Cambridgeshire and Peterborough NHS Foundation Trust

MENTAL HEALTH ACT 1983

APPLICATIONS TO THE FIRST TIER TRIBUNAL (PART 6 OF THE MHA) POLICY AND PROCEDURES

Author:	Mental Health Law Manager
Sponsor/Executive:	Medical Director
Responsible committee:	Quality, Safety and Governance Committee
Ratified by:	Quality, Safety and Governance Committee
Consultation & Approval: (Committee/Groups which signed off the policy, including date)	Mental Health Law Operational Group Meeting 21.03.18
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Version:	V1.1
Policy Number:	MHA37
Purpose of the Policy:	Provide guidance and information to staff and patients about the First Tier MHA Tribunals Service and ensure that practitioners enable patients to fulfill their right of appeal against their detention. Clarify the legislation and guidance in respect of preparation and participation in the overall appeal process as it affects both Responsible Clinicians and those giving evidence in respect of the patient's social circumstances.
If developed in partnership with another agency, ratification details of the relevant agency	Original policy was developed in consultation with all relevant CPFT Directorates and the First Tier MHA Tribunal Service regulations.
Policy in-line with national guidelines:	MHA 1983 MHA CoP 2015 HRA 1998 MCA 2005 Tribunals Judiciary's Practice Direction 2013

Signed on behalf of the Trust: ……

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Version Control Sheet

Version	Date	Author	Comments
1.0	March 2015	Orna Clark Mental Health Manager	The policy was written to supplement the already existing Managers Hearings Standard Operating Procedures, Hearing Conduct and relevant documentation.
1.1	March 2018	Orna Clark Mental Health Manager	Minor changes) Change in role titles, Meeting Titles. Link to the new Mental Health Tribunal Report Templates. Appendix 6 – Letter from First Tier Tribunal Service re Enforcement procedure, directions and summonses.

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1. INTRODUCTION

1.1 The Tribunal is an independent judicial body. Its main purpose is to review the cases of detained, conditionally discharged, and Community Treatment Orders (CTOs) patients under the Mental Health Act and to direct the discharge of any patients where it thinks it appropriate. It also considers applications for discharge from guardianship.

1.2 The Tribunal provides a significant safeguard for patients who have had their liberty curtailed under the Mental Health Act. Those staff giving evidence at hearings should do what they can to help enable Tribunal hearings to be conducted in a professional manner, which includes having regard to the patient's wishes and feelings and ensuring that the patient feels as comfortable with the proceedings as possible.

1.3 Care should be given to ensuring all information provided for a Tribunal is as up to date as possible to avoid adjournment. All information must be clear and concise.

1.4 This procedure must be read in conjunction with the MHA Code of Practice (CoP) 2015, in particular; Chapter 1 – the Guiding Principles, Chapter 3 - Human rights, equality and health inequalities and Chapter 12 ' The Tribunal'. The CoP provides statutory guidance to registered medical practitioners, approved clinicians, managers and staff of providers, and approved mental health professionals on how they should carry out functions under the MHA in practice. It is statutory guidance for registered medical practitioners and other professionals in relation to the medical treatment of patients suffering from mental disorder.

1.5 Staff must ensure that they are familiar with its contents and should reason and record any deviation in practice from the guidance outlined in the CoP in the patient's RiO clinical records.

1.6 **The five Guiding Principles** - It is essential that all those undertaking functions under the Act understand the five sets of overarching principles, which should always be considered when making decisions in relation to care, support or treatment provided under the Act. This chapter provides an explanation of the overarching principles and stresses that they should be considered when making decisions under the Act. Although all are of equal importance the weight given to each principle in reaching a particular decision will depend on context and the nature of the decision being made.

1.6.1 The five overarching principles are:

- **Least restrictive option and maximising** independence - Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.

- **Empowerment and involvement -** Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken, which are contradictory to views expressed, professionals should explain the reasons for this.

- **Respect and dignity** - Patients, their families and carers should be treated with respect and dignity and listened to by professionals.

- **Purpose and effectiveness** - Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.

- **Efficiency and equity** - Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

2. PURPOSE AND SCOPE

2.1 The First Tier Tribunal (Mental Health) policy and guidance is written to provide information about Tribunals and ensure practitioners enable patients to fulfill their right of appeal against their detention.

Appendix 1 to the policy/guidance details when patients can appeal and there is a section in the main body of the policy/guidance on how to challenge the decision of a Tribunal within the legislative powers available.

2.2 The policy also clarifies legislation and guidance in respect of preparation and participation in the overall appeal process as it affects both Responsible Clinicians and those giving evidence in respect of the patient's social circumstances. Detailed guidance is provided in Appendice3 on how reports should be written and presented.

3. DUTIES AND RESPONSIBILITIES

3.1 **The Trust Board** has a duty to ensure patients are able to appropriately exercise their right of appeal under Part V of the Mental Health Act 1983. As Responsible Authority the Trust must ensure reports for Tribunals are produced in a timely and satisfactory manner and appropriate clinicians attend the Tribunal hearing.

3.2 **Medical Director** - The Medical Director is the accountable director for Mental Health Legislation within the Trust and has the responsibility of ensuring that the Trust has adequate and robust policies and procedures - in order to ensure compliance with the legal requirements of the Act and support staff in their delegated responsibilities. The Medical Director chairs the MHA Legislation (operational) meeting.

3.3 Clinical Directors and General Managers

Are responsible for the implementation of this policy into practice within their Directorates and service areas and taking action should any aspects of this policy were to breach.

3.4 Service Managers and Associate Clinical Directors

Have a delegated responsibility for ensuring that this policy is known to all staff and that its requirements are followed by all staff within their directorate/department

3.5 **Service Managers and Ward/Team Managers** - Responsible for bringing to the attention of their staff the publication of this document, providing evidence that the document has been cascaded within their team, or department, ensuring this document is effectively implemented, ensuring that staff have the knowledge and skills to implement the policy and provide training where gaps are identified.

3.6 **Ward and Team nursing and medical staff** - Responsible for adherence to this policy, ensuring any training required is attended and kept up to date, ensure any competencies required are maintained, co-operating with the development and implementation of policies as part of their normal duties and responsibilities, identifying the need for a change in policy as a result of becoming aware of changes in practice/statutory requirements/revised professional or clinical standards and local/national directives, and advising their line manager accordingly. Identifying training needs in respect of policies.

3.7 **Responsible Clinicians (RCs)** - To prepare reports for the Tribunal Hearings and to attend to present them and make the case for continued detention/use of CTOs.

3.8 Approved Mental Health Professionals (AMHPs)/Care Co-ordinators

To prepare ‘social circumstances’ reports for MHA Managers Hearings and to attend to present them as necessary.

3.9 **Named Nurses** - To act as escort for patients detained in hospital at MHA Tribunal Hearings . To prepare ‘nursing reports’ and present them as necessary.

3.10 **Locality MHA Administrators/MHA Clerks**- To co-ordinate the administration of the MHA Tribunal Hearings, arrange automatic referrals for patients, in accordance with the legal requirements outlined in the Act and MHA CoP. Liaise with the Tribunal Office to set a date for the hearing, communicate dates and coordinate the submission of the reports. Book staff to attend the Tribunal hearings. Advise staff on issues relating to the administration of the MHA Tribunals process and to raise concerns relating to the Tribunal functions with the Mental Health Legislation Manager.

3.11 **Mental Health Law Manager** - To support the process of the MHA Tribunal functions through advice to all involved. Provide feedback and report performance to the Mental Health Law Policy & Practice and the Quality, Safety and Governance Committee. To produce regular reports covering the Tribunal functions, including the outcome. The number of Hearings, the rate and reason for discharges, adjournments, deferrals etc.

4. EXPLANATIONS OF TERMS USED

RC – Responsible Clinician

NR - Nearest Relative – As defined in section 26 of the MHA '83

Tribunal – The First Tier Tribunal to which patients appeal against their detention, CTO or guardianship

Primary In-patient Nurse / Care Coordinator - The patient's named Nurse/Allied Health Professional.

CTO – Community Treatment Order – An order under S.17A of the Mental Health Act, applicable to some patients previously detained under S3 or S37.

5. APPLICATION TO THE FIRST TIER TRIBUNAL

5.1 An application is made to the First Tier Tribunal either through the Trust's Mental Health Act Administrator, or the patient can appeal direct or through their solicitor (see Appendix 1 for who can appeal and when).

