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*Judgment: approved by the Court for handing down (subject to editorial corrections)**	*Delivered:* **07/09/2021**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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QUEEN'S BENCH DIVISION
(JUDICIAL REVIEW)

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IN THE MATTER OF AN APPLICATION FOR LEAVE TO APPLY FOR JUDICIAL REVIEW BY SM
(AS FATHER AND NEXT FRIEND OF RM)

AND IN THE MATTER OF A DECISION A REVIEW TRIBUNAL DATED 16 FEBRUARY 2021

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Mr David Heraghty (instructed by Higgins Hollywood Deazley, Solicitors) for the applicant
Mr Matthew Corkey (instructed by the Departmental Solicitor's Office) for the respondent
Mr Adian Sands (instructed by the Departmental Solicitor's Office) for the Department of Justice

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COLTON J

Introduction

[1] The applicant is SM, father and next friend of RM. RM suffers from a significant intellectual disability. He has a history of engagement with mental health services. He does not have the capacity to conduct legal proceedings on his own behalf. He was born in 1988. On 2 March 2018 he was sentenced for a series of offences including indecent assaults of females and males, gross indecencies with or towards a child, sexual assault of a child under 13 and threats to kill. He had previously been determined to be unfit to plead to the matters. Having been found to have committed the acts alleged the Crown Court imposed a hospital order subject to special restrictions and without limitation of time pursuant to Articles 44 and 47 of the Mental Health (Northern Ireland) Order 1986 ("the Order"). Pursuant to Article 46 of the Order he was admitted to and detained at Muckamore Abbey Hospital on or about 13 March 2018.

[2] On 16 January 2019 he made an application to a Review Tribunal appointed under Article 78 of the Order seeking his discharge from detention. There was delay in dealing with the matter involving adjournment of the application and various High Court applications. The matter was ultimately dealt with by a Review Tribunal on 16 February 2021. The Tribunal determined that RM ("the Patient") should remain subject to detention under the Order. It is that decision which is the subject matter of this judicial review application.

[3] The Tribunal consisted of a President, who is legally qualified, a medical member and a lay member. The Panel gave a written statement of reasons running to 49 paragraphs.

The Decision

[4] A consideration of the application requires careful scrutiny of the decision itself. In terms of structure the decision sets out the background to the application, the history of the adjournments and the history of the medical and expert evidence received by the Tribunal. The Statement of Reasons sets out all of the material received and records the exchanges with counsel who appeared for the patient and for the Department (Mr Heraghty and Mr Sands – who appeared in this application). The Tribunal sensibly encouraged the parties to come to a resolution but unfortunately this proved elusive. The key passages of the Statement of Reasons are from paragraphs 29 onwards which I propose to set out in full. The reference in the text to the "adjournment decision" refers to the decision of the Tribunal on 12 June 2020 to adjourn the case. References in the reasoning to RMO refer to the Responsible Medical Officer for the patient's treatment.

> *"29. As is noted in the adjournment decision RM was admitted to Muckamore Hospital on 13 March 2018 following a Hospital Order. RM had first been assessed by Learning Disability Services in January 1994. As noted in the RMO's report of 28 February 2019 there had been concerns about the fact that RM lacked any sense of danger and was acting with aggression. In 1997 his verbal IQ was assessed to be 54, his performance IQ to be 60 and his full scale IQ to be 53. These results are in keeping with severe impairment of his intelligence. RM's history evidences severe impairment of social functioning associated with abnormally aggressive and seriously irresponsible conduct. In 2008 he was charged with arson endangering life and with possessing a knife in a public place. In October of that year he was urgently seen at hospital on two occasions after episodes of self-harm. He was admitted to Muckamore Hospital for assessment and remained there until January 2009. In 2010 there were concerns about RM using cannabis and drinking heavily. The report notes RM's*

disengagement from mental health services and non-compliance with medication when in the community.

