IN THE UPPER TRIBUNAL **Appeal No. HM/13/2021**
ADMINISTRATIVE APPEALS CHAMBER

On appeal from the First-trier Tribunal (HESC Chamber)

Between:

DA

Appellant

- v –

Central and North West London NHS Foundation Trust

First Respondent

Secretary of State for Justice

Second Respondent

Before: Upper Tribunal Judge Ward

Decision date: 23 April 2021
Decided on consideration of the papers

Representation:
Appellant: Helen Curtis, instructed by Duncan Lewis (pro bono)
First Respondent: Shaline Tewarie, Acting Mental Health Law Locality Manager

The Second Respondent did not participate in the proceedings.

DECISION

The decision of the Upper Tribunal is to allow the appeal. The decision of the First-tier Tribunal made on 27 October 2020 under number MP/2020/10725 was made in error of law. Under section 12(2)(a) and (b)(i) of the Tribunals, Courts and Enforcement Act 2007 I set that decision aside and remit the case to be reconsidered by a wholly differently constituted panel at an oral hearing.

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 appellant patient by name.

REASONS FOR DECISION

The proceedings

1. The appellant appeals, with permission given by a judge of the First-tier Tribunal ("FtT") against a decision dated 27 October 2020 by the FtT that he remain liable to

recall but that the conditions previously attaching to his conditional discharge be removed.

2. The appeal is supported by the first respondent. Their brief response does not enter into the issue of whether the FtT erred in law but is based on the view, set out in more detail below, that absolute discharge is appropriate for their patient, the appellant. Regrettably, the second respondent has not participated in the proceedings. No party has applied for an oral hearing and I do not consider that one is required to enable me to dispose of the appeal justly.

Background

3. The appellant has an established diagnosis of paranoid schizophrenia, in remission at the time of the FtT hearing. There has in the past been concern about the use of cannabis and misuse of alcohol, the former of which in particular was considered to have had an exacerbating effect on his mental illness.

4. The appellant already had a criminal record for offences relating to drugs, weapons and violence before in 2011, when unwell, he committed further offences of violence, the more serious of which resulted in a conviction for wounding with intent to cause grievous bodily harm. The court made a hospital order and restriction order under sections 37 and 41 of the Mental Health Act 1983.

5. His condition responded to treatment and in 2016 he was granted a conditional discharge by a previous tribunal with conditions relating to the following matters:

> a. to reside at a specified address and only to change it with prior notice and by agreement;
> b. to comply with prescribed medication;
> c. to engage with the community team and to keep all arranged relevant appointments;
> d. to abstain from illicit drugs and submit to random testing as required;
> e. not to contact specified individuals nor enter specified areas.

The evidence

6. The evidence before the FtT included the following:

a. The Responsible Clinician stated that the appellant's illness was effectively treated; his mental health was stable, he had been compliant with his treatment plan and had engaged with the clinical team; he had complied with all conditions since discharge without exception; and had demonstrated an ongoing ability to cope in decreasingly supported environments while remaining well. He considered that neither the nature nor degree, nor risks posed to the appellant's health and safety or the health and safety of others required ongoing statutory supervision and thus that there was no need for him to remain liable to recall. His recommendation was for absolute discharge. He addressed the need for liability to recall by noting that since the conditional discharge in 2016 there had been no consideration given to a potential recall to hospital. He noted that while one could never predict with complete certainty, on the basis of the appellant's stability for the last seven years and since September 2016 while being in the community "it seems a reasonable assessment

that recall to hospital is not an imminent likelihood". He gave evidence that it was proposed to transfer the appellant's care from the Focus team (a service for forensic service users in the community) to the Community Mental Health Team (CMHT). As expressed in the Reasons, para 8, he acknowledged the transfer was "a possible stress point with associated dangers" but pointed out there had been some joint working for a period of time and offered to remain as Responsible Clinician for a period if it would assist the FtT in determining that an absolute discharge was appropriate.