5.2 Staff in the Trust should make every effort to help the patient (either directly or via their advocate) understand their rights of appeal and should help them appeal against their detention. This might involve, where the time scales to appeal are tight, allowing the patient use of a Trust fax machine. The Trust will ensure throughout the Tribunal process all service users or patients, together with their relatives, or carers as appropriate, are able to fully understand the Tribunal process and this may necessitate the provision of information and communications in a language or format they can easily understand including the use of a professional interpreter or translator.

5.3 Section 67 of the Act permits the Secretary of State to refer a patient to the Tribunal. Usually this would be in exceptional circumstances; for example where a S2 patient has missed the 14-day deadline through no fault of their own, or where the S2 has been extended to displace the nearest relative. While we do

not have a duty to ask the Secretary of State to refer a patient to the Tribunal, consideration should be given by the patient's responsible clinician as to whether the Secretary of State should be asked to consider the circumstances of an individual's case. Mental Health Act Administrators should determine whether the responsible clinician thinks it appropriate to refer and ensure due process is followed if we wish to make the Secretary of State aware of the patient's circumstances. Guidance on the process is contained in Appendix 2.

6. SECTION 117 AFTER CARE

6.1 In line with the Trust's section 117 policy, patients detained under one of the relevant sections who are due to be heard by a First Tier Tribunal should have, as far as is possible, a section 117 Care Plan prepared for the Tribunal. The more likely it is that the Tribunal or Hearing will discharge the patient, the more detail that will be required within the care plan. It will help the process of providing written and oral evidence to the Tribunal, especially where the nature or degree of the patient's mental disorder is such that the provision of after-care would be feasible or likely to prove very difficult.

7. LEGAL REPRESENTATION

7.1 Where the patient intends to make an application to the First Tier Tribunal, the following must be considered:

7.2 There is a regularly updated list of solicitors approved by The Law Society as able to act for patients pertaining to their compulsion under the Mental Health Act 1983. A copy of this list is available on each ward, or from each Locality Mental Health Act Administration office.

7.3 The patient might ask staff to recommend a legal representative. In this situation, staff should ask the patient to choose from the list and should not recommend a particular legal representative.

7.4 If the patient refuses or is unable to choose a legal representative, then staff should refer the matter to the Mental Health Act Administration team who will choose one from the list, or arrange for the patient to be seen by an Independent Mental Health Advocate (IMHA)

7.5 All discussion and action should be documented in the patient's RiO notes.

7.6 Once the legal representative has been appointed, s/he will contact the ward to arrange a time to see the patient.

7.7 Where practicable, staff should arrange for a suitable room to be available, which is private, safe and which does not contain any confidential information.

7.8 On arrival the legal representative should show appropriate identification and make it known whom it is they are to see.

7.9 There may be occasions when legal representatives arrive at the ward without an appointment, i.e. if they are on site having seen a client and want to pass on some information to another client while in the vicinity. Where practicable, every effort should be made to accommodate this meeting.

7.10 Once the patient has instructed the legal representative, s/he must give written permission for the legal representative to view their medical case notes to help prepare the case. This should be sent, either by the solicitor or via the ward, to the MHA Administrator.

7.11 The Trust does not allow advertising in the form of posters or the distribution of business cards, other than those given to their client. This is to ensure that all patients see the full list of available legal representatives and make a free choice as to which representative they would like to contact.

7.12 Legal representatives should never be allowed to access areas where patient information is stored or displayed.

7.13 As in all other situations staff should never share information about patient's to anyone unless they have the authority to do so.

7.14 If a legal representative arrives on the ward or telephones to make an appointment to see a particular service user, staff should first check to see that the patient has, in fact, instructed the legal representative; it should never just be assumed. This may necessitate a request for the solicitor to show proof of their instruction, a call to the Mental Health Act Administrator, and/or asking the patient for confirmation.

7.15 Unsolicited visits or telephone calls are not permitted according to The Law Society Solicitor's Publicity Code 2001.

7.16 If there is any doubt regarding issues connected with a patient's legal representation, staff should seek advice from their manager and/or the Mental Health Act Administration office.

7.17 The Trust, though it will have witnesses appearing in a clinical and social care capacity, is not automatically represented at a Tribunal. Any witness intending to act as such must make this known to the Tribunal and Mental Health Act Administration prior to the commencement of the Hearing. If it felt that formal legal representation is required because of the complex nature of the case, the Medical Director should be informed as soon as possible. If appropriate, they will ensure a solicitor represents the Trust employee. This should happen via the MHA Administrator.

7.18 The Trust must ensure the patient fully understands the Tribunal procedure and process and, if necessary, should consider the use of a professional translator or interpreter to ensure this is the case.

8. **TRIBUNAL REPORTS - See Tribunal repots form templates** http://hmctsformfinder.justice.gov.uk/HMCTS/GetForms.do?court_forms_category=Mental%20Health%20Tribunal

8.1 It is the responsibility of the Responsible Clinician (RC), or whichever doctor provides the medical report, to ensure that the reports in respect of medical issues concerning the patient are of sufficient quality.

8.2 It is the responsibility of the Ward Manager to ensure that nursing reports are of sufficient quality.

8.3 It is the responsibility of the relevant team manager to ensure that social circumstances reports are of sufficient quality.

8.4 Appendix 4 provide an aide-memoir for practitioners, which will enable them to ensure they have addressed all relevant points and have presented their report in a structured way.

8.5 All reports must be signed and dated by the author.

8.6 As soon as the Mental Health Act Administrator is made aware of the application, requests will be made to the Responsible Clinician and relevant Team for reports. All report writers will be sent a report template relevant to the patient's detention status. The template must be followed.

8.7 There is a statutory responsibility on the Responsible Authority to provide the Tribunal with all relevant reports within the dictated time scale following the receipt of the tribunal's request for reports. The Tribunal office requires copies of the reports, which should be signed and dated. **Failure to do so has significant consequences. The Trust will receive a summons from the Tribunal Office. See appendix**

Upon receipt, the Mental Health Act Administration department will arrange for the copies to be made and sent to the Mental Health Review Tribunal office. Mindful of the tighter time scales, reports for patients detained on S.2 should be completed as soon as is practicable.

8.8 In the case of a restricted patient, it is essential that copies of all reports be sent directly from the Trust to the Ministry of Justice. The Mental Health Act Administrator will arrange for this to be done.

8.9 The Trust will be vulnerable to serious legal challenge where the statutory time scales as to the provision of reports are not met, particularly where the hearing is delayed or adjourned for late or non-receipt of reports.

8.10 Any document/report not for disclosure to the patient should be annotated clearly and a written explanation attached as to the reasons for requesting non-disclosure. A separate document, which can be shown to the patient, should be submitted. The Tribunal will consider carefully the request for non-disclosure and all the issues involved before deciding whether to override the wishes of the author of the report. The Tribunal will only agree to non-disclosure where there are compelling reasons to do so, and where they are convinced that 'disclosure would adversely affect the health or welfare of the patient or others'. All reports will however be made available to the patient's legal representative although he/she will be bound by any ruling of the Tribunal. Any information to the patient must be in a format which they can easily understand. This may involve translation into a different format.

8.11 Note that section 76 of the Mental Health Act authorises any registered medical practitioner (doctor) instructed by or on behalf of the patient, to visit the patient at any reasonable time, make an examination in private and inspect any records relating to the compulsion powers and treatment of that patient. Although not a legal requirement, prior to the visit, the independent doctor should have made contact with the Responsible Clinician and/or ward giving notice. If this does not happen, or other independent professionals have been asked to examine the patient, the Responsible Clinician should be notified immediately.

8.12 If the patient has recently been or is shortly to be transferred between wards, this information must be communicated to the Mental Health Act Administrator. The referring Responsible Clinician and ward must also inform the receiving Responsible Clinician and ward that the patient has made an application for appeal. If not already done so, a discussion must take place between the two Responsible Clinicians, and a decision made as to who will be providing the medical report and who will be attending the hearing itself. This must be communicated to the Mental Health Act Administrator.

9. SETTING THE DATE OF THE HEARING

9.1 On receiving an application from a patient, (other than an s2 application), the Tribunal Listing Team will identify several available dates for the Hearing. These will be 4 or 5 weeks ahead (12-14 weeks for restricted patients). One or two of these dates will be offered to our Mental Health Act Administration Team, and to the patient's Legal Representative, by telephone or e-mail, within 24 hours of receipt of the application. If these dates are not suitable, other dates can be negotiated.