30. The Tribunal noted that RM has remained a patient in Muckamore Hospital since his admission following the Hospital Order. There has been no change in his mental state. The evidence of all Forensic Psychiatrists who have submitted reports in this case agree that RM is suffering from severe mental impairment as defined in the Order.

31. The Tribunal is satisfied that RM is suffering from a severe mental impairment as defined in the Order.

32. The Tribunal then went on to consider whether RM's severe mental impairment is of a nature or degree which warrants his detention in hospital for medical treatment.

33. The adjournment decision records the positive progress of RM since his detention. It noted his need for structured boundaries and, at an earlier point in his time in hospital, the significant inputs he required from trained and skilled medical nursing staff. The adjournment decision notes the positive impact of intensive psychological and psychotherapeutic interventions and refers to the Forensic Psychology Reports which clearly outlined the progress RM had made.

34. The adjournment decision also records that Dr Milliken:

> *'gave his very clear opinion that RM's severe mental impairment was no longer of a nature or degree which required his detention in hospital for medical treatment. He was of the view that the accommodation now identified at K was suitable and appropriate. He indicated the staff there had the specialist training, expertise and knowledge required to manage and safely maintain someone like RM. He said that the recently submitted risk management and care plan outlined the high level of supervision which RM would receive at K. He was of the view that this level of supervision was required. He said that the clinical team agreed that the risks which RM presented were now manageable outside the hospital environment.'*

35. In the adjournment decision the evidence of Ms Keating is also noted. It is recorded that Ms Keating gave evidence that RM did not require detention in hospital for medical treatment.

He had completed the appropriate psychological interventions. She believed that the risks which RM presented could be safely managed in supported accommodation such as that provided by K. Ms Keating had referred the Tribunal to the Armadillo Assessment which indicated thatRM's dynamic risk was low to moderate. She had agreed that the risk he posed was still significant. She said that there would always be a risk but confirmed that, given RM's genuine and positive progress, she did not think that he required detention in hospital. She was of the view that the treatment required for offence focussed risk reduction work had been successfully completed and that, if any further treatment was required, it could and should take place in a community setting. She confirmed that she envisioned that this treatment would be in the form of ongoing check-ins using assessment tools such as DRAMS and Armadillo. Ms Maloney had confirmed that her view was in accordance with that of Dr Milliken and Ms Keating.

36. Dr Milliken in his reports has given his opinion that RM's severe mental impairment was no longer of a nature or degree which required his detention in hospital for medical treatment. He was of the view that the accommodation identified at K was suitable and appropriate. He had been of the view that the staff at K had the specialist training, expertise and knowledge required to manage and safely maintain someone like RM although he maintained that this could only be achieved through a view high level of supervision which would have amounted to a deprivation of liberty.

37. The evidence presented to the Tribunal for the hearing by Dr Devine both in his report and orally differs in a very significant way from that of Dr Milliken. Dr Devine is of the opinion that RM is at a stage in his treatment where he should be allowed to leave the hospital with the approval of the department on Art 15 Leave. It is his view that Art 15 Leave is an important part of the treatment plan and allows for medical support and rehabilitation of a patient. He told the Tribunal that this represented 'a significant amount of medical supervision and treatment.' Dr Devine in his evidence outlined that treatment under Art 15 would allow testing of the care plan and allow RM to put into practice the skills that he had learned in a setting outside hospital and to build upon those skills. He said that a lot of personnel would be involved in assessing RM's care needs and ongoing risk assessment and in providing regular refresher psychological reports. His role as RMO would be to have oversight of all of that. Dr Devine submitted that the Art 15 Leave would allow rigorous testing