b. The social supervisor confirmed the effectiveness of the current care plan and the appellant's engagement. She noted his mental health to be "very stable" and how he had built "positive social structure" and had been proactive about finding employment (and indeed had found one, unfortunately curtailed by the Covid-19 pandemic). She recorded his acceptance that his medication was effective, that he would continue to take it if no longer the subject of an order under the Act and his "very good insight" into his historic drug use and its adverse effects upon him and his plans to remain abstinent.

c. There was evidence from the victim liaison officer that neither of the victims of the offences in 2011 had raised any concerns about the appellant's absolute discharge.

d. A consultant psychiatrist, proposed to be the Responsible Clinician in future, gave evidence of the arrangements that would be in place if the appellant's care were to be transferred to the Community Mental Health Team, including those for follow-up if there were to be poor engagement or signs of deteriorating mental health. She referred to the period of joint working and likewise supported the application.

The witnesses mentioned at a., b., and d. all gave oral evidence, as did the appellant himself.

7. The second respondent filed a submission, noting that prior to the index offences the appellant had been using cannabis and alcohol to harmful levels. Cannabis in particular was "severely detrimental" to his mental health and ongoing abstinence was "of the utmost importance in his ongoing recovery and stability". It noted his "considerable" risk history. It continued:

> "There is some indication that [the appellant] might not remain compliant with his conditions in the future. The Secretary of State notes that [the appellant's] potential risk to others and himself is dependent on his mental state. Risk factors include non-compliance with his medication, potential use of illicit substances and becoming more isolated. There is a likelihood of relapses if he disengaged with his clinical team which in turn will affect his concordance with his medication. His risk of violent behaviour to others is closely related to his risk of relapse of psychosis.
>
> Given the nature of the index offence and the risk to himself and to the public that [the appellant] might pose when mentally unstable, the Secretary of State takes the view that the restrictions in place are of vital importance in ensuring that [the appellant] remains compliant with his conditions in case he becomes unwell at some point in the future.

> The Secretary of State therefore, considers that [the appellant] should remain subject to statutory supervision and liable to be recalled to hospital."

The legislation and caselaw

8. The legislative scheme in summary is that s.37 of the Act authorised the appellant's initial admission and detention and s.41 restricted his discharge. It is a prerequisite of s.37 that the person has been convicted of an offence punishable with imprisonment and of s.41 that

> "it appears to the court, having regard to the nature of the offence, the antecedents of the offender and the risk of his committing further offences if set at large, that it is necessary for the protection of the public from serious harm"

to make the order.

9. The appellant's application for a conditional discharge fell to be considered under s.73, which so far as relevant provides:

> "(1) Where an application to the appropriate tribunal is made by a restricted patient who is subject to a restriction order, or where the case of such a patient is referred to the appropriate tribunal, the tribunal shall direct the absolute discharge of the patient if—
> (a) the tribunal is not satisfied as to the matters mentioned in paragraph (b)(i), (ii) or (iia) of section 72(1) above; and
> (b) the tribunal is satisfied that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment.
>
> (2) Where in the case of any such patient as is mentioned in subsection (1) above—
> (a) paragraph (a) of that subsection applies; but
> (b) paragraph (b) of that subsection does not apply,
> the tribunal shall direct the conditional discharge of the patient.
>
> (3) Where a patient is absolutely discharged under this section he shall thereupon cease to be liable to be detained by virtue of the relevant hospital order, and the restriction order shall cease to have effect accordingly.
>
> (4) Where a patient is conditionally discharged under this section—
> (a) he may be recalled by the Secretary of State under subsection (3) of section 42 above as if he had been conditionally discharged under subsection (2) of that section; and
> (b) the patient shall comply with such conditions (if any) as may be imposed at the time of discharge by the tribunal or at any subsequent time by the Secretary of State.
>
> (5) The Secretary of State may from time to time vary any condition imposed (whether by the tribunal or by him) under subsection (4) above.

