UPPER TRIBUNAL CASE NO: HM/1386/2017

DECISION OF THE UPPER TRIBUNAL (ADMINISTRATIVE APPEALS CHAMBER)

Save for the cover sheet, this decision may be made public (rule 14(7) of the Tribunal Procedure (Upper Tribunal) Rules 2008 (SI No 2698)). That sheet is not formally part of the decision and identifies the patient by name.

This decision is given under section 11 of the Tribunals, Courts and Enforcement Act 2007:

The decision of the First-tier Tribunal under reference MP/2016/11134, made on 13 March 2017, did not involve the making of an error on a point of law.

REASONS FOR DECISION

A. Introduction

1. In 2006, the patient was convicted of burglary and arson and made the subject of hospital and restriction orders under sections 37 and 41 of the Mental Health Act 1983. He currently has diagnoses of schizophrenia and personality disorder. He had been convicted of a range of offences from 1982 and had been known to the mental health services since late 2003. He applied to the First-tier Tribunal on 25 April 2016 and his application was heard over six days, at the end of which the tribunal decided that he should remained liable to be detained. The First-tier Tribunal gave him permission to appeal to the Upper Tribunal.

2. The patient and the hospital at which he is detained both made submissions on the appeal. Neither asked for an oral hearing and I consider that one is not required. The Secretary of State did not take any part.

3. It is convenient to deal with the issues raised by this appeal under the headings that were used by the patient's solicitor in the application for permission and adopted by the judge who gave permission. Before I come to them, I need to need with a preliminary issue raised in the patient's reply to the hospital's response.

B. Evidence not referred to in the tribunal's decision

4. In its response, counsel for the hospital referred to evidence that was before the tribunal but not mentioned in its reasons. In his reply, counsel for the patient objected, arguing that this material was 'extraneous to the decision' and that the correct approach was that the tribunal's reasons had to 'comprehensible on its own terms without needing to be buttressed by evidence not referred to in the decision itself.' I reject that argument. A tribunal's reasons have to be adequate, but adequacy is tested in a context and that context includes the whole of the evidence before the tribunal. Tribunals exercising different jurisdictions take different approaches to setting out the evidence. Some set it out extensively;

others merely refer to it as required. And within jurisdictions, judges differ in their approaches. But whatever the approach of the particular jurisdiction or the individual judge, the Upper Tribunal is entitled to have regard to the whole of the evidence when considering whether the First-tier Tribunal's decision involved the making of an error of law.

5. Take an obvious example that shows why that must be right. Assume that all the evidence agreed that the patient had schizophrenia. In the tribunal's reasons, the judge did not mention this evidence and merely recorded the diagnosis. Would a party be entitled to criticise the tribunal's reasons for inadequacy when the whole of the evidence supported its finding and the matter had not been in issue? Obviously not.

C. Ground 1 – evidence of religious beliefs

6. This issue is whether in relation to religious beliefs the tribunal was entitled to prefer the evidence of medical experts to that of the religious expert.

7. The context in which this issue arises is this. The patient argued that he was not manifesting signs of mental disorder but of religious belief. In his support, he had the evidence of his present and former hospital chaplains that his beliefs were within the range of those considered normal in the Pentecostal Church, although his present chaplain said that he 'struggled' with the patient's belief that he was John the Baptist. The medical evidence accepted that the patient had strong religious beliefs, but did not accept that his ideas and behaviour were solely attributable to them.

8. The tribunal looked at all the patient's beliefs, religious and others, in making its decision. It found that he had clear evidence of positive symptoms of mental disorder independent of any religious beliefs. These were: (i) expressions of paranoia; (ii) a belief that consuming alcohol would bring him closer to God; (iii) he claimed to understand flashes from satellites around the Bermuda Triangle; and (iv) his beliefs about seeking out a former girlfriend regardless of her views. The tribunal accepted the medical evidence that the patient was exhibiting delusional beliefs, which included his belief that he was John the Baptist.

9. On analysis, this issue is really about the assessment of evidence. An appeal to the Upper Tribunal lies only on a point of law. In deciding whether the First-tier Tribunal's decision involved the making of an error on a point of law, the Upper Tribunal does not undertake its own assessment of the evidence or substitute its findings of facts for those of the First-tier Tribunal. The issue for the Upper Tribunal is whether the First-tier Tribunal's assessment was rational. This is sometimes expressed by saying that there will only be an error of law if the tribunal's findings were perverse in the sense that no tribunal acting judicially could properly have made them. The result is that, within the bounds of rationality, the assessment of the evidence and the finding of facts are essentially matters for the First-tier Tribunal.

10. The only way to avoid this approach would be if there were a rule of evidence that only the evidence of religious experts is admissible on matters of

religion. There is no such rule and it is well that there is not. The borderline between religious beliefs and mental disorder can be a fine one and one that is difficult to draw. It is right that evidence from both sides of the divide should be admissible to help the tribunal make a soundly-reasoned decision.

11. In this case, the tribunal was obliged to consider the evidence as a whole. It did so and the judge has explained how it assessed that evidence. His explanation discloses a rational approach to the task. The tribunal's assessment and findings based on it were not perverse. There was no error of law, either in the admitting of any of the evidence on this issue or in the assessment of its value in deciding whether the statutory criteria were satisfied.

