decision

20 The judge summarised the immediate response of the interested parties:

B "The hospital was surprised at the tribunal's decision. No one in the hospital had considered H's discharge a realistic possibility. Indeed, it is clear that there was consternation on the part of the hospital and the local authority, and subsequently the local health authority, none of whom believed that the immediate discharge of H was justified under the Act or in his or the public interest. Neither the local authority nor the local C health authority had made arrangements for H's accommodation or aftercare. H was naturally delighted at the decision. There was, however, nowhere for him to go. On 22 March he signed an agreement to remain in the hospital as an informal patient until he or the hospital could find suitable accommodation, and to abide by hospital rules. It stipulated that he was free to leave the hospital between 10 a m and 5 p m."

D **21** An urgent case conference was convened by LBH on 23 March. In a witness statement, David Worth, the assessment and advice manager of LBH's homelessness and advice service, records the view of those who attended the conference:

"The decision of the mental health tribunal to discharge H with no notice and without an adequate care package denies the department the E opportunity to find suitable appropriate accommodation for H. We are left only with the option of providing unsuitable accommodation in B and B type accommodation which may well involve unacceptable risk to his own mental health and to other vulnerable people if he were to relapse into violent behaviour. Had the tribunal itself recommended a period of further assessment and treatment in a medium secure hospital setting then we would have been able to liaise with colleagues there to make F appropriate arrangements for his housing in a sensible time scale in the interests of H himself as well as the wider community."

22 Immediately after the tribunal's decision, Ashworth sought legal advice as to the possibility of a challenge by judicial review proceedings. By 26 March advice had been received that there were grounds for seeking judicial review, and instructions had been given to start proceedings. Later G that day Dr Croy signed Form 12, a report under section 5(2) of the Act. The effect of this was that H became liable to detention until the evening of 29 March.

23 As I have already said, on 28 March Dr Croy and Dr Silva made their recommendations for the purpose of section 3 of the Act. On 29 March Ms Berry completed her application for the detention of H under that section, and this was accepted by the management of Ashworth. The H reasons given at the time by Dr Croy for taking these steps were that H was suffering from paranoid schizophrenia; although he was relatively settled on medication, he was likely to stop taking it when he left hospital; he had no after-care package; and he was unlikely to remain "informally" in hospital now that he knew that the tribunal's decision was being challenged. The

reasons given by Dr Silva were not materially different. Both doctors have amplified their thinking in witness statements prepared for these proceedings. It is clear that they disagreed fundamentally with the decision of the tribunal. Dr Croy said:

> "I feel I should say that it is my clear view as a clinician that it is not at all in his best interest to be discharged rapidly into an environment where he is likely to relapse, may even cause harm to others and, certainly, will not further the process of his becoming well. I had well in mind, having taken advice, the latest learning in this area from the Court of Appeal and I made my section 3 application in the full knowledge of the tribunal decision on other matters that had gone before. My clinical judgment remained the same, and, in the light of the legal view which had been expressed that the tribunal decision was, arguably, challengeable and unlawful, therefore it is my duty to proceed under section 5 and section 3."

24 In addition to his criticisms of the tribunal's decision, Dr Silva said that it seemed to him that there were further material matters that had come to light of which the tribunal appeared to be unaware. These were that (a) it did not appear to know that there was *no* accommodation available and (b) there was evidence of clinical psychosis which seemed to be a "significant change of circumstances from the patient's presentation in the tribunal". Dr Silva continued: "I say this because it is impossible to believe that they would have released him had he presented to them as he presented to me."

25 Ms Berry was given H's case on 29 March. Later that day Mr Lloyd sent a fax to Ashworth's solicitors stating that H was willing to remain in hospital voluntarily to allow a reasonable time for an appropriate section 117 careplan to be set up and suitable community care arrangements to be put in place. Ms Berry interviewed H and considered the information that she had. She had to take a decision urgently. She was aware of the judicial review proceedings and the interim relief that had been granted by the court. She had been told that Ashworth was not seeking an injunction since it had been advised that it was preferable to detain H under section 3. She knew of Dr Williams's recommendation of supervised discharge; that no care package was in place; and she took account of the views expressed by Dr Croy and Dr Silva. She decided to make the application.

26 H's case was discussed at the most senior levels within Ashworth. The thinking that lay behind the decision to detain H is explained in detail by Dr James, Ashworth's medical director. In her witness statement, she says:

> "A decision had already been taken on legal advice to judicially review the decision. This is because we believed and were advised that the decision was arguably unlawful. Accordingly, we were aware that the decision of the tribunal was not to be accorded the same weight as it would otherwise have been. Secondly, it was not clear to us on reading the decision that the tribunal had grappled with the important issues in relation to H. Even after discussion with Dr Croy we were not able to satisfy ourselves that the tribunal had grappled with the relevant issues. Thirdly, we were very well aware that there were no after-care arrangements in place and that if H were discharged he would have nowhere to go. Fourthly, we were concerned about the risk posed by H were he to be discharged into the community in these circumstances . . .

A I should add that H had, by then, been discussed at the most senior levels. Very great consideration was given to the prospect of resectioning H. Following this, the view was taken that in the circumstances the appropriate assessments should be undertaken which could lead to completion of the medical recommendations and application for admission. In reaching this view we were fully aware of the undertaking signed by H on 22 March 2001. We were not, however, convinced that it B would be appropriate for us to rely wholly upon the undertaking, given H's history of going back on his assurances as to treatment and conduct generally. In any event, it was brought to my attention that on 26 March he indicated a present indication to leave the hospital immediately. Moreover, Dr Croy in her section 5(2) report stated that 'He has no current after-care package (which is being examined) and has now C become aware of the legal challenge to the tribunal decision to discharge him . . . and is therefore unlikely to stay informally' . . . Equally, when it was decided to apply for admission of H under section 3 on 29 March 2001 the managers decided to accept the admission, we were of the firm view that notwithstanding the injunction, this was necessary."

Summary of judgment below

D **27** The judge held that the decision of the tribunal was one which no "sensible tribunal acting with due appreciation of its responsibilities would have made". He laid particular emphasis on the fact that no after-care arrangements were in place, so that the decision to discharge was a "step in the dark that was unnecessary and unjustified". He went on to consider the adequacy of the tribunal's reasons, and found these wanting. He, therefore, E decided to quash the decision on these two grounds.

28 He then addressed H's challenge to his readmission. He held that, since H had been discharged at 14.00 on 22 March, the stay that he had granted on 29 March was of no effect and that, save in exceptional cases, it would not have been proper for the court to grant an injunction after 14.00 on 22 March prohibiting the release of H from detention. He then considered the position of Drs Croy and Silva, Ms Berry and the hospital F managers in the light of the decision of this court in *R (Von Brandenburg) v East London and The City Mental Health NHS Trust* [2002] QB 235, and decided that the decisions taken by them were not unlawful.

29 It will be necessary to examine the judge's reasoning in more detail later, but this bare summary will suffice to enable me to identify the issues that arise on this appeal.

G *The issues*

30 The principal grounds of appeal advanced by Mr Walker on behalf of H are that the judge was wrong to hold that (a) interim relief could not lawfully be granted in a case where judicial review is sought of a tribunal decision to discharge a patient once the time stipulated for discharge has been reached; (b) the principles enunciated by this court in *Von Brandenburg* H do not apply to a case where the recent decision of a tribunal is arguably open to judicial review; (c) the tribunal's decision was unreasonable in the *Wednesbury* sense (see *Associated Provincial Picture Houses Ltd v Wednesbury Corpn* [1948] 1 KB 223); and (d) the tribunal's reasons were inadequate.

The statutory framework

31 Like the judge, I do not propose to set this out since it is conveniently summarised at paragraph 7 of the judgment of Lord Phillips of Worth Matravers MR in *Von Brandenburg* to which reference should be made.

Is there jurisdiction to grant a stay?

32 The judge reasoned as follows. As from 14.00 on 22 March H was discharged from detention and Ashworth ceased to have any power to detain or treat him against his will. A stay may defer the legal consequences of a decision, but it cannot turn the clock back to undo what has already been done. As regards an injunction, although the court has power under section 37 of the Supreme Court Act 1981 to grant an injunction prohibiting a patient from leaving a hospital, and requiring him to agree to treatment, the judge could not think of any circumstances in which it would be proper to use the power. He concluded "with reluctance" that "except possibly in the most exceptional cases, the court has no power to grant effective interim relief in a case in which judicial review is sought of the decision of a mental health review tribunal to direct the immediate discharge of a patient".

33 It followed that the advice communicated to Ms Berry as to the doubtful effects of the order for interim relief was correct, and that if effective relief was to be sought in a case such as the present case it must be sought under the provisions of the Act.