9.2 The MHA Administrator and Legal Representative will be requested to respond to the Listing Team, setting out which of these dates would/would not be suitable hearing dates, within 48 hours of the initial telephone/ email request. Mental

Health Act Administrators will have confirmed the suitability of these dates with report writers prior to telephoning or e-mailing the Listing Team.

9.3 In light of these responses the Listing Team will list the case, and confirm the hearing date by telephone to Mental Health Act Administration and the Legal Representative/patient, with a follow-up confirmation letter. The whole listing process should therefore be completed within 72 hours of the initial application being received.

9.4 If the parties do not respond within this timescale, a hearing date will be imposed by the Listing Team, and all the parties informed accordingly.

9.5 Normally, once a date has been fixed it will not be changed by the Tribunal office. All applications to postpone the hearing/change the date must be forwarded to the Tribunal office in writing with reasons for making the request. If there are exceptional reasons, the Tribunal office will seek the consent of the Regional Chair to offer another date within target/statutory time scales.

9.6 An application can be withdrawn at any time by the patient/applicant subject to the Tribunal accepting the withdrawal. The request should be made in writing to the Tribunal office. Where the patient is represented he/she will be approached and encouraged to make contact with their client to discuss the request.

9.7 Where the patient is not represented the Regional Chair will be advised of the request, and will decide whether or not it should be accepted.

9.8 The Tribunal office will advise where a Tribunal has been cancelled, for whatever reason, but practitioners should never assume that the Tribunal hearing is cancelled without notification from the Tribunal office.

9.9 The Trust must ensure it makes any necessary adjustments, such as meeting any disability or sensory impairment needs, for those attending the Tribunal.

10 THE TRIBUNAL MEDICAL MEMBER

10.1 The Tribunal medical member has a statutory duty to examine the patient prior to the hearing and is entitled to see any patient notes as well as taking copies of them for the purposes of the application/reference.

10.2 The medical member will contact the ward to make arrangements to see the patient before the hearing, explaining to the nurse in charge who he or she is, the purpose of the visit, and time and date. It is important that the patient is told of the visit in advance and is present on the ward when the medical member visits. If the patient is on leave of absence the ward should make arrangements for the patient to return to the ward for the medical examination.

10.3 The Tribunal office should be informed immediately of the patient's discharge from section. If this happens outside office hours it is helpful if a nurse from the ward leaves a message on the Tribunal office's answering machine, particularly where a hearing is set for the following day.

10.4 Where a patient refuses to be examined by the medical member of the Tribunal, the medical member will inform the Tribunal office.

11. THE HEARING

11.1 The hearing is conducted in private unless the patient requests a public hearing and the Tribunal accepts the request. Generally, a Tribunal Clerk will be booked and present on the day of the hearing to assist the Tribunal panel.

11.2 The Tribunal will seek to avoid formality to help put the patient at ease. Normally the patient will be present throughout the hearing, unless one of the parties requests otherwise and the Tribunal agree and accept that the presence of the patient at a particular stage will adversely affect the patient's health or the welfare of the patient or others. The Tribunal has the power to exclude any person from the hearing or part of the hearing, subject to the provisions in Rule 38(4) of the First Tier Tribunal (Health, Education and Social Care) Rules 2008 (Part 4).

11.3 Rule 36 of the First Tier Tribunal (Health, Education and Social Care Chamber) Rules 2008 (Part 4) allows for any party to be represented (including the Responsible Authority). Careful consideration should be given in each case as to whether or not the Trust wishes to be represented, and the implications of being a representative for the individual concerned. Any authorised representative will be expected to stay for the entire hearing, and will have the same rights as the patient's representative to examine witnesses, including the patient, and to address the Tribunal Panel. The patient or their representative will however always be given the final word.

11.4 If required, the patient should be provided with an interpreter.

11.5 The Tribunal will expect to see the Responsible Clinician or a deputy who knows the patient and in the opinion of the Responsible Clinician has sufficient knowledge and experience of the patient and psychiatry to represent the responsible authority.

11.6 It is essential that an appropriate professional who knows the patient well attends the hearing to give further, up to date information about the patient, home circumstances and after-care facilities in the event of a decision to discharge. Failure by the hospital to ensure that the appropriate professionals attend the hearing, as above, will usually be treated by the Tribunal as a serious matter, possibly requiring an explanation by the Trust's Chief Executive Officer and potentially a subpoena for the absent party.

12. THE TRIBUNAL'S DECISION

12.1 Tribunals are encouraged to announce the decision immediately after the hearing. On occasions where the patient has gone back to the ward or their community setting, the decision may be conveyed to the solicitor who is expected to communicate this to their client the same day. It is important that where the patient is discharged that he or she and a representative of the hospital is also advised. A completed form 6 will be given to the MHA Administrator by the Tribunal judge. The Administrators will distribute to the patient and all professionals involved in the Hearing.

12.2 If the Tribunal makes statutory recommendations e.g. for transfer to another hospital, for leave of absence, the hospital is not legally obliged to follow them, but the tribunal can reconvene at a later stage to find out why their recommendations have not been followed, and rehear the matter as appropriate.

12.3 The Tribunal's decision must be communicated to the patient in a format which can be easily understood. This may involve the use of a professional translator or interpreter to ensure this is the case.

13. ADJOURNMENTS

13.1 A Tribunal has the power to adjourn a hearing. This may be for further information in the form of reports or for a witness to attend a reconvened hearing. Directions may be made as to when and how the information should be provided, and for the issuing of a subpoena if necessary. A Tribunal cannot adjourn to monitor a patient's progress.

13.2 If the Tribunal issues Directions, the Mental Health Act Administrators will be responsible for ensuring that the appropriate people are aware of their need to comply.

14. CHALLENGING THE DECISION OF A FIRST TIER TRIBUNAL

There are two formal means of challenging a Tribunal's decision:

a) Appeal by way of case stated

14.1 Section 78(8) of the Mental Health Act 1983 provides that a First Tier Tribunal may, and if so required by the High Court shall, state in the form of a special case for determination by the High Court any question of law which may arise before them.

14.2 The Tribunal may 'state a case' and seek determination by the High Court of its own volition, but may also be asked to state a case by one of the parties; the patient, the nearest relative, the responsible authority or the Secretary of State.

14.3 A written request must be made within 21 days of the Tribunal's decision being communicated. If the Tribunal refuses or fails to do so within 21 days, an application to the High Court for an order compelling the Tribunal to state a case must be made within the next 14 days.

14.4 Once the Tribunal has stated a case, an application for determination on the relevant point of law can be filed at the High Court, with notice being served on all the parties. The Court may determine that the Tribunal's interpretation of the law was wrong, and if so, it can give any direction that the Tribunal ought to have given, including possibly a direction for discharge.

b) Judicial Review

14.5 No application for judicial review will be considered by the High Court unless a High Court judge has first granted leave. To obtain leave, an application must be filed promptly and within three months of the decision to be challenged. Judicial review is not an appeal against the Tribunal's finding of facts.

14.6 The purpose of the proceedings is most usually to persuade the court to quash the Tribunal's decision on the grounds that it has acted unlawfully (made an error in interpreting/applying the law), irrationally (reached a decision that no reasonable Tribunal could possibly have reached), or improperly (failed to act in accordance with the rules of natural justice). If a decision is quashed, the court has the power to remit the case back to the Tribunal with a direction that it be reconsidered in accordance with the court's judgment.

14.7 In *R v Ashworth Hospital Authority and Others ex Parte H*, the Court of Appeal held that the Court had jurisdiction to stay the Tribunal's decision, but that such discretion should be used sparingly, and, wherever possible, the judicial review application should be determined "within days" of the stay. The court can grant the stay even after the decision of the tribunal has been implemented; so for instance if the Tribunal had directed the discharge of a patient and that patient had subsequently left the hospital premises, the stay can still be made and the patient therefore could be returned to hospital under the authority of section 18.

14.8 If a stay was not to be imposed, then, unless the Tribunal had been unaware of material circumstances indicating compulsion when making its discharge order, the Tribunal's view had to prevail unless and until quashed by a court.

14.9 Professionals seeking to 'resection' a patient before the court hearing would need to satisfy themselves that their sole or principal ground for resection was not one that the Tribunal had rejected in substance and it was in accordance with the House of Lords judgment in the *von Brandenburg* case, where it was held that for this to happen the AMHP in the case must have formed the reasonable and bona fide opinion that s/he now had information not known to the Tribunal which put a significantly different complexion on the case as compared with that which was before the tribunal.