out of a care plan and allow a support plan and risk management plan to be fully developed and adapted to meet RM's needs. He said that he hoped that RM could quickly move to a less supervised condition under Art 15 and by the end of six months be in a position where his case could be referred to RT with a recommendation for a conditional discharge. It was the evidence of Dr Devine that uncertainty remained as to how RM would cope with the change in his daily life which a move to living in K would entail. Dr Devine when questioned about the view of Dr Milliken told the Tribunal that he felt that Dr Milliken had been mistaken in his opinion and that he had failed to take account of the medical supervision which RM would require in any move out of hospital. He said that, in his opinion, Art 15 Leave could have been started some time ago. Dr Devine clarified that under Art 15 Leave the RMO would direct what conditions are to be applied to a patient but that such leave was subject to departmental approval. The Tribunal noted that Dr Devine agreed, as reported in Dr East's report, that initially the conditions which would be applied to RM would be more restrictive than those currently imposed on him in hospital. Dr Devine pointed out that this would be the case so as to safely manage RM's transition from hospital to the community setting of K. It had been agreed that, subject to the outcome of the RT proceedings, and given the present Covid-19 restrictions, RM would move under Art 15 Leave to live on a full-time basis in K. Dr Devine explained that his oversight as RMO would take place while RM was living full-time in K.

38. Ms Keating's reports outlined the progress RM had made and in her evidence, she confirmed there had been some testing out of RM through unsupervised time and visits with his father. In her report Ms Keating noted at paragraph (v) that RM had availed of four Art 15 approved leaves to K in February/March 2020 and that there had been further in-reach by K staff after the Covid-19 restrictions had eased in September 2020. The Tribunal noted that leaves had been limited and had been impacted by Covid-19 restrictions. Ms Keating in her reports and in her evidence was clear that it was time for RM to progress out of hospital and that he had completed all psychological work which had to be undertaken in hospital. She agreed that the care plan had not yet been fully mapped out and that a short period of Art 15 Leave followed by a conditional discharge would be an effective way forward.

39. It is evident through his evidence to the Tribunal Dr East explained that he had been asked by the Trust to

complete a report since Dr Milliken was not in a position to do so. He had completed that report but the Trust had decided not to rely on it and had then instructed Dr Devine. Dr East's report indicated that RM 'with the right care plan can be safely managed in the community.' Dr East told the Tribunal that he 'agreed 100% with Dr Devine.' He said that Art 15 Leave was medical treatment and was a necessary, safe and appropriate way to manage this case. He said that his report had not gone into such detail and that Dr Devine in his report had had the opportunity to develop detail.

40. In submission Mr Sands referred the Tribunal to the case of ***R(CS) v Mental Health Review Tribunal [2004] EWHC (Admin) 2598****. In that case at para 46 it is noted that 'in the closing stages of treatment in hospital her (the RMO's) grasp on the claimant was gossamer thin, but to view that grasp as insignificant is, in my view, to misunderstand the evidence.'*

41. The Tribunal recognised that Dr Milliken has been RM's RMO for a long time and knew him very well. However, the Tribunal finds that the evidence of Dr Devine and Dr East is more persuasive in relation to the question of whether RM's severe mental impairment is of a nature or degree which warrants his detention in hospital for medical treatment. The Tribunal is satisfied that RM is at a stage in his treatment when it is appropriate for him to be tested in the community. However, it is clear to the Tribunal, on the evidence, that treatment will have to continue in the form described by Dr Devine and that it should be continued whilst RM is still subject to detention until such time as he does not require detention in hospital for medical treatment. The Tribunal accepts the evidence of Dr Devine and Dr East that the oversight, care and risk management as described by Dr Devine does amount to treatment. Part II of the Order defines medical treatment as including nursing, and care and training under medical supervision. From the evidence it is (sic) seems that K does not, at this stage, provide such treatment as is required by RM. The evidence was the staff at K required further training and experience of RM in order to develop an understanding of the warning signs of a deterioration of RM's emotional well-being, indicators of low self-esteem and poor coping and a resistance to working within agreements – all of which had been noted in Ms Keating's report as indicators of RM being on a risk pathway to re-offending."