34 Mr Walker submits that the judge was wrong to say that the grant of a stay presupposes that it involves undoing the order under challenge. A stay merely suspends the effects of the order. It holds the ring. There is no doubt that the court can, at a substantive judicial review hearing, undo the order under challenge. If that is so, there is no good reason why the court should not be able to suspend that order in the interim. He refers to *R (Epsom and St Helier NHS Trust) v Mental Health Review Tribunal* [2001] EWHC Admin 101, a decision of Sullivan J. In that case a tribunal ordered the patient to be immediately discharged from detention under section 3. The decision was challenged by the hospital by proceedings for judicial review. In view of what the judge described as "these wholly exceptional circumstances", he expedited the hearing of the application and granted a stay of the order pending the hearing. He said (paragraph 30) that this course

> "was necessary to allow PEG feeding to continue, if necessary by the use of physical restraint, in order to preserve W's life pending the resolution of the legal challenge to the decision to release her from liability to section 3 detention."

35 We have been referred to two authorities where the scope of the power to order a stay is discussed. The first is *R v Secretary of State for Education and Science, Ex p Avon County Council* [1991] 1 QB 558. In this case a local authority was granted leave to apply for judicial review of decisions of the Secretary of State concerning the reorganisation of education in the county, and applied for a stay of the implementation of the decisions pending determination of the application for judicial review. Although a stay was refused on the facts, this court held that the phrase "the proceedings" in RSC Ord 53, r 3(10)(a) should be construed widely, and that

so construed it embraced not only judicial proceedings but also administrative decisions "and the process of arriving at such decisions": see p 562B. Glidewell LJ gave the leading judgment with which Taylor LJ and Sir George Waller agreed. He said, at pp 562–563: "The effect of a stay would not be to nullify the various statutory provisions. It *would* be to defer the date for the implementation of the proposals until the judicial review proceedings were concluded."

36 The second authority is a decision of the Privy Council, *Minister of Foreign Affairs, Trade and Industry v Vehicle and Supplies Ltd* [1991] 1 WLR 550. Section 564B(4) of the Judicature (Civil Procedure Code) Law of Jamaica provided that the grant of leave to apply for an order of prohibition or certiorari should, if the judge so directed, operate as a "stay of the proceedings in question" until the determination of the application or until further order. The minister instructed the sole specified importer of approved motor vehicles to order certain vehicles for importation and to distribute them in accordance with the minister's allocation. The applicant dealers applied for leave to apply for an order of certiorari to quash the minister's allocation or an order prohibiting him from implementing it. The Privy Council dismissed the appeal from the Court of Appeal of Jamaica on the grounds that there was no basis for interfering with the decision of the first instance judge, in the exercise of his discretion, to set aside the stay. But the Privy Council went on to say that there was in any event "every ground for challenging the order of a stay as a matter of law": p 556E. The opinion was given by Lord Oliver of Aylmerton. He said, at p 556:

> "It seems in fact to have been based upon a fundamental misunderstanding of the nature of a stay of proceedings. A stay of proceedings is an order which puts a stop to the further conduct of proceedings in court or before a tribunal at the stage which they have reached, the object being to avoid the hearing or trial taking place. It is not an order enforceable by proceedings for contempt because it is not, in its nature, capable of being 'breached' by a party to the proceedings or anyone else. It simply means that the relevant court or tribunal cannot, whilst the stay endures, effectively entertain any further proceedings except for the purpose of lifting the stay and that, in general, anything done prior to the lifting of the stay will be ineffective, although such an order would not, if imposed in order to enforce the performance of a condition by a plaintiff (eg to provide security for costs), prevent a defendant from applying to dismiss the action if the condition is not fulfilled: see *La Grange v McAndrew* (1879) 4 QBD 210."

37 He then referred to section 564B(4) and continued:

> "This makes perfectly good sense in the context of proceedings before an inferior court or tribunal, but it can have no possible application to an executive decision which has already been made. In the context of an allocation which had already been decided and was in the course of being implemented by a person who was not a party to the proceedings it was simply meaningless. If it was desired to inhibit JCTC from implementing the allocation which had been made and communicated to it or to compel the minister, assuming this were possible, to revoke the allocation or issue counter-instructions, that was something which could be achieved only

by an injunction, either mandatory or prohibitory, for which an appropriate application would have had to be made. The minister's apprehension that that was what was intended by the order is readily understandable, but if that was what the judge intended by ordering a stay, it was an entirely inappropriate way of setting about it."

38 It will be seen that there is a conflict between these two authorities as to whether the court has power to grant a stay of administrative decisions. This court is bound to follow *Avon*, but, in any event, the present case is not concerned with the decision of an administrative body, but that of a court.

39 Mr Pleming, supported by Miss Morris and Mr Knafler, submits that, in the light of these two authorities, and as a matter of principle, the court has no jurisdiction to grant a stay of a tribunal order for the discharge of a patient once that order has been implemented. Mr Pleming helpfully identifies three different situations, which I shall call respectively "case A", "case B" and "case C". In case A the tribunal orders discharge, but the order has not yet taken effect because the tribunal directs under section 72(3) that the discharge of the patient is to be deferred to a specified future date. In case B the tribunal orders discharge to take effect immediately, but the patient chooses not to leave the hospital. The present case falls into this category. In case C the tribunal orders discharge to take effect and it is implemented, and the patient leaves the hospital before any application is made to the court for a stay.

40 Mr Pleming concedes that the court would have jurisdiction to grant a stay in case A because the order of the tribunal has not been implemented. In case B, however, Mr Pleming submits that there is no jurisdiction to grant a stay. The order for discharge has been fully implemented. The hospital no longer has power to detain the patient. The patient is a free person, as free to leave as a visitor to the hospital or a member of the hospital staff. There are no further steps in the process of carrying the decision of the tribunal into effect, and therefore there are no proceedings to stay. Mr Pleming submits that case C is in principle no different from case B.

41 So does the court have jurisdiction to grant a stay in cases B and C? I see no difference in principle between the two categories of case. The relevant rule is CPR r 54.10, which is in substantially the same terms as its predecessor, RSC Ord 53, r 3(10), and so far as material provides: "(1) Where permission to proceed is given the court may also give directions. (2) Directions under paragraph (1) may include a stay of proceedings to which the claim relates."

42 The purpose of a stay in a judicial review is clear. It is to suspend the "proceedings" that are under challenge pending the determination of the challenge. It preserves the status quo. This will aid the judicial review process and make it more effective. It will ensure, so far as possible, that, if a party is ultimately successful in his challenge, he will not be denied the full benefit of his success. In *Avon*, Glidewell LJ said that the phrase "stay of proceedings" must be given a wide interpretation so as apply to administrative decisions. In my view it should also be given a wide interpretation so as to enhance the effectiveness of the judicial review jurisdiction. A narrow interpretation, such as that which appealed to the Privy Council in *Vehicle and Supplies*, would appear to deny jurisdiction even in case A. That would indeed be regrettable and, if correct, would

A expose a serious shortcoming in the armoury of powers available to the court when granting permission to apply for judicial review. As I have said, this extreme position is not contended for by Mr Pleming. Thus it is common ground that "proceedings" includes not only the process leading up to the making of the decision but the decision itself. The Administrative Court routinely grants a stay to prevent the implementation of a decision that has been made but not yet carried into effect, or fully carried into effect.
B A good example is where a planning authority grants planning permission and an objector seeks permission to apply for judicial review. It is not, I believe, controversial that, if the court grants permission, it may order a stay of the carrying into effect of the planning permission.

43 In some, and perhaps many, contexts the result desired by the court can be achieved by the grant of an injunction. This was, in effect, the point
C that was made by Lord Oliver in the passage that I have cited. But that would not be an appropriate remedy in a case concerning the detention of a patient pursuant to the Act. The judge recognised that, if there were no jurisdiction to grant a stay, there was a serious lacuna in the law, unless it could be overcome by a fresh admission to hospital. He said that there was power in the court under section 37 of the Supreme Court Act 1981 to grant an injunction prohibiting a patient from leaving hospital, and requiring him
D to agree to treatment. But, he added, he could not think of circumstances in which it would be proper to use this power. As he pointed out:

> "The court should not deprive a person of liberty by injunction, or compel him to submit to treatment, except in the most exceptional cases. Moreover, an injunction cannot authorise a doctor to treat a patient: it can only require the patient to agree to treatment. If, notwithstanding the
E injunction, the patient does not agree to the treatment in question, the only remedy is committal for contempt. Difficulties would also arise in specifying the treatment in question."

44 For these and other reasons, the judge held that the solution to the problem did not lie in the jurisdiction to grant an injunction. It was common
F ground before us that the judge was right, and I agree. Where the patient has actually left the hospital, the arguments in favour of an injunction have even less attraction. It is unthinkable that the court would grant an injunction to order the patient to return to hospital and submit to the regime of the Act.

45 I return, therefore, to the question whether the court has jurisdiction to grant a stay in cases B and C. As I have said, the essential effect of a stay of proceedings is to suspend them. What this means in practice will depend on
G the context and the stage that has been reached in the proceedings. If the inferior court or administrative body has not yet made a final decision, then the effect of the stay will be to prevent the taking of the steps that are required for the decision to be made. If a final decision has been made, but it has not been implemented, then the effect of the stay will be to prevent its implementation. In each of these situations, so long as the stay remains in
H force, no further steps can be taken in the proceedings, and any decision taken will cease to have effect: it is suspended for the time being.