14.10 Should any situation arise where consideration is being given to challenge the decision of a First Tier Tribunal, it should be discussed with a member of the Mental Health Act Administration team and ultimately with the Director of Nursing, who can instruct a solicitor where appropriate.

15. TRAINING REQUIREMENTS

15.1 Training will be provided for those required to produce reports for First-Tier Tribunals (Mental Health): Responsible Clinicians, Care Coordinators and Nurse Key Workers. Training needs will be assessed by line manager and provided by mentoring. The Mental Health Legislation Manager will continue to assess the over all training need and ensure that staff are training on the MHA Tribunal functions as part of the classroom based mandatory MHA Training.

16. MONITORING COMPLIANCE AND EFFECTIVENESS

Monitoring arrangements for compliance and effectiveness

16.1 The Trust will monitor issues arising from First Tier Tribunal activity via the Mental Health Legislation Group. Overall monitoring will be by the Quality, Safety and Governance Committee. As a sub-group, the Mental Health Legislation Group (chaired by the Medical Director) is accountable to the Committee and the Board.

Responsibilities for conducting the monitoring

16.2 The Chair of the Quality, Safety and Governance Committee will ensure feedback reports from the Mental Health Legislation Group are timetabled within the Committee's reporting schedule and present on appropriate agenda.

16.3 The Mental Health Legislation Group will monitor procedural compliance and effectiveness where they relate to First Tier Tribunals and feedback to the Committee.

Methodology to be used for monitoring

16.4 Regular discussions of the following will be recorded within the MH Legislation Group minutes/reports:

- complaints monitoring
- incident reporting and monitoring via DATIX
- new significant risks to be reported to the QSG Committee

16.5 Frequency of monitoring:

- Quarterly Quality Assurance Report to the Mental Health Legislation Group
- Quarterly Quality Assurance Report to the QSG Committee
- Quarterly Quality Assurance Report to the Trust's Commissioners
- Annual Report to all of the above.

16.6 Process for reviewing results and ensuring improvements in performance occur.

Issues arising will be discussed at the MHL Group who will identify good practice, any shortfalls, action points and lessons learnt. The outcome of the issues and any change in policy will be presented to the Divisional Senior Managers/ PREs who will be responsible for ensuring improvements, where necessary, are implemented.

17. EXTERNAL REFERENCES

- Jones R. 'Mental Health Act Manual – 19th Edition - Sweet & Maxwell 2017
- MHA '83 Code of Practice 2015
- Tribunal Office Guidance Documents
- Reference Guide to the Mental Health Act 2015

Appendix 1

APPLICATIONS TO MENTAL HEALTH TRIBUNAL SERVICE – PART II PATIENTS

Category of Admission or Circumstances	Maximum Duration	Application to TRIBUNAL SERVICE by Patient	Application to TRIBUNAL SERVICE by Nearest Relative	Automatic Reference by the Hospital Managers
Admission for assessment (s.2)	Up to 28 days	Once within first 14 days of admission	No	No (but see comments)
Admission for treatment (s.3)	Up to 6 months, renewable for 6 months and 12 months thereafter	Once within the first 6 months, once within second 6 months and once each 12 month period after	No	On renewal if the Tribunal Service have not considered case in first 6 months (including any time under section 2*). Also if the Tribunal Service has not considered case for 3 years (1 year if a child under 18) *Any Tribunal hearings that were taken during the S2 period are discounted when considering the 6 months period on S3)
Emergency Admission (s.4)	Up to 72 hours	No	No	No
Doctor's holding power (s.5(2))	Up to 72 hours	No	No	No
Guardianship (s.7)	Up to 6 months, renew for 6 months and then every 12 months	Once within the first 6 months, once within second 6 months and once each 12 month period after	No	No
Patient transferred from guardianship to hospital (s.19)	Remainder of original duration under guardianship then as section 3 above	Once within the initial period and once in each period thereafter	No	On renewal if the Tribunal Service have not considered case in first 6 months. Also if The Tribunal Service has not considered case for 3 years (1 year if child under 16)
Nearest relative barred from discharging patient (s.25)		No	s.2 – No s.3 within 28 days of report	No
Nearest Relative displaced by County Court (s.29)		No	Once within the first year following displacement and in each subsequent year	No
Patients subject to Community Treatment orders and liable to be recalled (S17A)	Up to 6 months, renewable for 6 months and 12 months thereafter	Once within the first 6 months, once within second 6 months and once each 12 month period thereafter. If the order is revoked, within the period of six months starting on the day the order is revoked.	No	If the order is revoked or on renewal if the Tribunal Service have not considered case in first 6 months(Including any time under section 2) Also if the Tribunal Service has not considered case for 3 years (1 year if child under 18)

Category of Admission or Circumstances	Maximum Duration	Application to TRIBUNAL SERVICE by Patient	Application to TRIBUNAL SERVICE by Nearest Relative	Automatic Reference by the Hospital Managers
Sections 35, 36, 38, 44	Various	No	No	No
Guardianship Order (ss. 7 & 8)	Up to 6 months, renewable for 6 months and 12 months thereafter	Once within the first 6 months, once within second 6 months and once each 12 month period thereafter.	Once within the first 6 months, once within second 6 months and once each 12 month period thereafter.	No
Hospital Order (s.37)	Up to 6 months, renewable for 6 months and 12 months thereafter	Once in second 6 months and once in each 12 month period thereafter	Once in second 6 months and once in each 12 month period thereafter	If the Tribunal Service have not considered case for 3 years (1 year if child under 16)
Hospital Order with Restriction Order (ss.37 & 41)	Usually without limit of time	Once after 6 months and once in each 12 month period thereafter	No	If the Tribunal Service have not considered case for 3 years (1 year if child under 16)
Conditionally Discharged Restricted Patient	Usually without limit of time	Once after 12 Months following discharge and once every 2 years thereafter	No	If the Tribunal Service have not considered case for 3 years (1 year if child under 16)
Conditionally Discharged Restricted Patient who has been recalled to hospital under s.42 (ss.37 & 41)	Usually without limit of time	Once after 6 months and once in each 12 month period thereafter	No	Home Secretary must refer to the Tribunal Service within 1 month of recall
Hospital Direction (s.45A)	Dependant on sentence	Once after 6 months and once in each 12 month period thereafter	No	If the Tribunal Service have not considered case for 3 years
Transfer from Prison to Hospital (ss.47 or 48)	Variable	Once within the first 6 months and once in each 12 month period thereafter	Once in second 6 months and once in each 12 month period thereafter	If the Tribunal Service have not considered case for 3 years
Transfer from Prison to Hospital with Restrictions (ss.47 or 48 with s.49)	Variable	Once within the first 6 months and once in each 12 month period thereafter	No	If the Tribunal Service have not considered case for 3 years

Category of Admission or Circumstances	Maximum Duration	Application to TRIBUNAL SERVICE by Patient	Application to TRIBUNAL SERVICE by Nearest Relative	Automatic Reference by the Hospital Managers
Patients remaining in hospital under s37 on expiration of Restriction Order	Up to 6 months, renewable for 6 months and 12 months thereafter	Once within the first 6 months, once within second 6 months and once each 12 month period thereafter	Once within the first 6 months, once within second 6 months and once each 12 month period thereafter.	If the Tribunal Service have not considered case for 3 years
Hospital Order under Criminal Procedure (Insanity) Act (s.5(1))	Up to 6 months renewable for 6 months and 12 months thereafter	Once within the first 6 months, once within second 6 months and once each 12 month period thereafter		If the Tribunal Service have not considered case for 3 years (1 year if child under 16)
Hospital Order with Restriction Order under Criminal Procedure (Insanity) Act (s.5(1))	Usually without limit of time	Once after 6 months and once in each 12 month period thereafter	No	If the Tribunal Service have not considered case for 3 years (1 year if child under 16)
Patients subject to Community Treatment Orders and liable to be recalled (s17A)	Up to 6 months renewable for 6 months and 12 months thereafter	Once within the first 6 months, once within second 6 months and once each 12 month period thereafter. If the order is revoked, within the period of six months starting on the day the order is revoked.	Once within the first 6 months, once within second 6 months and once each 12 month period thereafter. If the order is revoked, within the period of six months starting on the day the order is revoked.	If the order is revoked or if the Tribunal Service have not considered case for 3 years (1 year if child under 16)

The Secretary of State for Mental Health and the Secretary of State for the Home Office also have powers to make references to First Tier Tribunal under sections 67 and 71 of the Mental Health Act (1983)

Appendix 2

HM Courts & Tribunals Service

Jurisdictional Support Team (HESC)
HM Courts & Tribunals Service
Wellington House
134-136 Wellington Street
Glasgow
G2 2XL

T 0141 333 4111
E doug.easton2@justice.gov.uk

ww.gov.uk

06 September 2017

To: All Responsible Authorities and authors of reports

Subject: Mental Health Tribunal Report Templates

The Practice Direction made by the then Senior President of Tribunals, Sir Jeremy Sullivan, on 28 October 2013 specifies the content of the statements and reports that must be sent or delivered to the tribunal (and, in restricted cases, to the Secretary of State) by the Responsible Authority, the Responsible Clinician and any Social Supervisor (as the case may be).