[5] The Tribunal went on to consider whether or not the patient's discharge created a substantial likelihood of physical harm to himself or others. Given their

findings that the patient could be lawfully detained in hospital for medical treatment it was not strictly necessary to do so given that this question only falls to be considered when it has been decided the Trust has not satisfied the Tribunal that detention in hospital is warranted. In any event the Tribunal set out its reasoning and findings in this regard at paragraphs 42-48 and concluded that it was satisfied that the risk posed by the patient would create a substantial likelihood of serious physical harm to others.

[6] The Tribunal concluded its reasoning as follows:

> *"49. The Tribunal has also taken full account of RM's rights under Human Rights legislation and his right to life, his right to liberty and to respect for his private and family life. The Tribunal recognises that detention in hospital amounts to an infringement of a patient's right to liberty and to respect for his private and family life. However, having regard to all the evidence, the Tribunal is satisfied that any such interference in this case is in accordance with the law, is necessary and is proportionate."*

The Applicant's Case

[7] Although the history of this case has been prolonged and complex the issue for this court to determine is relatively straightforward. It is the applicant's case that the Tribunal has made an error of law in applying the test under Article 78 of the Order in considering whether the patient should be discharged. Article 78 provides:

> "**Power to discharge restricted patients subject to restriction orders**
>
> *78.—(1) Where an application to the Review Tribunal is made by a restricted patient who is subject to a restriction order, … the tribunal shall direct the absolute discharge of the patient if—*
>
> *(a) the tribunal is not satisfied as mentioned in paragraph (1)(a) or (b) of Article 77; and*
>
> *(b) the tribunal is satisfied that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment.*
>
> *(2) Where in the case of any such patient as is mentioned in paragraph (1)—*
>
> *(a) sub-paragraph (a) of that paragraph applies; but*

(b) sub-paragraph (b) of that paragraph does not apply,

the tribunal shall direct the conditional discharge of the patient.

(3) …"

[8] This provision must be read in conjunction with Article 77, which provides:

"**Power to discharge patients other than restricted patients**

77.—(1) Where application is made to the Review Tribunal by or in respect of a patient who is liable to be detained under this Order, the tribunal may in any case direct that the patient be discharged, and shall so direct if—

(a) … the tribunal is not satisfied that he is then suffering from mental illness or severe mental impairment or from either of those forms of mental disorder of a nature or degree which warrants his detention in hospital for medical treatment; or

…

(b) the tribunal is not satisfied that his discharge would create a substantial likelihood of serious physical harm to himself or to other persons; or

…

(5) Paragraph (1) shall not apply in the case of a restricted patient except as provided in Articles 78 and 79."

[9] Pursuant to Article 2(2) of the Order the term 'medical treatment' is defined as follows:

"…

'medical treatment' includes nursing, and also includes care and training under medical supervision."

[10] It will be seen that the Review Tribunal shall direct the discharge of the patient if it is not satisfied that he is then suffering from mental illness or severe mental impairment or from either of those forms of mental disorder of a nature or degree which warrants his detention in hospital for medical treatment (subject to Article 77(1)(b)).

[11] If the Tribunal is not so satisfied the next issue is to consider whether the patient should be discharged absolutely or conditionally and this depends on

whether or not the Tribunal is satisfied that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment.

[12] It is the applicant's case that the evidence heard by the Review Tribunal established that the patient was to be moved out of hospital and to be placed in a residential facility pursuant to Article 15 of the Order.

[13] If one examines the summary of the evidence provided in the Statement of Reasons at paragraph 37 the applicant says that it is clear that this plan would not involve medical treatment taking place in hospital.

[14] It is therefore argued that as a matter of law and in accordance with the clear provisions of the Order, the patient in this case should have been discharged unless a significant component of his medical treatment is being administered or to take place within a hospital or equivalent health care authority.

[15] Since no such treatment is envisaged and considered necessary in the patient's case then pursuant to Article 78 he must be discharged from hospital (subject to Article 77(1)(b)) and the only remaining issue is whether the discharge is on an absolute or conditional basis. Mr Heraghty characterises the question for the court in the following way. Can detention in a hospital for medical treatment be said to be taking place when:

(a) the patient is not in hospital;

(b) he is on extended Article 15 leave;

(c) medical treatment within the meaning of Article 2 of the Order is taking place at a location other than a hospital; and

(d) when no medical treatment of any kind is taking place at a hospital, nor is same envisaged at any time in the future.