46 I now turn to the third situation, which occurs where the decision has not only been made, but it has been carried out in full. At first sight, it seems nonsensical to speak of making an order that such a decision should be *suspended*. How can one say of a decision that has been fully

implemented that it should *cease* to have effect? Once the decision has been implemented, it is a past event, and it is impossible to suspend a piece of history. At first sight, this argument seems irresistible, but I think it is wrong. It overlooks the fact that a successful judicial review challenge does in a very real sense rewrite history. Take a decision by a tribunal to discharge a patient. The order has effect for the purposes of being implemented, i e, releasing him into the community. But it also has effect in a more general sense: it declares that at the time it was made the tribunal was not satisfied that the criteria for the patient's continued detention were fulfilled. If the order is ultimately quashed it will be treated as never having had any legal effect at all: see *R (Wirral Health Authority) v Finnegan* [2001] EWCA Civ 1901. If that occurs it will be treated as if it had never been made, and the patient will once again become subject to the Mental Health Act regime to which he was subject before the order was made. It is, therefore, difficult to see why the court should not in principle have jurisdiction to say that the order shall temporarily cease to have effect, with the same result for the time being as will be the permanent outcome if it is ultimately held to be unlawful and is quashed. I would hold that the court has jurisdiction to stay the decision of a tribunal which is subject to a judicial review challenge, even where the decision has been fully implemented as in cases B and C.

When should the court grant a stay of a tribunal's order to discharge a patient?

47 As CPR r 54.10 makes clear, the grant of permission to apply for judicial review is a necessary condition of a stay. But, in the special context of orders for discharge by mental health review tribunals, it is, in my view, not a sufficient condition. The mere fact that an arguable case for judicial review has been demonstrated is not a sufficient reason for granting a stay. It is important to bear in mind that the consequence of granting a stay is that the patient once again becomes subject to the regime of the Act and is deprived of his liberty. That is because the effect of the stay is to suspend the tribunal's order, and temporarily to treat it as being of no effect. If the patient refuses to return to the hospital following the grant of a stay, the machinery of the Act can be mobilised to ensure that he does: see, for example, section 18. This is a particularly grave consequence in the light of the fact that he has only recently been given his liberty by the specialist tribunal designated by Parliament to determine these matters. This is an important consideration that has to be weighed against the public interest in seeing that patients who may be a danger to themselves as well as to other members of the public are deprived of their liberty, and given the treatment that they need. In striking that balance, it seems to me that the court should usually refuse to grant a stay unless satisfied that there is a strong, and not merely an arguable, case that the tribunal's decision was unlawful. Even in such a case the court should not grant a stay in the absence of cogent evidence of risk and dangerousness. In *Epsom and St Helier NHS Trust* there was compelling evidence that the patient might die unless a stay was granted. In a case where a stay is ordered it is essential that the validity of the tribunal's decision be determined by the court with the greatest possible speed. By this I mean that degree of speed that is appropriate and usual where a detained person seeks habeas corpus.

A **48** To summarise, I consider that there is jurisdiction to grant a stay even after the decision of the tribunal has been fully implemented. But the jurisdiction should be exercised sparingly, and where it is exercised, the court should decide the judicial review application, if at all possible, within days of the order of stay.

B *Readmission under section 3*

49 I turn to consider in what circumstances a patient may lawfully be readmitted following a recent decision by a tribunal to order his or her discharge. This issue was considered in *R (Von Brandenburg) v East London and The City Mental Health NHS Trust* [2002] QB 235. In that case the applicant patient was compulsorily admitted to hospital on 15 March 2000. On 22 March he applied for a tribunal hearing. On
C 31 March the tribunal ordered discharge, but deferred it until 7 April. On 6 April the patient was further detained under section 3, on the application of an ASW and the recommendation of two doctors. The patient applied for judicial review of the decisions of 6 April.

50 Lord Phillips of Worth Matravers MR said, at pp 252–253:

"30. The nature of mental illness is such that the severity of the
D symptoms and the need for treatment will often fluctuate over time. A sequence of discharge, readmission, discharge and readmission is not uncommon. Normally a sensible period is likely to elapse between discharge and readmission. In such circumstances the implied statutory requirement of change of circumstances for which Mr Gordon contends is neither necessary or sensible. If the professionals concerned are acting
E objectively and bona fide, the application for readmission is likely to be triggered by behaviour of the patient that is, at least in part, a reaction to life in the community. This will almost certainly constitute a change of circumstances when compared with the patient's reaction to the hospital regime that was prevailing when the tribunal discharged the patient. To require the professionals involved to investigate and attempt a
F comparison between the two sets of circumstances in order to decide whether or not there has been a relevant change of circumstances would not be helpful or even meaningful.

"31. The position is very different where an application for readmission is made within days of a tribunal's decision to discharge, which carries the necessary implication that the criteria for admission are not present—the more so if the patient has remained under the hospital
G regime because discharge has been deferred, so that there has been no change in the patient's'environmental circumstances. In such a situation there is likely to have been, as Mr Gordon pointed out, a difference of view between the patient's responsible medical officer and the tribunal as to whether or not the criteria justifying detention were established. Under the statutory scheme, where such a conflict exists, it is the opinion of the tribunal that is to prevail.

H "32. In such circumstances I do not see how an approved social worker can properly be satisfied, as required by section 13, that 'an application ought to be made' unless aware of circumstances not known to the tribunal which invalidates the decision of the tribunal. In the absence of such circumstances an application by the approved social worker should,

on an application for judicial review, be held unlawful on the ground of irrationality.

"33. In conclusion I agree with Burton J that Mr Gordon has failed to establish the premise upon which he has based his case, namely that as a matter of statutory interpretation of the Act an application and admission of a patient under sections 2 or 3 of the Act cannot lawfully be made after the patient has been discharged by a tribunal unless either the relevant professionals have satisfied themselves that there has been a relevant change of circumstances or it is not reasonably practicable for them to do so . . .

"35. For the reasons that I have given I do not consider that the statutory scheme leaves it open to professionals effectively to overrule a decision to discharge taken by a tribunal. The tribunal has sufficient of the attributes of a court to satisfy the requirements of article 5(4) and there is no incompatibility between the sections of the Act that provide for compulsory admission of a patient to hospital and article 5(1) of the Convention."

51 Buxton LJ agreed with the reasoning of Lord Phillips of Worth Matravers MR, at p 253. Sedley LJ said, at pp 253–254:

"39. In a great many cases, especially those where readmission comes hard on the heels of discharge by the tribunal, there may in the light of this be little practical difference between what Mr Gordon has sought and what he has achieved. Any decision made in the exercise of statutory powers and affecting a person's liberty must not only be made in good faith but must, among other things, have proper regard to any relevant facts.

"40. The need for good faith in this context is well illustrated by Mr Knafler's correct concession on behalf of the social worker that an application to readmit will not be lawful if the approved social worker believes that a mental health review tribunal will thereupon order the patient's discharge; and the same, in my view, is true of the recommending doctors.

"41. A recent—and often a not so recent—order of a tribunal for discharge will always be a relevant fact. If so, it is the duty of the subsequent decision-maker to take it into account; a failure to do so, albeit through ignorance, will vitiate a subsequent decision to seek admission. The principle that the weight to be given to such facts is a matter for the decision-maker, moreover, does not mean that the latter is free to dismiss or marginalise things to which the structure and policy of the Act attach obvious importance. Thus a recent mental health review tribunal decision to discharge a patient, if the circumstances have not appreciably changed, must be accorded very great weight if the second decision is not to be perceived as an illicit overruling of the first. Put another way, there will have to be a convincing reason, in such a case, for readmission. This is particularly so if the United Kingdom's Convention obligations are to be respected. But neither the Act nor the Convention inhibits the detention by a proper decision-making process of those who, although recently discharged, have deteriorated or whose mental well being otherwise requires admission.

A "42. In this sense (reverting to the formulation of Laws J in *Ex p M* [1993] QB 683) it can be said that, while not legally bound in the absence of a change of circumstances by a recent mental health review tribunal decision in favour of discharge, those concerned in a section 3 application cannot lawfully ignore it. They must have due regard to such a decision for what it is: the ruling of a body with duties and powers analogous to those of a court, taken at an ascertainable date on ascertainable evidence. The second decision must be approached with an open mind, but it is not necessarily going to be written on a clean slate."

52 The judge distinguished *Von Brandenburg* on the grounds that the Court of Appeal did not consider the position of mental health professionals or of a hospital in a case where a tribunal has ordered an immediate discharge and the hospital is advised on substantial grounds that the decision of the tribunal is arguably unlawful, that judicial review proceedings which have been or are about to be started have a reasonable prospect of success, and that no effective interim relief is available. The judge referred to paragraph 83 of the judgment of Scott Baker J in *R (Wirral Health Authority) v Finnegan* [2001] EWHC Admin 312:

"To section under section 3 immediately after a release under section 37 by a tribunal, just because the sectioning doctors disagree with the tribunal's decision would, in my judgment, be an abuse of process as it would effectively usurp the tribunal's decision. But that is not this case, where I am satisfied: (a) that efforts were made to see if the decision of the tribunal could be implemented; and (b) there were genuine grounds for thinking, and in the event it has proved to be the case, that the tribunal's decision was unlawful."