We have now created these reports and statements as templates which can be found on the HMCTS form finder.

The form numbers of the templates are shown below.

T131 In-Patient: Responsible Clinician's report
T132 In-Patient: Statement of Information about the Patient
T133 In-Patient: Social Circumstances report
T134 In-Patient: Nursing report
T135 Social circumstances report: Supplementary information required for patients under the age of 18
T136 Community Patient: Responsible Clinician's report
T137 Community Patient: Statement of Information about the Patient
T138 Community Patient: Social Circumstances report
T139 Guardianship Patient: Responsible Clinician's report
T140 Guardianship Patient: Statement of information about the Patient
T141 Guardianship Patient: Social Circumstances report
T142 Conditionally discharged Patient: Responsible Clinician's report
T143 Conditionally discharged Patient: Social Circumstances report

Doug Easton
Jurisdictional Support Team (HESC)

http://hmctsformfinder.justice.gov.uk/HMCTS/GetForms.do?court_forms_category=Mental%20Health%20Tribunal

Appendix 3

REFERENCES BY THE SECRETARY OF STATE FOR HEALTH TO THE FIRST-TIER TRIBUNAL

Under section 67, the Secretary of State for Health can refer the following patients to the Tribunal on any occasion when he considers it appropriate to do so:

- any patient detained in hospital as a result of an application for assessment or treatment under sections 2, 3 or 4 of the Act
- most patients detained in hospital by the courts or as a result of being transferred by the Secretary of State for Justice from prison – except those subject to special restrictions (restricted patients)
- any patient on supervised community treatment (community treatment orders) under the Act
- any patient subject to guardianship under the Act
- some patients who are detained under other legislation but who are treated as if they are subject to an unrestricted hospital or guardianship order under section 37 of the Act.

The Secretary of State for Justice considers requests under section 71 for references to the Tribunal in respect of restricted patients. The Tribunal does not deal with people who are remanded by the courts for report under section 35 or under section 36 for treatment, or who are on interim hospital orders under section 38.

Requests for references under section 67

Anyone may ask the Secretary of State for Health to make a reference for any reason at any time. In practice, requests are most commonly made in cases where:

- a patient detained under section 2 misses the 14-day deadline for applying to the Tribunal through no fault of their own and there is still time for a hearing to be arranged before the section 2 is due to expire;
- a patient's detention under section 2 has been extended pending resolution of proceedings under section 29 to displace their nearest relative (the Act does not give patients the right to apply directly to the Tribunal in these circumstances).

These examples do not preclude references being made under section 67 in other situations.

Requests for references under section 67 of the Act should be sent to the following address:

Department of Health
Mental Health Legislation
Area 224 Wellington House
133-155 Waterloo Road
London
SE1 8UG
Fax: 020 7972 4147
E-mail: mentalhealthact2007@dh.gsi.gov.uk

Information required to support the request

Your letter will need to set out clearly why a Secretary of State's reference under section 67 is being sought. You will need to fill in the relevant tribunal application form on the Tribunal website http://www.mhrt.org.uk/FormsGuidance/forms.htm

when requesting a s67 reference and attach it to your letter. Please do not sign or date the form. In addition to the information to be given in the form, please indicate in your letter the length of time the patient has been on the section of the Act.

The issues that the Secretary of State for Health will take into account when considering making a reference under section 67

The issues that the Secretary of State for Health will take into account include but are not limited to:

- the reason for the request;
- the length of time since the case was last considered by a Tribunal (if ever);
- the length of time it may be before an application may (or a reference must) be made under other sections of the Act; and
- whether any decision being sought falls within the remit of a Tribunal.

These are not, however, the only factors. Each case will be considered on its merits. The Secretary of State will not refer cases where the patient has already been discharged from their section.

If the Secretary of State makes a reference under section 67, he will ask the Tribunal Secretariat to make the necessary arrangements, and the person who made the request will be informed.

Applications for a Tribunal hearing by the patient and/or their nearest Relative

It is of course far more common for patients (and, in some instances, their nearest relatives) to make their own applications for a Tribunal hearing.

Wherever they can make an application, they should do so rather than seek a reference under section 67.

Appendix 4

Cambridgeshire & Peterborough NHS Foundation Trust

FIRST TIER MENTAL HEALTH TRIBUNAL PROCESS (V2)

Times when MH Admin automatically refers patient:

- After **six** months of detention if the patient has not applied (including time on section 2 and section 3 if a Community Treatment Order (CTO)
- Every 3 years if the patient has not applied from the date of the last tribunal (every year if On revocation of SCT or if under 18)
- If a CTO is revoked

Times when the patient and NR have the right to apply:

- Within 14 days of S2 commencing (patient only)
- Once in each period of S3 detention (patient only)
- Once in each period of S37 (starting from 2nd period) (patient and NR)
- Following displacement of NR (12 months) (NR)
- Following barring of discharge by NR (28 days) (NR)

If patient has requested Tribunal notify MH Admin who can provide MHRT form.

MH Admin will forward application to Tribunal office

Tribunal will request via MHA Admin:

1. Authority's statement (MHA Admin supply this from)
2. RC's report
3. Social circumstances report from the Care Co-ordinator
4. In-patient nursing report or an AHMP or care co-ordinator report for CTO patients

As per CoP guidance – Chapter 12.9
The Tribunal will expect to be provided with information on what after-care arrangements might be made for the patient under section 117 if they were to be discharged. Some discussion of after-care needs, involving LSSAs and other relevant agencies, should take place in advance of the hearing"

Reports must be printed on Trust headed paper, signed, dated and returned to the MHA Admin team by the <u>due date on the letter, which is stipulated by the MHRT</u>. Failure to submit the reports on time will result a formal complaint by the Tribunal to the Trust and the Hearing may be cancelled.

<u>Section2:</u> Tribunal is arranged to be held within 7days of receipt of application at Tribunal office 66(1) (a) and the date and time is imposed

<u>Section 3:</u> Tribunal is arranged to be held usually within 5-8 weeks of receipt of application at Tribunal.
<u>Restricted patients:</u> Tribunal is usually arranged to be held within 20 weeks of receipt of application
N.B.
<u>Recall:</u> Patient recalled from Conditional Discharge should have a tribunal within 5-8 weeks

Medical member of tribunal will examine patient before the hearing (this may be on the actual day of the tribunal)

Tribunal panel sits at the hospital to review the case.
The panel is comprised of a lawyer (or judge for restricted cases), a psychiatrist and a lay member. None have any connection with the hospital. Patient, patient's solicitor, RC, Care Co-ordinator, patient's nurse attend. Nearest relative and advocate may also attend.

The Tribunal panel will discharge the patient if they are not satisfied:

- That the patient is suffering mental disorder of a nature or degree which makes it appropriate for him to be liable to be detained in hospital for medical treatment
- That it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment
- That appropriate medical treatment is available for him

(see section 72 for variation for S2 patients & CTO patients)

Linked Policies:
Section 3
Section 2
CTO (SCT)
MHA Managers Hearings
First Tier Tribunal

After discussion, the decision of the tribunal will be announced verbally at the end of the hearing. The patient does not always stay to hear the decision, however, a representative of the hospital must always be present to hear the Tribunal outcome.
The written decision will be sent by the Tribunal to the MHA Admin team, who will immediately inform all parties concerned

Patient must be informed of their rights Reading of rights must be documented on **Form IP13**

Appendix 5

Tribunal Report Writing Standards

A. In-patients

A patient is an in-patient if at the time of the application or referral they are receiving in-patient treatment in hospital for mental disorder, even if it is being given informally or under an application, order or direction other than that to which the Tribunal application or reference relates. This includes patients detained for assessment or treatment under sections 2 or 3 of the Mental Health Act.