[16] At the time the Tribunal considered the matter the patient was still receiving treatment in hospital at Muckamore.

[17] The Tribunal accepted the evidence it heard from Dr Devine and Dr East that the patient had reached the stage in his treatment when it would be appropriate for him to be tested in the community. This would be achieved by permitting the patient to leave the hospital under the provisions of Article 15 of the Order. Article 15 provides:

> "**Leave of absence from hospital**
>
> *15.—(1) The responsible medical officer may grant to any patient who is for the time being liable to be detained in a*

hospital under this Part leave to be absent from the hospital subject to such conditions, if any, as that officer considers necessary in the interests of the patient or for the protection of other persons.

(2) Leave of absence may be granted to a patient under this Article either on specified occasions or for any specified period; and where leave is so granted for a specified period, that period may be extended by further leave granted in the absence of the patient.

(3) Where it appears to the responsible medical officer that it is necessary to do so in the interests of the patient or for the protection of other persons, he may, upon granting leave of absence under this Article, direct that the patient remain in custody during his absence; and where leave of absence is so granted the patient may be kept in the custody of any officer of the responsible authority, or of any other person authorised in writing by that authority.

(4) Where leave of absence is granted to a patient under this Article or where a period of leave is extended by further leave and the leave or the extension is for a period of more than 28 days, it shall be the duty of the responsible authority to inform RQIA within 14 days of the granting of leave or of the extension, as the case may be, of the address at which the patient is residing and, on the return of the patient, to notify RQIA thereof within 14 days.

(5) Where –

(a) a patient is absent from a hospital in pursuance of leave of absence granted under this Article; and

(b) it appears to the responsible medical officer that it is necessary to do so in the interests of the patient's health or safety or for the protection of other persons or because the patient is not receiving proper care;

that officer may, subject to paragraph (6), by notice in writing given to the patient or to the person for the time being in charge of the patient, revoke the leave of absence and recall the patient to the hospital.

(6) A patient to whom leave of absence is granted under this Article shall not be recalled under paragraph (5) after he has ceased to be liable to be detained under this Part."

[18] The issue of what is meant by warrants detention in hospital for medical treatment in this context has been considered by the courts in England and Wales under similar mental health provisions. In its decision the Tribunal referred to the case of In *R (On the application of CS) v Mental Health Review Tribunal and managers of Homerton Hospital* [2004] EWHC 2958 (Admin). In that case *CS* was applying for discharge at a time when she was on extended leave from hospital (section 17 leave which is equivalent to Art 15 leave). The key passages of the judgment are at paragraphs 41-44:

> *"[41] What, then, was the treatment in hospital? It comprised ward rounds with the claimant which it was planned would take place once every four weeks. Dr Sanders explained their significance in her second witness statement:*
>
> > *'... the ward round reviews attended by CS consisted of discussions with her about how her leave was progressing, how her medication was suiting her and whether any adjustments were necessary to the dose of her medication. In addition they included supportive and motivational interviewing to help CS to move out of the hospital-based model of care to community-based care under the AOS. This included support with her compliance with medication including achieving insight into the role of medication as an important part of her package of treatment. The treating teams experienced some difficulty getting CS to engage in care, hence her referral to AOS, and efforts to encourage her to continue to engage are still an important part of her care plan. Also in the ward rounds, we would agree the care plan for the next period of leave and negotiate the length of the next period of leave. On the basis of the suitable agreement I would authorise the next section 17 leave.'*
>
> *[42] It included, in addition, weekly sessions with the ward psychologist, Dr Chippendall; and it included, upon the submission of Miss Stern, the continued provision of a place of refuge and stability, a reference point for CS in her attempts to disengage with treatment in the hospital and engagement with treatment in the community.*
>
> *[43] To see the treatment plan in context Miss Stern invited me to consider what happened next. RMO responsibility was handed over to Dr Cross on 12th March 2004, as a result of an*

agreement between himself and Dr Sanders that CS's mental state and compliance with medication was stable enough for her care to be delivered in the community. This was seen as a progression of the care plan and was in preparation for her care to continue on an informal basis. CS was in fact discharged on 27th April 2004. Dr Cross has continued to monitor her medication and has recently reduced it to help reduce side-effects and aid compliance. CS is in contact with AOS between once and twice per week."