53 Stanley Burnton J then continued, at para 104:

"That statement is applicable in the present case. However, when they make their decisions the ASW and the doctors cannot know whether the decision of the tribunal will subsequently be held to be unlawful. In my judgment, it is sufficient if they are advised, on substantial grounds, that the decision is unlawful, and that either proceedings for judicial review of the decision have been commenced or that such proceedings are imminent. In circumstances such as those of the present case, where the court cannot order a stay of the tribunal's decision, I do not think that the professionals are required to give to the tribunal decision the authority that it may subsequently be held not to have. A social worker or doctor who takes into account the alleged unlawfulness of the tribunal's decision, and therefore discounts it, is not acting irrationally or improperly. In such circumstances, the professionals must act in accordance with their professional judgments. The patient's remedy is to apply to the mental health review tribunal."

54 Mr Pleming submits that the judge was right and for the reasons that he gave. Applying the language of Sedley LJ, there was a "convincing reason" for the readmission on 29 March: it was that given by the judge. Mr Pleming also submits that there were new circumstances of which the tribunal was unaware which rationally justified the decisions of 29 March. The judge upheld these. But I shall come to those later. The question of

principle raised by this appeal is what steps are open to the mental health professionals and the hospital managers if they are faced with a tribunal decision for immediate discharge which they honestly and reasonably believe is perverse or arguably perverse. Can they procure his readmission as was done in the present case, simply on the grounds that, acting conscientiously and honestly in accordance with their professional opinions, they believe that the tribunal's decision was perverse? Mr Pleming submits not only that they can but that they must. In this way the patient enjoys the full protection of the Act. If he wishes to challenge the hospital's decision to readmit him he can do so speedily by a fresh application to a tribunal. Mr Pleming submits that, even if the court does have jurisdiction to stay the order of a tribunal, once discharge has taken effect the section 3 route is preferable to the grant of a stay. This is because, if a stay is granted, the original section 3 detention will be reinstated and any challenge to the original detention is likely to be heard less quickly than a challenge to the readmission. Moreover, judicial review proceedings are not suitable for deciding whether a person should be detained under the Act.

55 It is true that in *Von Brandenburg* the court did not consider what the position would be if there were to be a judicial review challenge of the tribunal's decision. But Lord Phillips of Worth Matravers MR said emphatically that, if there is simply a difference of view between the professionals and the tribunal, it is the opinion of the tribunal that is to prevail. There is undoubtedly a tension between (a) the need for certainty and respect for the rule of law and (b) the duty on mental health professionals to perform their duties in accordance with their consciences and professional judgment. But in a case of simple difference of opinion between the two that tension has been resolved in favour of the former. If the position were otherwise it would be open to the professionals to subvert the clear provision of article 5(4) of the European Convention on Human Rights:

> "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."

56 The tribunal is the court whose function it is to perform the role identified in article 5(4). In the absence of material circumstances of which the tribunal is not aware when it orders discharge, in my judgment it is not open to the professionals, at any rate until and unless the tribunal's decision has been quashed by a court, to resection a patient. I do not consider that the fact that the professionals have been advised that there are substantial grounds for saying that the tribunal's decision is arguably unlawful is a sufficient reason for sanctioning as lawful a decision to resection a patient in the absence of material circumstances of which the tribunal was not aware when it made its decision. To countenance such a course as lawful would be to permit the professionals and their legal advisers to determine whether a decision by a court to discharge a detained person should have effect. I cannot think that this is consonant with article 5(4). It is true that the patient can challenge the resection by application to another tribunal, but that cannot obscure the fact that the first tribunal's decision has been rendered nugatory simply by the professionals' disagreement with it, and the fact that their legal advisers have advised that there are substantial grounds for contending that

A the tribunal's decision is arguably unlawful. Quite apart from the fact that it is objectionable that the decision to sideline the effect of the tribunal is taken away from a court altogether, there are two other objections. First, the suggested criterion is no more than that the decision is *arguably* unlawful. The threshold of arguability is a low one. I do not believe that it should be possible to sweep aside so easily respect for the rule of law and the protection afforded to detained persons by article 5(4). Secondly, the test of arguability B is notoriously uncertain. In my view, the suggested basis for distinguishing *Von Brandenburg* is inimical to the principle of legal certainty.

57 I was at one stage attracted by a slightly different solution from that advocated by Mr Pleming and accepted by the judge. One of the objections to which I have referred would be met if it were not lawful to resection a patient unless the court had first granted permission to apply for judicial C review of the tribunal's decision. That would at least have the merit that the decision to resection was not taken without any input from the court. But this solution does not meet the other objections to which I have referred. In my view, where there is a simple difference of view between the professionals and the tribunal (and no more), the view of the tribunal must prevail until and unless the court decides that the tribunal's decision *was* unlawful. Nothing less will do if there is to be compliance with article 5(4) and the D respect for the tribunal's decision that the rule of law demands. I do not think that this is inconsistent with what I have said earlier in relation to the grant of a stay. As I made clear, a stay should only be granted if there is strong evidence to justify it, and it should be followed very swiftly indeed with a substantive hearing at which the lawfulness of the tribunal's decision will be determined. I would regard the grant of a stay for a very short period E in the circumstances that I have postulated as being justified to meet emergencies. I bear in mind that in *Winterwerp v The Netherlands* (1979) 2 EHRR 387, 403 the European Court of Human Rights said:

> "In the court's opinion, except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of 'unsound mind'. The very nature of what has to be F established before the competent national authority—this is, a true mental disorder—calls for objective medical expertise. Further, the mental disorder must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends upon the persistence of such a disorder."

58 So far, I have discussed the paradigm case of a tribunal decision with G which the professionals disagree and which is, or is about to become, the subject of judicial review proceedings, where the professionals do not rely on any circumstances of which the tribunal was unaware when it made its decision. But in the real world the position may well not be as clear-cut as this. As was pointed out in argument, it may be a difficult question to decide whether there are material circumstances of which the tribunal was not aware when it made its decision. For example, is the fact that the patient H presented badly and did not impress the two doctors and the ASW who interviewed him a few days after the tribunal hearing a new circumstance, when the patient had presented well at the hearing and had impressed the members of the tribunal? I accept that these are difficulties which are inherent in the scheme of the Act as interpreted in *Von Brandenburg*. I do

not, however, consider that the fact that, in the present case, Ashworth was advised that it had sufficient grounds to obtain permission to apply for judicial review should have affected the judgment that had to be made by the professionals in deciding whether the case was one in which it was proper to procure the readmission of H.

59 It seems to me that, when considering whether to resection a patient who has only very recently been discharged by a tribunal, the question that the professionals must ask themselves is whether the sole or principal ground on which they rely is one which in substance has been rejected by the tribunal. If it is, then in my view they should not resection. In deciding whether the grounds on which they rely are ones which have been very recently rejected by the tribunal they should not be too zealous in seeking to find new circumstances. As in the present case, the tribunal will have made an assessment of the degree of the patient's insight into his mental problems, his willingness to comply with the treatment regime in the community, his willingness to engage with doctors, nurses, social workers and so on. If experience of what happens when he is released shows that the tribunal seriously misjudged the patient, then that might well be sufficient evidence of new circumstances: a straightforward application of the proof of the pudding principle. But if the professionals form the view that the tribunal's assessment was wrong not on the basis of what happens upon release, but simply on the basis of their assessment at interview before the patient has actually left the hospital, then it may well be difficult for them reasonably to justify a resection on the basis of circumstances of which the tribunal was unaware.

60 Nothing that I have said affects the ability of the professionals to resection a patient if he does or threatens to do something which imperils or might imperil his health or safety, or that of members of the public.

The lawfulness of the section 3 application in this case

61 H seeks an order quashing his detention under section 3 on the grounds that Drs Croy and Silva, Ms Berry and Ashworth erred in law in failing to respect the decision of the tribunal of 22 March. Moreover, Ms Berry and Ashworth acted unreasonably since, in view of H's willingness to remain voluntarily and the interim relief granted by the court, it was unnecessary for H to be detained under section 3. As the decision on the facts of this case is now only of academic interest, I do not propose to burden this long judgment with a detailed examination of the issues raised on the particular facts of this case. I have already sufficiently summarised the relevant facts.

62 It follows from what I have said above that I do not agree with the judge's primary reason for holding that the recommendations of the doctors, the application by the ASW and Ashworth's decision to admit H were lawful. It was not open to them to act as they did simply because they disagreed with the decision of the tribunal, whether or not they had been advised and believed that the decision was arguably unlawful. In reaching his conclusion, the judge was heavily influenced by his view that there was no jurisdiction to grant a stay once the order for discharge had been implemented.

63 The judge explained his reasons for deciding that, even if the tribunal's decision was lawful, Drs Croy and Silva and Ms Berry had

A sufficient reasons to cause H to be detained, ie, on a straightforward application of the *Von Brandenburg* test. These included: that by 28 March H was aware of the judicial review proceedings and had stated that he would leave the hospital and go to bed and breakfast accommodation that the professionals considered to be unsuitable, when there was no after-care plan in place. The judge said that Dr Croy could not have thought that this
B situation had been reasonably envisaged by the tribunal. I have referred to the substance of the evidence of Dr Croy, Dr Silva and Ms Berry at paragraphs 23 to 25 above.