A patient is also an in-patient if they are detained in hospital through the criminal justice system, or if they have been transferred to hospital from a custodial establishment. This includes patients detained under a Hospital Order (section 37) or Direction - whether or not the patient is also a Restricted Patient (section 41) or subject to a Restriction or Limitation Direction.

In the case of a Restricted Patient detained in hospital, a Tribunal may be thinking about discharging a patient subject to a condition that the patient will remain liable to be recalled to hospital for further treatment, should it become necessary. Before it finally grants a Conditional Discharge, the Tribunal may defer its decision so that proper arrangements to its satisfaction can be put in place. Until the Tribunal finally grants a Conditional Discharge, the patient remains an in-patient, and so this 'inpatient' part of the guidance applies.

If the patient is detained in hospital as an in-patient, then the Responsible Authority must send the Tribunal a statement that contains or has attached:

1. Statement of Information about the Patient
2. Responsible Clinician's Report
3. In-patient Nursing Report (a copy of the patients current nursing plan12 must be appended to the report).
4. Social Circumstances Report

In all cases, except where a patient is detained under Section 2 of the Act, the Responsible Authority must send or deliver to the Tribunal the required documents, containing the specified information, so that the documents are received by the Tribunal as soon as is practicable and in any event within 3 weeks after the Responsible Authority made the reference or received a copy of the application or

reference. If the patient is a restricted patient the Responsible Authority must also at the same time, send copies of the documents to the Secretary of State. Where a patient is detained under Section 2 of the Act - the Responsible Authority must prepare the required documents as soon as practicable after the receipt of a copy of the application or a request from the Tribunal. It may be that some of the specified information will not be immediately available.

The Responsible Authority must balance the need for speed with the need to provide as much of the specified information as possible within the time available. If information is omitted because it is not available, then that should be mentioned in the relevant document. These documents must be made available to the Tribunal panel at least one hour ahead of the hearing.

1. <u>Statement of information about the patient</u>

The statement provided to the Tribunal must, in so far as it is within the knowledge of the Responsible Authority, include the following up-to-date information:

a. the patient's full name (and any alternative names used in his patient records);
b. the patient's date of birth, age and usual place of residence;
c. the patient's first language and, if it is not English, whether an interpreter is required, and if so in which language;
d. if the patient is deaf whether the patient will require the services of a British Sign Language interpreter, or a Relay Interpreter;
e. the date of admission or transfer of the patient to the hospital in which the patient is detained or liable to be detained, together with details of the application, order or direction that constitutes the original authority for the detention of the patient, including the Act of Parliament and the section of that Act by reference to which detention was authorised and details of any subsequent renewal of or change in the authority for detention;
f. details as applicable of the hospital at which the patient is detained;
g. details of any transfers between hospitals under section 19 or section 123 of the Mental Health Act since the original application, order or direction was made;
h. where the patient is detained in an independent hospital, details of any NHS body that funds, or will fund the placement;
i. where relevant, the name and address of the local social services authority and NHS body which would have the duty under section 117 of the Mental Health Act to provide after-care services for the patient, were the patient to leave hospital;
j. the name of the patient's Responsible Clinician and the period which the patient has spent under the care of that clinician;
k. the name of any Care Co-ordinator appointed for the patient;
l. except in the case of a restricted patient, the name and address of the patient's nearest relative or of the person exercising that function, and whether the patient

has requested that this person is not consulted or kept informed about their care or treatment, and if so, the detail of any such requests and whether the Responsible Authority believes that the patient has capacity to make such requests;
m. the name and address of any person who plays a significant part in the care of the patient but who is not professionally concerned with it;
n. the name and address of any deputy or attorney appointed under the Mental Capacity Act 2005;
o. details of any registered lasting power of attorney made by the patient that confers authority to make decisions about the patient, and the donee(s) appointed;
p. details of any existing advance decisions to refuse treatment for mental disorder made by the patient.

2. <u>Clinician's report</u>

This report must be up-to-date and specifically prepared for the Tribunal. Unless it is not reasonably practicable, the report should be written or counter-signed by the patient's Responsible Clinician and must describe the patient's relevant medical history and current presentation, including:

a. full details of the patient's mental state, behaviour and treatment for mental disorder;
b. so far as it is within the knowledge of the person writing the report, a statement as to whether, at a time when the patient was mentally disordered, the patient has ever neglected or harmed themselves, or has ever harmed other persons or threatened them with harm, together with details of any neglect, harm or threats of harm;
c. an assessment of the extent to which the patient or other persons would be likely to be at risk if the patient were to be discharged by the Tribunal, and how any such risks could best be managed;
d. an assessment of the patient's strengths and any other positive factors that the Tribunal should be aware of in deciding whether the patient should be discharged.
e. whether the patient has a learning disability that may adversely affect their understanding or ability to cope with the Tribunal hearing, and whether there are any approaches or adjustments that the panel may consider in order to deal with the case fairly and justly.

3. In-patient nursing report

This report must be up-to-date and specifically prepared for the Tribunal. In relation to the patient's current in-patient episode it should include full details of the following:

a. the patient's understanding of and willingness to accept the current treatment for mental disorder provided or offered;
b. the level of observation to which the patient is subject;
c. any occasions on which the patient has been secluded or restrained, including the reasons why seclusion or restraint was considered to be necessary;
d. any occasions on which the patient has been absent without leave whilst liable to be detained, or occasions when the patient has failed to return when required, after being granted leave of absence;
e. any incidents where the patient has harmed themselves or others, or has threatened other persons with violence.
f. A copy of the patient's current nursing plan must be appended to the report.

4. Social circumstances report

This report must be up-to-date and specifically prepared for the Tribunal. It should include full details of the following:

a. the patient's home and family circumstances, and housing facilities available;
b. so far as it is practicable, and except in restricted cases, a summary of the views of the patient's nearest relative, unless (having consulted the patient) the person compiling the report thinks it would be inappropriate to consult the nearest relative;
c. so far as it is practicable, the views of any person who plays a substantial part in the care of the patient but is not professionally concerned with it;
d. the views of the patient, including the patient's concerns hopes and beliefs in relation to the Tribunal proceedings and their outcome;
e. the opportunities for employment available to the patient;
f. what (if any) community support or after care is, or will be made available to the patient and its effectiveness, if the patient were to be discharged from hospital;
g. the patient's financial circumstances (including entitlement to benefits);
h. an assessment of the patient's strengths and any other positive factors that the Tribunal should be aware of in coming to a view on whether the patient should be discharged;
i. an assessment of the extent to which the patient or other persons would be likely to be at risk if the patient were to

C. Community Patients

A Community Patient is a patient who has previously been detained in hospital for treatment but who has been discharged from hospital on a Community Treatment Order. The patient is subject to a condition that they will remain liable to be recalled to hospital for further treatment, should it become necessary.

If the patient is a Community Patient, under Section 17a of the Act, then the Responsible Authority must send or deliver to the Tribunal the following documents, containing the specified information, so that the documents are received by the Tribunal as soon as practicable and in any event within 3 weeks after the Responsible Authority made the reference or received a copy of the application or reference:

1. Statement of Information about the Patient
2. Responsible Clinician's Report
3. Social Circumstances Report
1. Statement of Information about the Patient

The statement provided to the Tribunal must, in so far as it is within the knowledge of the Responsible Authority, include the following up-to-date information:

a. the patient's full name (and any alternative names used in his patient records);
b. the patient's date of birth, age and usual place of residence;
c. the patient's first language and, if it is not English, whether an interpreter is required, and if so in which language;
d. if the patient is deaf whether the patient will require the services of a British Sign Language interpreter, or a Relay Interpreter;
e. details of the place where the patient is living;
f. the name of any Care Co-ordinator appointed for the patient;
g. the name and address of any deputy or attorney appointed under the Mental Capacity Act 2005;
h. details of any registered lasting power of attorney made by the patient, and the donee(s) appointed;
i. details of any existing advance decisions to refuse treatment for mental disorder made by the patient.
j. the name of the patient's Responsible Clinician and the date when the patient came under the care of that clinician;

k. the name and address of the local social services authority and NHS body having a duty to provide after-care services for the patient under Section 117 of the Act;
l. the name and address of the patient's nearest relative or of the person exercising that function, and whether the patient has requested that this person is not to be consulted or kept informed about their care or treatment, and if so, the detail of any such requests and whether the Responsible Authority believes that the patient has capacity to make such requests.