The conclusion of the court was set out in the following paragraph:

"[44] Viewed as a whole the course of treatment should be seen, it is submitted, as a continuing responsive programme, during which the need for treatment in hospital and on leave was being constantly reassessed depending upon the circumstances, including CS's responses to AOS and the ward round. Until such time as the transition was complete, the element of treatment at hospital remained a significant part of the whole. I am not convinced that the mere existence of the hospital and its capacity to be treated by the patient as a refuge and stability is part of the treatment of the patient at that hospital. Otherwise, I accept the submissions made by Miss Stern in this context."

The court went on to say at paragraph [46]:

"I consider Mr Simblet's characterisation of the treatment in hospital as too crude an analysis. It is clear to me that the RMO was engaged in a delicate balancing exercise by which she was, with as light a touch as she could, encouraging progress to discharge. Her purpose was to break the persistent historical cycle of admission, serious relapse and readmission. It may be that in the closing stages of the treatment in hospital her grasp on the claimant was gossamer thin, but to view that grasp as insignificant is, in my view, to misunderstand the evidence. I accept the submission of Miss Stern based upon the following passage from Dr Sanders' evidence:

> *'It is not appropriate to abruptly discharge a patient who has been subject to compulsory admission and treatment as an in-patient for a number of months. I would strongly disagree with an assertion that it is better for a patient to be discharged straight into the community without adequate phasing of care and then re-sectioned if the patient suffers a relapse. Such a statement shows little insight into modern*

means of engaging and treating patients with severe mental illness. With the rest of her multi-disciplinary treating team, I have worked hard with CS to engage her in thinking about her own illness in a way that allows her to accept medical treatment. To allow CS's section to lapse or bring it to an abrupt end only to re-section her would greatly upset CS and damage the relationship between her and the clinical team. It would also mean that mental health services were only able to engage once CS has suffered a significant deterioration. CS has a very distressing illness when it is in its acute phase and we have attempted to help her to avoid acute exacerbations of her illness. Bringing her back from leave at the earliest sign of deterioration has avoided a significant descent into her severest symptoms and has led to limited rather than prolonged periods spent on the ward before further leave could be granted.'"

The court rejected the applicant's claim of a breach of Article 5 under the European Convention of Human Rights (ECHR).

[19] The court in **CS** referred to the decision of Wilson J in *R (On the Application of DR) v Mersey Care NHS Trust* [2002] EWHC 1810. In that case the applicant challenged the decision to renew authority for her detention under the mental health provisions in England and Wales. The issue in the case related to the treatment plan for her adopted by the Trust which provided for very extensive leave of absence from the hospital which it intended to continue to grant to her under the provisions of section 17 (equivalent to Art 15). Her treatment plan envisaged that she would attend for occupational therapy at the hospital between 9am and 5pm each Friday and that she would attend a ward round at the hospital each Monday morning so that the multi-disciplinary team could monitor her progress, seek to engage with her and review her plan. Subject to that she continued to have leave of absence from the hospital. A community psychiatric nurse would visit her home every fortnight and members of an outreach team would visit her home each Tuesday and Thursday.