12. The patient's representative has criticised the way that the tribunal used the evidence from the hospital chaplain about struggling with the patient's belief that he was John the Baptist. If the tribunal made a mistake in understanding that evidence, I do not consider that it was material. As I read its decision, the point made by the tribunal was that there was 'clear evidence of positive symptoms' of a mental disorder over and above anything that might be attributable to religious beliefs. It set those out and I have summarised them. It mentioned his belief that he was John the Baptist, but it did not base its decision on that alone and I consider that its analysis would have been the same if that evidence had not been before the tribunal.

13. The claimant's representative has also criticised the tribunal for not explaining why it regarded the factors it listed as not being manifestations of religious beliefs. It seems to me that they speak for themselves in the context of the evidence as a whole and the tribunal's overall analysis. Just to take an example, the claimant's willingness to pursue contact with his former girlfriend regardless of her wishes seems difficult to reconcile with religious beliefs.

D. Ground 2 – diagnosis of a personality disorder

14. This issue is whether the tribunal was entitled to make its own diagnosis contrary to the evidence at the hearing.

15. The context in which this issue arises is this. The psychiatric and psychological evidence was agreed that the patient's dominant, if not sole, disorder was of emotionally unstable (impulsive type) personality disorder. The tribunal made a diagnosis of dissocial personality disorder. It did so by reference to the criteria for that diagnosis in IDC-10, setting out relevant criteria with supporting evidence.

16. The answer to this issue lies in the judicial nature of a tribunal's functions, supported by the terms of the Mental Health Act 1983.

17. The finding of facts is a matter for the First-tier Tribunal. It is part of its judicial function. In making its findings, the tribunal must take account of the evidence. That is also part of its judicial function. In the case of a mental diagnosis, the relevant evidence will consist entirely or partly of expert evidence. The expert evidence may not be medical, as was the position in this case. And

some of the evidence may not be expert, since any diagnosis will depend on underlying matters of fact about such matters as the patient's behaviour.

18. The tribunal must not abdicate its fact-finding function. If it were to do so, its decision would be in error of law. And it would abdicate its function if it were to rely on expert evidence of diagnosis that it did not consider to be correct. No tribunal is obliged to accept expert evidence, even if all the evidence agrees, but it must have good reasons for not doing so.

19. So far, what I have said is a matter of basic principle. In the case of mental health, it is supported by the terms of the tribunal's jurisdiction under the Mental Health Act 1983. In the case of a restricted patient, that jurisdiction is conferred by section 73 and, by reference, section 72(1)(b). The tribunal is under a duty to discharge the patient unless all the necessary conditions are satisfied. One of those conditions involves the patient having a mental disorder (section 72(1)(b)(i)). Given that the person would not be a patient if the clinical team thought that he did not have a mental disorder, it follows that the tribunal must be entitled to disagree with expert evidence on diagnosis. This may involve more than a mere rejection of the clinical team's diagnosis. It may involve a differential diagnosis. This follows from the provisions of section 1(2A) and (3), under which learning disability or dependence on alcohol or drugs do not count as a mental disorder for some or all purposes. So it is inherent in the statutory duty imposed on the tribunal that it may have to reject expert evidence of the clinical team – see what I have said under the first ground about this – and may have to make findings on diagnosis from its own expertise.

20. It follows that there is no prohibition in principle on a tribunal substituting its diagnosis for that of the experts whose evidence was before the tribunal. It must, of course, have reasons for doing so and it must allow the patient's representative a chance to deal with its view before making a decision. But those are procedural safeguards that do not affect the existence of the tribunal's power.

21. The patient's representative asked in the grounds of appeal how the tribunal, constituted as it was, could prefer its view to that of an expert witness. The answer is that it did so by reference to the diagnostic criteria and the facts found from the evidence.

22. Moreover, as I read the tribunal's reasoning, (a) it gave its diagnosis as additional rather than a substitution, and (b) nothing in its ultimate analysis turned on the precise form of the patient's personality disorder.

E. Ground 3 – clarity of reasons

23. This issue is whether the tribunal failed to explain its reasoning in a way that allowed the patient to understand how the tribunal reached its conclusions. The details given in the application for permission show that this relates to a variety of matters. I have dealt with some already under the other grounds. The remainder consist of a variety of criticisms of the details of the tribunal's reasoning. The flaw in the approach shown by this ground is materiality. In other words, even if the tribunal did make the mistakes on the matters itemised, there would still be ample justification within its findings and reasons to show that

detention was required and that treatment was available. That makes it unnecessary to go through every single point raised under this head. I do, though, generally accept the detailed response from the hospital.

24. It is sufficient to say this. The tribunal found that the claimant had schizophrenia and one or more forms of personality disorder. There are numerous ways in which the former had benefited from his medication and psychological treatment. Even if some of the criticisms about those supposed benefits may be valid, that leaves the rest, which amply support the tribunal's decision that the patient benefits from the treatment he is receiving. The need for that to be delivered in hospital is shown by his denial of his diagnoses and the inherent danger that he would not comply with medication, which would result in a deterioration in his own health, aside from any risk he might pose to others. That alone supports the tribunal's decision aside from any similar points that might be made in respect of his personality disorder.

F. Conclusion

25. That is why I have dismissed the appeal.

Signed on original
on 28 September 2017

Edward Jacobs
Upper Tribunal Judge