2. Responsible Clinician's Report (CTO)

This report must be up-to-date and specifically prepared for the Tribunal. Unless it is not reasonably practicable, the report should be written or counter-signed by the patient's Responsible Clinician and must describe the patient's relevant medical history and current presentation, including:

a. where the case is a reference to the Tribunal, an assessment of the patient's capacity to decide whether or not to attend, or be represented at, a hearing of the reference;
b. whether the patient has a learning disability that may adversely affect their understanding or ability to cope with the Tribunal hearing, and whether there are any approaches or adjustments that the panel may consider in order to deal with the case fairly and justly;
c. detail of the date of, and circumstances leading up to, the patient's underlying section 3 order, and a brief account of when and why the patient came to be subject to a community treatment order.
d. full details of the patient's mental state, behaviour and treatment for mental disorder, and relevant medical history;
e. in so far as it is within the knowledge of the person writing the report, a statement as to whether at a time when the patient was mentally disordered, the patient has ever neglected or harmed themselves, or has ever harmed other persons or threatened them with harm, or damaged property or threatened to damage property, together with details of any neglect, harm or threats of harm;
f. an assessment of the extent to which the patient or other persons would be likely to be at risk if the patient were to be discharged by the Tribunal, and how any such risks could best be managed;

g. an assessment of the patient's strengths and any other positive factors that the Tribunal should be aware of in coming to a view on whether the patient should be discharged;
i. the reasons why the patient can be treated as a Community Patient without continued detention in hospital, and why it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) of the Mental Health Act to recall the patient to hospital;
h. details of any specific conditions in force regarding the patient under section 17B of the Mental Health Act.

3. <u>Social circumstances report (CTO)</u>

This report must be up-to-date and specifically prepared for the Tribunal. It should include full details of the following:
a. the patient's home and family circumstances, and the housing facilities available;
b. in so far as it is practicable a summary of the views of the patient's nearest relative, unless having consulted the patient the person compiling the report thinks it would be inappropriate to consult the nearest relative;
c. the views of any person who plays a significant part in the care of the patient but is not professionally concerned with it;
d. the views of the patient, including their concerns, hopes and beliefs in relation to the Tribunal;
e. the opportunities for employment, available to the patient;
f. what (if any) community support or after-care is being, or would be, made available to the patient, and the author's views as to it's likely effectiveness were the community treatment order to continue, or were it to be discharged;
g. details of the patient's financial circumstances (including entitlement to benefits);
h. an assessment of the patient's strengths and any other positive factors that the Tribunal should be aware of in coming to a view on whether the patient should be discharged;
i. an account of the patient's progress while a Community Patient, and any conditions or requirements to which the patient is subject under the Community Treatment Order, and details of any behaviour that has put them or others at risk of harm;
j. an assessment of the extent to which the patient or other persons would be likely to be at risk if the Tribunal were to discharge the Community Treatment Order.

<u>MORE INFORMATION AND GUIDANCE CAN BE FOUND IN THE ORIGINAL MHA FIRST TIER TRIBUNAL REPORT WRITING GUIDANCE BOOKLET.</u>

Appendix 6

FIRST-TIER TRIBUNAL HEALTH, EDUCATION & SOCIAL CARE CHAMBER (MENTAL HEALTH)

ENFORCEMENT PROCEDURE, DIRECTIONS AND SUMM0NSES

The Responsible Authority's duty to provide its written evidence within 3 weeks.

1. Except where the patient is detained for assessment under Section 2 Mental Health Act 1983, or is already subject to a Conditional Discharge, the Responsible Authority has a statutory duty to send or deliver the written evidence specified in the "Senior President's Practice Direction on the Contents of Statements and Reports in Mental Health Cases" to the tribunal office so that the documents are received by the tribunal within the period of 3 weeks after the Responsible Authority made the reference or received a copy of the application or reference.

2. Generally, the Responsible Authority will be the Hospital Managers. Thus, for an NHS hospital, this will be the relevant NHS Trust, and for a private hospital, this will be the managing or controlling company owning or running the hospital.

3. For patients who are already subject to a Conditional Discharge, it is the Responsible Clinician and any Social Supervisor named by the Secretary of State who must send or deliver the written evidence specified in the Senior President's Practice Direction to the tribunal office – again, within the period of 3 weeks after being notified by the tribunal of an application or reference being received in the tribunal office.

4. The full disclosure in writing (in advance of the hearing) of the Responsible Authority's evidence, or the evidence of the Responsible Clinician and Social Supervisor, is essential in the interests of fairness and natural justice, and the timely and prompt submission of this written evidence (including key information about the patient) is vital, not least because the freedom of patients subject to the Mental Health Act 1983 is involved in all tribunal cases, even if the patient is not currently detained in hospital.

5. For Section 2 patients, due to the importance of a speedy and effective hearing, the specified written evidence cannot usually be made available more than a short time in advance, but it must be made available in the tribunal hearing room, and to the patient's legal representative, at least one hour before the hearing is due to start.

6. The written evidence specified in the Senior President's Practice Direction depends upon the type of case. For detained patients, the written evidence comprises a Statement of Information about the Patient (formerly known as the "Part A Statement"), the Responsible Clinician's Report, a Nursing Report, and a Social Circumstances Report.

7. If the patient is not detained in hospital, the requirement for a Nursing Report is dispensed with, and if the patient is subject to a Conditional Discharge, the requirement for a Statement of Information is dispensed with.

8. Whether or not the patient is placed out of area, the Responsible Authority must ensure that all statements and reports, including the Social Circumstances report, contain all the information listed in the relevant part of the Senior President's Practice Direction.

9. The obligation to arrange for the writing and submission of the specified statements and reports, on time, lies with the Responsible Authority and their nominated statement and report-writers including the Responsible Clinician, Key Nurse, and Social Workers or Supervisor. It is totally unacceptable for social circumstances reports to be delayed or missing because of negotiations with the locality team about who will prepare the social circumstances report. The Responsible Authority may ask the locality team to prepare the report, but they cannot hand over the legal duty to provide it on time.

The Responsible Authority's duty to cooperate with the tribunal, and provide the full identity and secure contact details of its statement and report writers.

10. The Responsible Authority has a legal duty to cooperate with the tribunal. Where the tribunal advises the Responsible Authority that a case has been registered it also (amongst other things) asks the Responsible Authority to provide the personal secure contact details of its statement and report writers. A personal secure email address or a postal address is acceptable, but a non-secure email address is not acceptable because confidential patient details will always be included in any subsequent directions sent by the tribunal.

11. The tribunal directs the provision of this contact information so that, if a statement or a report is not submitted by the three-week deadline, it can promptly remind the person responsible for the document that their personal written evidence is urgently due, and (by Form MH5 sent personally to the named person in default) direct its immediate submission to the tribunal.

12. Most Responsible Authorities discharge their duties to the tribunal via their Mental Health Act Administrator (MHAA). Thus, except where the patient is subject to a Conditional Discharge, it usually falls to the Responsible Authority's MHAA to provide the Statement of Information about the Patient, and to identify the professionals who must provide the written and oral evidence on behalf of the Responsible Authority. The MHAA is expected to provide the names and secure contact details of the person who will prepare the Statement of Information about the Patient (usually the MHAA himself or herself), and of the report writers that the Responsible Authority has nominated to prepare the Responsible Authority's written evidence. This is because the Responsible Authority's MHAA will (or should) know the identity of the patient's Responsible Clinician, Key Nurse and Social Worker(s), and it is the Responsible Authority's MHAA that will ask for, or arrange for, the statement and reports to be prepared for the tribunal.

13. If, before the written evidence is submitted to the tribunal, the identity or personal secure contact details of the relevant witness changes, the Responsible Authority must immediately provide updated information to the tribunal.

14. If a direct secure email address cannot be provided for any named report or statement writer, a generic secure email address may be provided BUT the following undertaking must be given and complied with by the MHAA:

"If a generic email address is given above, I undertake that any directions or summonses addressed to the named report-writer and sent to that address WILL be forwarded direct to the named person within one working day, AND that proof of this will be retained and produced to the tribunal upon request."