64 Further, although not dealt with by the judge, Mr Knafler has helpfully produced a table (which was also before the judge) which purports to show that a considerable amount of material which was relied on by the professionals in reaching their decision was not before the tribunal. I have
C considered the witness statements of Drs Croy and Silva and Ms Berry, as well as Mr Knafler's table. It seems to me that the principal, if not the sole, ground on which they relied in deciding to resection H was one which in substance had been rejected by the tribunal. In reality, there were no new circumstances in this case, or, at least, none of any significance. The simple fact is that the professionals formed a different view largely on the basis of
D their assessment of H at interview, and no more. For these reasons, and having regard to what I have said at paragraph 59 above, I do not consider that there were new circumstances here which justified the decision to resection H on 29 March. It follows, in my opinion, that, even if the tribunal's decision was unlawful, the professionals did not have sufficient reasons to resection him. I would, therefore, allow the appeal in relation to the decision of 29 March to resection H.

E

The lawfulness of the tribunal's decision

65 It is Ashworth's case that the decision was flawed in that (a) it was unreasonable in the *Wednesbury* sense and (b) the tribunal's reasons were inadequate. The judge held that the decision was flawed in both respects.

F *Unreasonable*

66 The judge concluded that the tribunal's decision was unreasonable in the *Wednesbury* sense because no reasonable tribunal could have made an order that H should be discharged immediately into the community without at the very least being satisfied that suitable after-care arrangements were in place. The evidence before the tribunal could not have given it confidence
G that such arrangements had been or would be made. The judge referred to the evidence of Ms Ariola which I have mentioned at paragraph 15 above, and to the fact that the tribunal had little or no information from the section 117 authorities. The question of after-care was fundamental to the issues before the tribunal. In these circumstances, the tribunal should not simply have ordered immediate discharge. It should have either deferred
H discharge to a future date under section 72(3) or adjourned and called for information from the section 117 authorities. The course that it took was an unjustified "step in the dark".

67 In my view the judge was right. This was a case in which, if the criteria for discharge were to be met, it was obvious that suitable after-care should be available. H was a man who had been detained in Ashworth for

about six years. He had a history of serious violence, and previous attempts to release him into the community had been unsuccessful. The tribunal accepted that H was still suffering from schizophrenia. The issue was whether it was of a "nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment": section 72(1)(b)(i) of the Act. The tribunal was also required to have regard to "the likelihood of the patient, if discharged, being able to care for himself, to obtain the care he needs or to guard against serious exploitation": section 72(2). The answer to the question whether H's mental illness was of a nature or degree which made it appropriate for him to be liable to be detained in a hospital for medical treatment was (to put it no higher) very likely to be heavily influenced by the after-care arrangements that were to be provided following his discharge. I refer to the observations of Lord Bridge of Harwich in *R v Oxford Regional Mental Health Review Tribunal, Ex p Secretary of State for the Home Department* [1988] AC 120, 127D, about the power under section 73(2) to order the conditional discharge of restricted patients. As Miss Morris points out, the tribunal cannot assume that any, still less any suitable, after-care services will be provided, since section 117 does not impose an absolute duty on the health and social services authorities to provide the services. The duty is no more than to use reasonable endeavours to provide after-care services: see *R (K) v Camden and Islington Health Authority* [2002] QB 198.

68 In agreement with the judge, I would therefore hold that H was a patient in respect of whom it was essential that the tribunal considered the availability of suitable after-care services when deciding whether to order his immediate discharge from hospital. If the tribunal had any doubt as to whether such services would be available, it should have adjourned to obtain any necessary information. I regard the alternative of a deferral under section 72(2) as less satisfactory. Section 72(3) authorises a tribunal to "direct the discharge of a patient on a future date specified in the direction". Under this subsection, therefore, the tribunal must specify a particular date for discharge. But if the tribunal is in doubt as to whether suitable after-care arrangements will be made available, it is difficult to see how it can specify a particular date for discharge. In cases of doubt, the safer course is to adjourn. On the facts of the present case, the tribunal could not reasonably have assumed that the services would be provided as soon as H was discharged into the community. For that reason alone, in my opinion the tribunal's decision was one which no reasonable tribunal could properly have made.

69 I would endorse the general observation of the judge:

> "In general, in a case in which after-care is essential, and satisfaction of the discharge criteria depends on the availability of suitable after-care and accommodation, as in H's case, a tribunal should not direct immediate discharge at a time when no after-care arrangements are in place and there is no time for them to be put in place. The tribunal should consider whether to exercise its power under section 72(3A) to recommend that the RMO should make a supervision application. If it considers that to be inappropriate (and it should be borne in mind that the previous unwillingness of an RMO to make an application may not persist in the face of the tribunal's views) or unnecessary, and there is uncertainty as to

A the putting in place of the after-care arrangements on which satisfaction of the discharge criteria depends, the tribunal should adjourn pursuant to rule 16 to enable them to be put in place, indicating their views and giving appropriate directions: cf *Ex p Hall* [2000] 1 WLR 1323, per Kennedy LJ at 1352D."

70 Having found that Mr Simms did say that immediate discharge was
B ordered because otherwise nothing ever happens at Ashworth, the judge said that this statement revealed an "unreasonable motivation" for the decision not to adjourn until it was known what after-care arrangements were in place, or to defer discharge to enable such arrangements to be put in place, thereby placing immediate and unnecessary pressure on the authorities charged under section 117 with responsibility for after-care. I agree with the
C judge. This merely reinforces the conclusion that I have already reached as to the reasonableness in the *Wednesbury* sense of the tribunal's decision.

Reasons

The Mental Health Review Tribunal Rules 1983 (SI 1983/942)

71 So far as material, the Rules provide:

D "23(2) The decision by which the tribunal determines an application shall be recorded in writing; the record shall be signed by the president and shall give the reasons for the decision and, in particular, where the tribunal relies upon any of the matters set out in section 72(1) . . . of the Act, shall state its reasons for being satisfied as to those matters

"24(1) The decision by which the tribunal determines an application
E may, at the discretion of the tribunal, be announced by the president immediately after the hearing of the case and, subject to paragraph (2), the written decision of the tribunal, including the reasons, shall be communicated in writing within 7 days of the hearing to all the parties . . ."

F *The authorities*

72 Numerous authorities were cited to us. In the recent case of *English v Emery Reimbold & Strick Ltd (Practice Note)* [2002] 1 WLR 2409, Lord Phillips of Worth Matravers MR, giving the judgment of the court, summarised the present state of the law, at any rate as regards appeals from lower courts to higher courts. He said, at p 2417, para 16, that, putting the matter at its simplest, "justice will not be done if it is not apparent to the
G parties why one has won and the other has lost". The adequacy of reasons depends on the nature of the case: p 2417, para 17. Then he said, at p 2418:

"19. It follows that, if the appellate process is to work satisfactorily, the judgment must enable the appellate court to understand why the judge reached his decision. This does not mean that every factor which weighed with the judge in his appraisal of the evidence has to be identified
H and explained. But the issues the resolution of which were vital to the judge's conclusion should be identified and the manner in which he resolved them explained. It is not possible to provide a template for this process. It need not involve a lengthy argument. It does require the judge to identify and record those matters which were critical to his decision. If

the critical issue was one of fact, it may be enough to say that one witness was preferred to another because the one manifestly had a clearer recollection of the material facts or the other gave answers which demonstrated that his recollection could not be relied upon.

"20. The first two appeals with which we are concerned involved conflicts of expert evidence. In *Flannery's* case [2000] 1 WLR 377 Henry LJ quoted from the judgment of Bingham LJ in *Eckersley v Binnie* (1988) 18 Con LR 1, 77–78 in which he said that 'a coherent reasoned opinion expressed by a suitably qualified expert should be the subject of a coherent reasoned rebuttal'. This does not mean that the judgment should contain a passage which suggests that the judge has applied the same, or even a superior, degree of expertise to that displayed by the witness. He should simply provide an explanation as to why he has accepted the evidence of one expert and rejected that of another. It may be that the evidence of one or the other accorded more satisfactorily with facts found by the judge. It may be that the explanation of one was more inherently credible than that of the other. It may simply be that one was better qualified, or manifestly more objective, than the other. Whatever the explanation may be, it should be apparent from the judgment.

"21. When giving reasons a judge will often need to refer to a piece of evidence or to a submission which he has accepted or rejected. Provided that the reference is clear, it may be unnecessary to detail, or even summarise, the evidence or submission in question. The essential requirement is that the terms of the judgment should enable the parties and any appellate tribunal readily to analyse the reasoning that was essential to the judge's decision."

73 There are a number of authorities which make the point that, in determining the adequacy of reasons, account should be taken of the fact that the decision is given to an "informed audience". Thus, for example, in *R v Mental Health Review Tribunal, Ex p Booth* (unreported) 22 September 1997 Laws J said, at para 29:

"It has to be remembered, as Mr Burnett submitted, that the quality of reasons required of a mental health review tribunal has to be looked at in light of the fact that the decision is addressed to an informed audience. Those who receive it and who are concerned with it will be familiar with the essential documents in the case, as here with the reports on the applicant. They will be familiar with what has been said at the tribunal by way of oral evidence and what the issues there were which had been argued. Given that necessary familiarity, if there was a case in which it could still be said that the parties simply were not told why the tribunal arrived at the decision it did, then no doubt there would be a sound basis for a legal challenge. That is not in my judgment the case here."