[20] The court in *CS* accepted and adopted the analysis of Wilson J in relation to DR's treatment which was as follows:

"[30] The question therefore, in my judgment, is whether a significant component of the plan for the claimant was for treatment in hospital. It is worth noting that by section 145(1) of the Act the words 'medical treatment' include rehabilitation under medical supervision. There is no doubt, therefore, that the proposed leave of absence for the claimant is properly regarded as part of our treatment plan. As para 20.1 of the

> *Code of Practice states 'leave of absence can be an important part of a patient's treatment plan.' Its purpose was to preserve the claimant's links with the community; to reduce the stress caused by hospital surroundings which she found particularly uncongenial; and to build a platform of trust between her and her clinicians upon which dialogue might be constructed and insight on her part into her illness engendered. Equally, however, the requirement to attend hospital on Fridays between 9am and 5pm and on Monday mornings was also in my judgment a significant component of the plan. The role of occupational therapy as part of the treatment of mental illness needs no explanation. But the attendance at hospital on a Monday morning seems to me to be likely to have been even more important. Such was to be the occasion of the attempted dialogue; for monitoring; for assessment and for review. In the Barking case both Lord Woolf at 114E and Thorpe LJ at 118B stressed the importance of the arrangements for weekly monitoring and assessment in the hospital."*

[21] In the case of *AL v Somerset Partnership NHS Foundation Trust* [2011] UKUT 233 (AAC) the Upper Tribunal dealt with a case in which the patient was living at home and receiving regular depot injections for schizophrenia. In that case the patient was on extended leave under section 17. He lived at home with his wife and daughter and attended his local community mental health treatment base fortnightly for medication and to see his key worker.

[22] The Upper Tribunal upheld the decision of the First Tier Tribunal that there was an element of hospital treatment in the patient's ongoing care plan. There was an analysis of whether or not the location at which she received the treatment was in fact "a hospital" however the court was clearly influenced by the fact that the patient's responsible clinician remained the responsible clinician based at the hospital where he had previously been actually detained. The key worker or community mental health nurse who the applicant saw each fortnight was not acting "in isolation" but in conjunction with the responsible clinician. The court determined it was therefore accurate to regard the appellant as receiving "out-patient" treatment and therefore hospital treatment as the First Tier Tribunal determined. The court relied on the decision in *DR* that reviews may be part of a patient's 'medical treatment.'

[23] In *R v Barking Havering and Brentwood Community Health Care Trust ex parte B* [1999] 1 FLR 106 the Court of Appeal in England and Wales dealt with a patient challenging the decision by the hospital not to discharge her although by then she had been granted leave to stay away from hospital seven days a week to be reviewed weekly. The proceedings were brought by way of applications for habeas corpus and judicial review. The court dismissed her appeal and held that the requirement that a patient had to return to hospital to be monitored and was liable to be recalled

and from time to time subjected to the discipline of being treated in hospital as an in-patient under direct supervision, with urinalysis and other tests being administered was an essential part of treatment as defined by the relevant act. The fact that that assessment of itself could not amount to treatment under section 3 of the Act did not mean that assessment could not be a legitimate part of a treatment package under sections 3 and 30. Furthermore, the appellant's presence at hospital at weekly intervals was an essential part of that treatment which could only be provided if she continued to be detained. The court dismissed the patient's appeal and held that the hospital had acted lawfully.

[24] Finally, in terms of reported decisions Mr Heraghty referred me to the case of *R(On the Application of Epsom and St Helier NHS Trust v Mental Health Review Tribunal* [2001] EWHC 101 (Admin) in which the Trust brought a challenge against the decision to discharge a patient. As the position was that the patient was on leave of absence to a nursing home, was not receiving any in-patient medical treatment and there was no hospital treatment in sight, the Tribunal's decision to discharge her was held to be lawful.

[25] In his judgment Sullivan J indicated that the matter should be looked at in the round and that regarding the decision as a whole he concluded the Tribunal did perform its function and had regard to relevant factors. The decision attached particular significance to the fact that there has been no in-patient treatment in hospital throughout the period of liability to detention, and the reality was that the patient was being, and had been, receiving the care and treatment that she needed in a nursing home.