15. Where it can, the tribunal will send notifications and directions to the relevant MHAA and to named report writers. However, due process cannot be defeated by a willful or negligent failure by the Responsible Authority, the MHAA or report-writers to provide the information and evidence that the tribunal needs, at the time that the tribunal needs it.

16. Ultimately, it is the Responsible Authority's Chief Executive that personifies and represents the Responsible Authority. So, if the MHAA or other professionals employed by or working with the Responsible Authority do not sufficiently cooperate with the tribunal in any case, or generally, then it is likely that directions and summonses will thereafter be sent to the Chief Executive personally, and the Chief Executive will then have a personal and enforceable duty to provide the evidence, and attend the hearing.

17. Unfortunately, some Responsible Authorities (or MHAAs) do not provide the tribunal with accurate identity and contact details, or they fail to keep the tribunal up to date if the details change. This is extremely unhelpful and prevents the tribunal taking any workable steps to enforce compliance with the law. It is also inconsistent with the legal duty on the parties to cooperate with the tribunal. If the tribunal is not provided with the information required as to the identity and contact details of statement and report-writers, it will send just one reminder (Form MH9) to the MHAA. Thereafter, if necessary, the tribunal will send directions and summonses to the Responsible Authority's Chief Executive.

18. Whether or not those responsible for giving the Responsible Authority's written evidence are identified by name with contact details provided, the tribunal expects that the statements and reports will be submitted by the legally required three-week deadline.

19. If need be, and if there are good grounds for doing so, an application to extend the threeweek deadline can be made to the tribunal and a judicial decision will be made as to whether (or not) to grant an extension. But the three-week deadline must not be ignored, and any extension granted must be adhered to without any additional delay.

The Responsible Authority's duty to arrange for the attendance of witnesses.

20. Once the Responsible Authority has provided its written evidence, as specified by law, the onus then falls upon the Responsible Authority, as a party to the proceedings, to ensure the attendance of such witnesses as it considers necessary to establish its case.

21. There is a convention and an expectation that all the report-writers will attend to give oral evidence. This is so that the report-writers can give the tribunal an update, and be questioned by or on behalf of the patient, and by the tribunal. Generally, there is no expectation that the MHAA will attend because the Statement of Information about the patient is likely to be factual, a matter of record, and uncontroversial. However, if the Statement of Information is not provided, the tribunal may have to formally direct a named MHAA to provide the Statement, and therefore the identity of the relevant MHAA is required. If the identity of the relevant MHAA is not provided, the tribunal will have to send any formal directions to the Responsible Authority's Chief Executive.

22. Despite the convention and expectation that the Responsible Authority will arrange for its report-writers to attend the tribunal hearing, the written evidence is ultimately the Responsible Authority's evidence, and it is for the Responsible Authority (and not the tribunal) to identify the required witnesses. It may also be necessary for a different professional to attend the hearing if the original report-writer is unavailable, and this is usually permissible to support the Responsible Authority's case so long as the alternative witness is suitable qualified and sufficiently aware of the patient's circumstances to substitute for the report-writer.

23. However, if the Responsible Authority is asked by the patient's legal representative to make a particular witness available at the hearing, then it should make arrangements to comply with the request, or advise the patient's legal representative why it will not, or cannot, do so.

The Legal Representative's Duties.

24. The patient is a party to the proceedings and, as in all legal cases before courts and tribunals, the parties' legal representatives must be prepared to take appropriate steps ahead of the hearing to obtain the written evidence and attendance of witnesses that they consider to be necessary, in order to properly prepare and present their client's case.

25. Consequently, in relation to the provision of evidence by the Responsible Authority, there is a clear duty on the patient's legal representative to chase up any missing written evidence directly with the Responsible Authority.

26. The tribunal considers that legal representatives cannot legitimately complain about a missing statement, report or witness if they have not taken all the necessary steps to ensure that the written evidence is made available to them in

advance of the hearing, and that any witness that they deem necessary will attend at the hearing.

27. If all efforts to engage directly with the Responsible Authority fail, the patient's legal representative may then ask the tribunal to issue directions or summonses. However, it will always be necessary for legal representatives to explain what efforts they have themselves made to secure compliance and the submission of the statements and reports.

28. Similarly, legal representatives cannot expect to be granted an adjournment at a hearing just because written evidence is missing, or because a witness has not attended, if they have not taken all necessary steps to obtain the evidence or secure the witness's attendance in advance of the hearing, or if they have failed apply for a postponement in good time, prior to the listed hearing, as soon as it became apparent that there was a problem that could not be resolved in time. Any request for a postponement (or to withdraw an application to the tribunal) must be made before 4.30pm on the working day before the hearing, otherwise it will be too late for it to be decided in the office, and the request will be left for the panel to decide after it has convened at the hearing venue.

What will the tribunal do to enforce compliance?

29. Although the tribunal has no duty laid down in the Act or the applicable procedure rules to chase-up the parties, it will generally try to take certain routine steps intended to advise and remind responsible professionals of their duties. However, these steps are inevitably standard procedures, require the full cooperation of the Responsible Authority and others, and do not and cannot replace the duty on all parties and their legal representatives to ensure that the required written and oral evidence is made available at the appropriate time. It is the parties' shared duty to avoid the upset and wastefulness of a panel convening - only then to be asked to adjourn because a report or witness is missing. If that happens, and all necessary steps have not been taken to secure the report or witness, the answer is likely to be a refusal to adjourn.

The MH5 direction to a named person to immediately provide written evidence.

30. If a statement or a report is not submitted by the three-week deadline, the tribunal may remind the person responsible that their written evidence is immediately due, and (by Form MH5 sent to the person in default) direct its immediate submission to the tribunal.

31. The purpose of the MH5 direction is to remind the person responsible, or the Chief Executive of the Responsible Authority, that the law has not been complied with and that the written evidence is immediately required. The tribunal needs, by law, to be able to send the MH5 direction to a named person, requiring that person immediately to give their written evidence to the tribunal in the form of a compliant report or statement.

32. For the MH5 direction to be of practical benefit and enforceable, it must be sent to the named person who has been nominated (by the Responsible Authority) to give the written evidence in question. This is why the MHAA is asked at an early stage to provide the identity and secure contact details of the Responsible Authority's statement and report writers. A personal secure email address or a postal address is acceptable, but a nonsecure email address is not acceptable because patient details are confidential.

33. An MH5 will only be sent if a statement or report is overdue, and the MH5 will, therefore, direct the immediate submission of the late report or statement. It is not appropriate for professionals to wait until an MH5 is received before starting to think about the required written evidence. The tribunal does not believe that failure to comply with the three-week deadline should result in (or be rewarded by) extra time being automatically given. By the time an MH5 direction is sent, the report is already late.

34. If the recipient of an MH5 direction considers that he or she has been wrongly identified by the Responsible Authority as responsible for providing a written statement or report, or if they are no longer responsible, then they must apply to have the direction set aside, and reasons for the request must be given. Thereafter, the tribunal will send directions to the Responsible Authority's Chief Executive as the tribunal cannot spend time chasing up the Responsible Authority for the correct or updated details, and cannot get involved in a dispute as to who is responsible for giving the written evidence to the tribunal.

Failure to comply with a personal MH5 Direction to give written evidence.

35. Failure to give the specified written evidence when directed to do so can result in the failure being referred to the Upper Tribunal for consideration of penalty. Even if we decide not to refer the failure, we are very likely to seek both an explanation and a binding undertaking that it will not happen again. If the First-tier Tribunal does refer the default, then the Upper Tribunal has a wide range of powers to impose a punishment.

Summonses.

36. The tribunal may issue a summons of its own volition, or on the request of a party. Following failure to comply with a direction to give written evidence, the tribunal will not issue any more directions to the person in default. It will simply move to a possible referral to the Upper Tribunal and may also issue a summons to the person in default, requiring their personal attendance at the hearing. Where it has been left with no alternative, the tribunal will summons the Responsible Authority's Chief Executive. It must be understood, however, that the issue of a summons does not mean that the outstanding report is no longer required because, obviously, the requirement remains

37. Failure to comply with a summons is punishable by the Upper Tribunal as contempt. The tribunal will generally be reluctant to summons a MHAA but, if a MH5 direction addressed to the MHAA has not been complied with, the tribunal may refer the matter to the Upper Tribunal because the Statement of Information is legally required, and provides the tribunal with vital information about the patient's history and circumstances.

M Hinchliffe (Deputy Chamber President) 24/7/2017