The judgment below

74 The central passage in Stanley Burnton J's judgment on this aspect of the case reads:

"80. I fully accept the submissions of counsel for the tribunal and H that the tribunal's written reasons show that they preferred the evidence of Dr Williams to that of Dr Croy, and that they did not accept

A the written reports that were inconsistent with Dr Williams's evidence. It is clear that the tribunal formed a favourable view of H as he presented to them. The tribunal gave reasons why they preferred Dr Williams's evidence: the good presentation of H and the fact that Dr Williams had known H for some years. (Parenthetically, I find the latter reason surprising. Dr Williams had ceased to be H's RMO in 1997. He had known H just as well in 1997, when he had reported that he was suitable B for discharge. H's medical history later in 1997, summarised in the chronology, amply justified the contrary views of other psychiatrists at that date and the refusal of the tribunal to discharge him in September 1997.) The tribunal gave reasons for their being satisfied that the discharge criteria were met. However, the tribunal's written reasons gave no indication as to whether they had considered H's after-care C arrangements. They gave no reason for not deferring discharge until those arrangements could be put in place. Moreover, this case is indistinguishable from *R (Wirral Health Authority) v Finnegan* [2001] EWHC Admin 312 . . . Furthermore, the written reasons of the tribunal did not address after-care other than medication.

"81. I am left concerned that the tribunal did not grapple with major issues: the well reasoned preponderance of medical opinion against D discharge; the fact that in the past when discharged into the community H had failed to comply with medication (although it must have been thought that he would) and had relapsed; that he had not been subject to, or tested under, the stresses of life in the community for a considerable time; that he needed professional help in the community, and that there were known questions in relation to after-care, as shown by Ms Ariola's E report and Dr Williams's own report: all against the background that if he relapsed in the community he would pose a high risk to himself and to others. The reasons did not sufficiently address these matters.

"82. As can be seen, my criticisms of the reasons of the tribunal largely reflect my criticisms of the reasonableness of their decision. In my judgment the written reasons of the tribunal were inadequate, and on this ground too its decision is liable to be quashed."

F

Discussion

75 Mr Walker submits that the judge was wrong to hold that the reasons of the tribunal were inadequate. He says that the judge adopted too strict an approach. It is by no means unusual to find a tribunal decision containing reasons as brief as those in this case. The judge failed to take G sufficient account of the fact that this decision was published to an informed audience who were aware of the issues and the details of the case. He also failed to pay sufficient regard to the practical realities of the workload imposed on tribunals and the limited resources that are available to them. The reality is that tribunal hearings are held at hospitals, members are part-time, and they do not have a wealth of administrative back-up to assist them. The judge found (correctly) that the tribunal gave adequate reasons for being H satisfied that the discharge criteria were met, but he was wrong to hold that they were required to give any reasons for not deferring discharge until after-care arrangements were in place. This was a "subsidiary" question, and not part of the decision "by which the tribunal determines an application": see rule 23(2).

76 I cannot accept Mr Walker's submissions. I am in no doubt that the reasons given by the tribunal in this case were inadequate. But before I explain why, I want to make two preliminary general comments. The first concerns Mr Walker's reference to the problems of excessive workload and inadequate resources. If tribunals do not have the time and back-up resources that they need to discharge their statutory obligation to provide adequate reasons, then the time and resources must be found. I absolutely reject the submission that reasons which would be inadequate if sufficient resources were available may be treated as adequate simply because sufficient resources are not available. Either the reasons are adequate or they are not, and the sufficiency of resources is irrelevant to that question. The adequacy of reasons must be judged by reference to what is demanded by the issues which call for decision. What is at stake in these cases is the liberty of detained patients on the one hand, and their safety as well as that of other members of the public on the other hand. Both the detained persons and members of the public are entitled to adequate reasons.

77 I note in passing that the Rules require reasons to be given within seven days of a decision. That is not an unreasonable period within which to produce adequate reasons. I note further that the handbook issued to tribunal members in September 2000 contains the following advice about reasons:

> "Tribunals must give detailed reasons, based on the evidence and the logical application of sound judicial principles, for their decisions (this has been given substance by decisions in the High Court). The reasons need not be elaborate but they must deal with the substantive points, which have been raised and must show the parties the basis on which the tribunal has acted. It is not sufficient merely to repeat the statutory grounds. It is not usually necessary to review the evidence at length. It is important to say which evidence has been accepted and often which has been rejected. It is not usually necessary to give lengthy reasons for acceptance or rejection of evidence. The reasons for the decision will be agreed by the tribunal members at the conclusion of the hearing, put in writing and signed by the president."

78 This correctly states that reasons should be given dealing with the "substantive" points. It does not expressly state, but it does imply, that reasons must be given for the acceptance or rejection of disputed evidence, although it is not usually necessary for these to be lengthy. In my opinion this advice is both useful and consistent with the law.

79 My second general preliminary comment concerns the significance of the so-called "informed audience" point. This was not identified in *English* as being relevant to the adequacy of reasons given by a judge of a lower court. And yet, in ordinary civil litigation, a judgment will usually be given to an audience that is at least as informed as the audience at a tribunal hearing. (I leave out of account those few cases where a judgment may be reported on the grounds that it is of public interest.) Although it is true that, in some cases, the interests of others who are not parties to civil litigation may be affected by a court decision, it is at least arguable that the "informed audience" point has less force in relation to a mental health review tribunal decision than to a decision by a lower court in the civil justice system. First, the ASW considering whether to make an application for readmission

pursuant to section 3 may well not have any prior knowledge of the case, let alone the reports on the patient and the oral evidence and argument that was deployed before the tribunal. In the light of *Von Brandenburg* it is essential that an ASW who is contemplating making such an application should know the facts and circumstances which a tribunal took into account when deciding to discharge a patient, and the reasons for its decision. Secondly, it is highly questionable whether a patient will always be able to supplement exiguous tribunal reasons with an accurate recollection of the evidence and arguments before the tribunal when he later considers a decision. Accordingly, I do not accept that the "informed audience" point can properly be relied on to justify as adequate a standard of reasoning in tribunals which would not be regarded as adequate in a judgment by a judge. It does not follow that tribunals are obliged to produce decisions which are as long as judgments by a judge often tend to be. Far from it. A brief judgment is no less likely to be adequately reasoned than a lengthy one.

80 Against the background of these two general comments, I shall now identify the two principal reasons why I consider that the tribunal's reasons were inadequate in this case. First, as often happens, the tribunal was required to resolve a difference of opinion between experts as to whether the patient should be discharged. In such cases, it is important that the tribunal should state which expert evidence (if any) it accepts and which it rejects, giving reasons. This is as important in a case where the tribunal rejects evidence in favour of discharge as it is in a case where the tribunal rejects evidence which advocates continued detention. It is not enough for the tribunal simply to state that it prefers the evidence of A and B to that of C and D. It must give reasons. As the handbook states, these may be brief, but in some cases something more elaborate is required. It must at least indicate the reasoning process by which it has decided to accept some and reject other evidence. What this court said in *Flannery v Halifax Estate Agencies Ltd (trading as Colleys Professional Services)* [2000] 1 WLR 377, 381–382 is as apt in relation to the decisions of tribunals as it is to lower courts generally. In giving the judgment of the court, Henry LJ said, at p 382, that the reach of what is required to fulfil the duty to give reasons depends on the subject matter:

> "Where there is a straightforward factual dispute whose resolution depends simply on which witness is telling the truth about events which he claims to recall, it is likely to be enough for the judge (having, no doubt, summarised the evidence) to indicate simply that he believes X rather than Y; indeed there may be nothing else to say. But where the dispute involves something in the nature of an intellectual exchange, with reasons and analysis advanced on either side, the judge must enter into the issues canvassed before him and explain why he prefers one case over the other. This is likely to apply particularly in litigation where as here there is disputed expert evidence; but it is not necessarily limited to such cases."

81 In my view this passage applies with even greater force where the tribunal decides to reject most of the expert evidence and adopt the minority view. The present case is a graphic illustration. Here, there were ranged against Dr Williams several other highly qualified doctors who had written apparently well-reasoned reports. All of these other doctors said that H should not be discharged, although they expressed differing views as to

whether he should remain at Ashworth or be transferred to an MSU. Even Dr Williams advised in his report that H should be made subject to a supervision application under section 25A, saying that "supervised discharge is the most appropriate step forward for his own health and safety and for the protection of others". Such an application can only be made in respect of a patient who is liable to be detained in a hospital for treatment. It was only at the hearing, when he realised that the RMO would not make a supervision application, that he stated unequivocally that H should be discharged from liability to detention. There was, therefore, powerful, if not overwhelming, expert evidence against discharge. If the tribunal decided to reject all of that evidence it was obliged to give cogent reasons for doing so. It is to be supposed that, before deciding to reject the evidence of the experts who opposed discharge, it carefully considered each report as well as the oral evidence given by Dr Croy. In his first witness statement, Mr Simms says that the tribunal did not find Dr Croy to be an "impressive witness". As regards the reports of the other doctors, he says that it carefully considered the report of Dr Heads, but he makes no reference to its consideration of the reports of the other doctors, and, as has already been seen, there is no reference in the written reasons to any of the doctors (apart from Dr Williams). The reasons given for deciding to accept the evidence of Dr Williams in preference to that of the other experts were wholly inadequate. The other doctors were aware of the four points that seem to have impressed the tribunal (see paragraph 19 above), and yet advised as they did. In view of (a) the number of doctors who disagreed with Dr Williams, including the two independent doctors instructed on behalf of H, (b) the fact that previous attempts to discharge H into the community had failed, and (c) the fact that he had not experienced life in the community for a number of years, the tribunal was required to explain carefully why it felt able to reject the opinions of the other doctors.