Consideration

[26] In determining this matter the court is conscious that this is a challenge to a specialist tribunal which has expertise dealing with the issues raised and includes a lawyer, a medical expert and a lay member. It is an expert tribunal charged with administering a complex area of law in challenging circumstances. That said, the court is dealing with the liberty of the patient and in those circumstances the overall reasoning of the panel requires proper, careful and anxious scrutiny.

[27] It is clear from the reasoning of the panel that it identified the appropriate legal test and referred to the relevant case law.

[28] Notwithstanding the complexity of the case the issue for this court is relatively straightforward. Mr Heraghty in his able and succinct submissions contends that, as a matter of law, the respondent Tribunal was not entitled to conclude that the test for detention was met because under the relevant care plan medical treatment would not be administered in a hospital or equivalent health care facility. It is clear from the authorities to which I have referred and from a proper analysis of the legislation that the courts have taken a broad approach as to what is meant by medical treatment "in hospital." Whilst Mr Heraghty accepts that, in the

words of Pitchford J, the hospital's grasp may be "gossamer thin" he submits that in this case there is simply no evidence that the patient warrants such treatment. He contrasts the circumstances of this case with the cases which have been considered by the court in that in all those cases the patient was required to attend the hospital albeit on a limited basis. The only case in which no hospital attendance was required (*the Epsom and St Helier NHS Trust case*) discharge was held to be lawful.

[29] This case, as in all such cases, must turn on the facts as lawfully found by the Tribunal. The key passage in this regard is paragraph 41. The Tribunal was satisfied that the patient was at a stage in his treatment when it was appropriate for him to be tested in the community. However, in the course of such testing the patient will continue to require medical treatment as described by Dr Devine, the RMO, in his evidence and with which Dr East agreed. He will require nursing and care under medical supervision. The staff at K to which it is proposed the patient will be released will require training for this purpose. He will remain under the care of Dr Devine who will continue to have oversight of his care. At all times he remains liable to be returned to hospital. In this case it is anticipated that medical treatment will be provided to the patient in a controlled, restricted environment as part of a "responsive programme" of the kind envisaged by Pitchford J in *CS*.

[30] The RMO is based in the hospital environment. There is a warranted and necessary link with the hospital, the RMO and the patient's treatment. From the contents of paragraph 37 of the reasoning it will be seen that Article 15 leave would form part of the treatment plan put in place by the RMO. That leave would allow for medical support of the applicant supervised by the RMO and would allow for the testing in the community of the care plan that was in place. There would be ongoing assessment of the patient. Whilst there would be an element of uncertainty as to how the patient would cope with a move to K there would be continued involvement with a multi-disciplinary team of clinicians who would continue to supervise and support the applicant during the Article 15 leave. Dr Devine described the care plan as involving 'a significant amount of medical supervision and treatment' and that he would have 'oversight' over all of that.

[31] In the circumstances described the court concludes that the Tribunal was entitled to conclude that the patient's severe and mental impairment warranted detention in hospital. The fact that the proposed future treatment will not take place physically in the hospital, i.e. Muckamore, is not determinative of the issue. The hospital's "grasp" may be slight, but remains significant.

[32] Having regard to the medical evidence in this case as analysed above the court concludes that the Tribunal has correctly applied the relevant law and has reached a rational and lawful conclusion.

[33] The applicant's submissions were focused on an alleged fundamental and serious error of law. The Order 53 Statement also alleged a breach of the applicant's rights under Article 5 of the ECHR. However, in light of the analysis set out above

the applicant has not established a breach of Article 5. He has been lawfully deprived of his liberty pursuant to a lawful sentence of the courts and a lawful review carried out by the Tribunal in accordance with the relevant statute. The interference with his liberty is in accordance with the law and is necessary and proportionate in light of the findings of the Tribunal, which have withstood the scrutiny of this court.

[34] This matter was dealt with as a "rolled-up" hearing in view of the previous history of delay. The court concludes that in a contested hearing leave would have been granted but dismisses the application for the reasons set out above.