82 My second reason is that I do not accept Mr Walker's submission that the tribunal was not required to give any reasons for not adjourning in order to see whether suitable after-care arrangements, or not making an order for discharge at a deferred date. As I explained at paragraph 67, the question of what after-care services will be available in the community is relevant to the issue of whether the statutory criteria are met. That was certainly the case here. Mr Walker does not suggest otherwise. In my view the judge was right to say that the tribunal took a step in the dark. And yet, it gave no reasons for doing so. Ms Ariola's report was sufficient to put it on notice that the local authority might be unable or unwilling to provide after-care services to H. In my view the judge was right to hold that the reasons given by the tribunal were inadequate.

Two procedural points

83 Towards the end of his judgment Stanley Burnton J made the following comments:

> "85. In *R v South West Thames Mental Health Review Tribunal, Ex p Demetri* (unreported) 2 July 1997 Kay J, at para 53 of his judgment, stated that in the circumstances of that case the tribunal was under a duty to draw to the attention of the legal representative of the applicant that the unavailability for cross-examination of one of the doctors materially

affected the weight that the tribunal proposed to give to his evidence, so as to give the legal rep of the applicant an opportunity to ask for an adjournment so that the doctor could be called. In my judgment, the tribunal in the present case were under a similar duty if they proposed (as they did) to reject the evidence of the several doctors whose recent written reports were before them and who were of the opinion that H should not be discharged. Particularly given the preponderance of that opinion in the written reports, it was inappropriate for the tribunal to determine the issues before them as if the only significant evidence was the oral evidence, and in any event without giving the hospital and the local authority the option of calling Dr Heads or Dr Lomax (neither of whom, incidentally, could be said to be other than independent of Ashford), provided that could be done without undue delay.

"86. Secondly, it appears from Mr Lloyd's note that at no stage of the hearing before the tribunal announced their decision were the parties before the tribunal informed of the findings of Dr Cashman as a result of his interview with H. The parties should be given the opportunity to address and to comment on any significant findings of the medical member, both because fairness so requires and because they may have comments or evidence to put before the tribunal that may lead it to depart from the provisional opinion formed by the medical member. That this should be the practice is supported by the guidance from regional chairmen of mental health review tribunals referred to at page 159 of the Leggatt Report on tribunals and in paragraph 57 of the judgment of Crane J in *R (H) v Mental Health Review Tribunal* (unreported) 15 September 2000."

84 Mr Walker criticises both comments. I cannot see anything objectionable in paragraph 86. It seems to me both fair and sensible that, if the medical member of the tribunal has formed any views on the basis of his or her interview with the patient, the substance of those views should be communicated to the patient and/or those who are representing him. I cannot think of any good reason why this should not be a requirement, although I would not wish to rule out the possibility of exceptional cases where such a course may not be practicable.

85 The comment in paragraph 85 does, however, concern me. I entirely agree that it would have been "inappropriate for the tribunal to determine the issues before [it] as if the only significant evidence was the oral evidence". But I do not accept that, as a matter of law, it was not open to the tribunal to accept the evidence of Dr Williams without allowing Ashworth and the local authority an adjournment to call some of the doctors who had made written reports. If a tribunal considers that the absence of doctors from a hearing is likely to affect materially the weight it feels able to give to the opinions expressed in their written reports, and if that is likely to be critical to its ultimate decision, then I would agree that fairness demands that the tribunal at least gives serious consideration to an adjournment to enable the doctors to give oral evidence which can be tested by cross-examination. But to go further, as the judge has done, is in my view to go too far. In the present case, although I have criticised the tribunal's decision and the quality of its reasoning, I would not criticise it for failing to invite an application to

adjourn so that Dr Heads or Dr Lomax or any of the other doctors could be called.

Conclusion

86 In the result, therefore, I would allow the appeal in relation to the decision to resection H on 29 March, but dismiss the appeal in relation to the tribunal's decision of 22 March.

87 In conclusion, I would echo the remarks of the judge in the coda to his judgment where he said:

> "I strongly endorse the recommendation of the Leggatt Report that there should be a second-tier tribunal to hear appeals from mental health review tribunals and their proposed successors. Mental health review tribunals make decisions as important as those of criminal courts, and it is unthinkable that there should not be a right of appeal from every criminal court."

88 The tribunal had to determine serious and difficult issues as to the mental health of H, and in particular as to whether his illness was of a nature or degree which made it appropriate for him to be liable to be detained in a hospital. Questions of the liberty of the subject and the safety of patients and the public are engaged in these cases. Everybody has an interest in ensuring that tribunals make good decisions. It is not satisfactory that the only means of challenge to these important decisions is by judicial review.

MUMMERY LJ

89 I have read in draft the judgments of Simon Brown and Dyson LJJ. Save for one short point, on which they differ, I would dismiss the appeal for the reasons given in their judgments.

90 The grant by a court of an interim stay of an order of a mental health review tribunal for the discharge of a patient would suspend its effect for the time being, pending a final decision on the lawfulness of that order at the substantive hearing of the judicial review application, or further order. The date for the discharge of the patient would accordingly be deferred while the interim stay is in force.

91 If the interim stay is granted before the order is implemented by the release of the patient into the community, the hospital authority would be entitled to refuse to release the patient, notwithstanding the order of the tribunal which is under challenge in judicial review or habeas corpus proceedings.

92 If the interim stay is granted after the patient has been released pursuant to the discharge order of the tribunal, the effect of the suspension of the order would be that, while the stay is in force, the patient could not rely on the order of the tribunal for his discharge in order to resist the exercise of compulsory powers under the 1983 Act, such as the power in section 18 to take into custody and to return to the hospital, which can be invoked where a patient, who is for the time being liable to be detained under Part I of the 1983 Act in a hospital, absents himself from the hospital without leave granted under section 17.

93 I agree with Simon Brown and Dyson LJJ that the judge giving permission for judicial review of the discharge order should only grant an interim stay if a strong prima facie case of irrationality (or other

A unlawfulness) is made out and that it should be for as short a time as possible (i e, days or weeks rather than months) pending an expedited substantive hearing.

94 I do not, however, agree with Simon Brown LJ that, if the patient has been discharged into the community before the matter could be brought before the court, the court should not, in the absence of any relevant change of circumstances, exercise its discretion to grant an interim stay. It is entitled B to grant an interim stay in an appropriate case with a view to the use by the hospital authority of available statutory powers to require the patient to return to and remain in the hospital. If, as I would hold for the reasons given by Simon Brown and Dyson LJJ, the court has power to grant an interim stay of an order and so suspend its legal effect for the time being, it should, in my judgment, be entitled to exercise that discretion in those circumstances in C which the court considers it just and convenient to do so for the purpose of enabling the hospital to secure the patient in hospital and thereby protect members of the public and the patient himself in those exceptional cases where cogent evidence is put before the court that there is a real and continuing risk of harm occurring if the patient does not immediately return to and remain in hospital. On this point I agree with the judgment of D Dyson LJ.

95 In a proper case such an order of the court is compatible with the rule of law and with article 5(1)(e) of the Convention, while at the same time preserving, in the interests of the public and of the patient, the position as it was at the time of the tribunal's order, pending a final decision of the court on the lawfulness of the order to discharge the patient from the hospital in which he was being lawfully detained and treated.

E

SIMON BROWN LJ

96 Many thousands of mental health review tribunal ("MHRT") hearings take place every year. Each is contested—many hotly so: the reason for most is because the patient is seeking, and his responsible medical officer ("RMO") resisting, discharge. It is the MHRT's task to balance the patient's right to liberty against the public's right to be protected from the mentally F disordered. The final decision on risk (danger) is its. (The risk, of course, includes that to the patient's own safety.)

97 Like all tribunals, the MHRT will on occasion make mistakes. Even more often, of course, it will reach decisions which one side or the other regards as mistaken. The most critical single question raised by this case (and the only issue I propose to touch upon) is what should happen when the G MHRT orders the patient's discharge and the hospital authority (an expression I use to include the approved social worker ("ASW"), all relevant doctors and the management) regards the decision as not merely mistaken but irrational—so plainly mistaken that as a matter of law it should not stand.

98 That MHRT decisions are amenable to judicial review is not in doubt. What is in doubt, however, is the action that can be taken prior to a H court order quashing the impugned decision.

99 Stanley Burnton J below, in a judgment which, right or wrong, admirably covered a lot of ground, reached two central conclusions upon the point: (i) "except possibly in the most exceptional cases, the court has no power to grant effective interim relief in a case in which judicial review is

sought of the decision of a [MHRT] to direct the immediate discharge of a patient"; (ii) in such a case, providing only the "hospital is advised, on substantial grounds, that the decision is unlawful and that either proceedings for judicial review have been commenced or . . . are imminent", the patient can be resectioned (a term I use compendiously to encompass any section 5(2) report, the making of recommendations by two registered medical practitioners for the patient's admission under section 3, the ASW's application under section 13, and the hospital manager's acceptance of such an application).

100 Mr Walker for H challenges both those conclusions. There is, he submits, power in the court, at the same time as it grants permission to move for judicial review, to stay the discharge order. (No longer does he suggest, I think, any useful role in this context for the court's injunctive powers.) He submits too that, unless and until the MHRT's decision is quashed, the hospital should take no further steps to resection the patient. Rather, if the decision is stayed, the hospital will continue to have all such powers of control and treatment as it had prior to the discharge order.

101 The last year or two has seen a great spate of decisions with regard to mental patients detained under the 1983 Act. Much the most important for present purposes is this court's decision in *R (Von Brandenburg) v East London and The City Mental Health NHS Trust* [2002] QB 235. True, as the judge below pointed out, there was no challenge in *Brandenburg* to the lawfulness of the tribunal's decision. The court was, however, concerned there with the resectioning of a patient, just six days after a discharge order, to prevent the order, deferred for seven days for accommodation to be obtained and a care plan concluded, taking effect. Giving the leading judgment, Lord Phillips of Worth Matravers MR (with whom Buxton LJ agreed) said, at pp 252–253:

> "30. The nature of mental illness is such that the severity of the symptoms and the need for treatment will often fluctuate over time. A sequence of discharge, readmission, discharge and readmission is not uncommon. Normally a sensible period is likely to elapse between discharge and readmission . . . the application for readmission is likely to be triggered by behaviour of the patient that is, at least in part, a reaction to life in the community. This will almost certainly constitute a change of circumstances when compared with the patient's reaction to the hospital regime that was prevailing when the tribunal discharged the patient . . .
>
> "31. The position is very different where an application for readmission is made within days of the tribunal's decision to discharge, which carries the necessary implication that the criteria for admission are not present—the more so if the patient has remained under the hospital regime because discharge has been deferred, so that there has been no change in the patient's environmental circumstances. In such a situation there is likely to have been . . . a difference of view between the patient's [RMO] and the tribunal as to whether or not the criteria justifying detention were established. Under the statutory scheme, where such a conflict exists, it is the opinion of the tribunal that is to prevail.

A "32. In such circumstances I do not see how an approved social worker can properly be satisfied, as required by section 13, that 'an application ought to be made' unless aware of circumstances not known to the tribunal which invalidate the decision of the tribunal. In the absence of such circumstances an application by the approved social worker should, on an application for judicial review, be held unlawful on the ground of irrationality . . .

B "35. . . . I do not consider that the statutory scheme leaves it open to professionals effectively to overrule a decision to discharge taken by a tribunal. The tribunal has sufficient of the attributes to satisfy the requirements of article 5(4) and there is no incompatibility between the sections of the Act that provide for compulsory admission of a patient to hospital and article 5(1) of the Convention."

C

102 The effect of that decision seems to me plain enough and, if I may respectfully say so, unsurprising: where there is a difference of opinion between the MHRT and the hospital authority, the tribunal's view must prevail; the authority cannot simply overrule the discharge order. Court orders must be respected—the rule of law is the imperative here.

103 No doubt there will be cases when, relatively shortly after a
D discharge order which the hospital authority in any event thinks to have been unwise, some change of circumstances occurs or the hospital authority becomes "aware of circumstances not known to the tribunal": *Von Brandenburg*, p 252, para 32. In such a case the hospital authority must be astute to ensure that it is not unfairly relying on such fresh circumstances to override what it perceives to have been a mistaken decision. The concept of
E change of circumstances is, as Mr Knafler for the ASW here submitted, a somewhat slippery one. That I recognise. In such cases, however, the touchstone question must surely be this: can the hospital authority conscientiously suppose that, had the tribunal itself been aware of the fresh circumstances, it would have reached a different conclusion and not ordered the patient's discharge?

104 I have difficulty, however, in regarding the present case as falling
F within that category. No one suggests any relevant change of circumstance here. This case from first to last has been recognised as one where the hospital authority regarded the MHRT's decision as irrational and believed it wrong to give it effect. That it acted with the utmost good faith and in what it conceived (and, indeed, was advised) to be the wider public interest and the proper discharge of its own public duties I have not the least doubt.
G For my part, however, I believe that it—and the judge below—were mistaken as to their powers.

105 In my judgment the tribunal's decision, whatever it may be, must be given effect unless and until the reviewing court orders otherwise. If, as here, the tribunal makes an order for immediate discharge, then the patient must duly *be* discharged unless he expressly agrees not to be. The hospital authority for its part, if it regards the discharge order as irrational and
H believes it necessary in the public interest to seek to avert its consequences (rather than await confirmation of its view by a relevant change of circumstance), should instigate judicial review proceedings without delay. If its application can be got before the court (on however short notice to the patient) before the patient actually leaves hospital (either because the

discharge order is deferred or because the patient has voluntarily remained in hospital), then I for my part can see no objection to the court granting, as an adjunct to permission for the challenge, a short stay of the discharge order so as to prevent the patient's release until the substantive challenge can be heard. If, as is common ground, a discharge order (whether or not immediate and whether or not it has actually been implemented) can be quashed, then for the life of me I can see no jurisdictional bar to the court preserving the status quo by granting an interim stay until the substantive hearing. In principle the position is no different from when this court retrospectively stays, say, a possession order, or a judgment for the delivery up of goods or the payment of money, although obviously the court will pause longer before imposing a stay whose effect is to curtail a person's liberty. Because, moreover, a stay would deprive the patient of his liberty without the court at that stage being able to reach a final view on the legality or otherwise of the discharge order, it should be granted (a) only if a strong prima facie case of irrationality is made out (and not, for example, merely because the tribunal's reasoning looks inadequate), and (b) for as short a time as possible. (If a stay is granted, the proceedings become, to my mind, no less urgent than a habeas corpus application and should accordingly be able to be heard within days, if not hours.)

106 If, before the matter can be brought before the court, the patient has already been discharged, then, absent any relevant change of circumstances, I for my part would not think it right for the judge granting permission to make any order with a view to the patient's forcible return to hospital. A stay preserving the status quo is one thing; an order akin to an injunction quite another. Nor, by the same token, would it be appropriate for the hospital authority to regard the grant of permission to move for judicial review as a change of circumstances sufficient to start resectioning the patient. I would similarly rule out the possibility, suggested by Mr Walker, of combining an order for a stay and the operation of section 18 of the 1983 Act to secure the patient's return to hospital pending the final hearing of the challenge. Rather, once the patient has been released, everyone's efforts, to my mind, should be concentrated upon securing the speediest possible hearing of the substantive challenge. Only if that were to succeed would it, in my judgment, be right to return the patient to hospital—and even then only if it were clear on up-to-date evidence that the patient (notwithstanding no misbehaviour in the community such as to constitute a change of circumstances sufficient in any event to justify resectioning him) remains dangerous to the extent that it was irrational to have ordered his discharge in the first place.

107 For whatever reasons—unexplored below—the substantive challenge in the present case was not heard for some $6\frac{1}{2}$ months. By then, of course, it was largely academic, at any rate on the issue of rationality: after a delay of that length fresh considerations will almost inevitably be in play. It is to be hoped that, following the guidance contained in Dyson LJ's judgment, there will be few such cases in the future—and certainly few (if any) where, in the face of strong medical evidence and in the absence of any after-care arrangements, the MHRT nevertheless orders immediate discharge. If such cases do occur, however, the Administrative Court should ensure that they are heard with the utmost priority.

A 108 Subject only to what I have said in paragraph 106 above as to returning an already discharged patient to hospital by means of a stay, I agree with everything said in Dyson LJ's judgment, which I have now had the opportunity of reading.

Appeal allowed in relation to decisions of professionals and hospital authority but dismissed in relation to tribunal's decision.
B *Permission to appeal refused.*

22 October. The Appeal Committee of the House of Lords (Lord Bingham of Cornhill, Lord Steyn and Lord Hobhouse of Woodborough) allowed a petition by the hospital authority for permission to appeal.
C

Solicitors: Hogans, Rainhill; Morgan Cole, Cardiff; Legal Director, Sefton Metropolitan Borough Council, Southport; Legal Services Division, Hammersmith and Fulham London Borough Council and Capsticks.

B O A

D

E House of Lords

*Maronier *v* Larmer

2002 Dec 9 Lord Nicholls of Birkenhead, Lord Hutton and Lord Rodger of Earlsferry

F **PETITION** by the claimant for leave to appeal from the decision of the Court of Appeal [2002] EWCA Civ 774; [2002] 3 WLR 1060

Leave to appeal was refused.

G

H