> (6) Where a restriction order in respect of a patient ceases to have effect after he has been conditionally discharged under this section the patient shall, unless previously recalled, be deemed to be absolutely discharged on the date when the order ceases to have effect and shall cease to be liable to be detained by virtue of the relevant hospital order.
> … ."

10. Reading sub-sections (1) and (2) together, the 2016 tribunal was not satisfied that it was not appropriate for the appellant to remain liable to recall. The conditions were imposed under sub-section (4). As to enforceability, Holman J noted in *R(SH) v Mental Health Review Tribunal* [2007] EWHC 884 (Admin) at [36]:

> "section 73 does not attach, or empower the attachment of, any sanction for failure to comply with a condition and the tribunal did not attach or purport to attach any sanction. The Secretary of State has a general power of recall under section 73(4)(a), but there is nothing to make recall an automatic sanction for non-compliance as such with a specific condition."

11. The application which is the subject of the present proceedings was made under s.75(2):

> "(2) Where a restricted patient has been conditionally discharged [under section 42(2), 73 or 74] but has not been recalled to hospital he may apply to the appropriate tribunal —
> (a) in the period between the expiration of 12 months and the expiration of two years beginning with the date on which he was conditionally discharged; and
> (b) in any subsequent period of two years.
>
> (3) Sections 73 and 74 above shall not apply to an application under subsection (2) above but on any such application the tribunal may—
> (a) vary any condition to which the patient is subject in connection with his discharge or impose any condition which might have been imposed in connection therewith; or
> (b) direct that the restriction order, limitation direction or restriction direction to which he is subject shall cease to have effect;
> and if the tribunal gives a direction under paragraph (b) above the patient shall cease to be liable to be detained by virtue of the relevant hospital order, hospital direction or transfer direction."

12. In *R(SC) v Mental Health Review Tribunal* [2005] EWHC 17 (Admin), Munby J examined the purpose behind the power to impose a conditional discharge of a restricted patient and the kind of factors likely to be relevant in deciding an application under s.75.

13. At [33] he noted that:

"What is for present purposes the important aspect of the legislative scheme had been recognised by the Court of Appeal in *R v Merseyside Mental Health Review Tribunal ex p K* [1990] 1 All ER 694 per Butler-Sloss LJ at p 699:

> "Section 73 gives to the tribunal power to impose a conditional discharge and retain residual control over patients not then suffering from mental disorder or not to a degree requiring continued detention in hospital. This would appear to be a provision designed both for the support of the patient in the community and the protection of the public, and is an important discretionary power vested in an independent tribunal".

As Moses J commented in *R (Secretary of State for the Home Department) v Mental Health Review Tribunal* [2004] EWHC 1029 (Admin) at para [25]:

> "It might very well be in such a case that, whilst a Tribunal would not be satisfied at one particular moment that someone was suffering from a psychopathic disorder, later on symptoms might emerge which would make it highly appropriate and indeed necessary for such a patient to be recalled to hospital."

14. Having reviewed those and other cases, Munby J noted at [36]:

> "These cases show that the purpose of conditional discharge is not necessarily to impose a requirement for ongoing treatment for a classified mental disorder. It may be no more, to use the words of the Tribunal in the present case, than to ensure monitoring "in case the clinical picture unexpectedly changes in the future".

15. At [56] –[60] he provided the following view:

> "56. Section 75(3) applies only to a restricted patient who, like SC, has been conditionally discharged. Bearing in mind the provisions of sections 37, 41 and 73 of the Act, one can, as it seems to me, readily identify the most important of the factors that are likely to feed into the exercise of discretion under section 75(3). Any patient applying under section 75(3) will, by definition, have been, just as SC was:
> i) convicted of a criminal offence sufficiently grave as to merit a possible sentence of imprisonment: section 37(1);
> ii) found to be suffering from mental disorder meriting his detention in hospital for treatment: section 37(2)(a)(i);
> iii) found to be someone whose risk of re-offending is such that a restriction order is "necessary for the protection of the public from serious harm": section 41(1); and
> iv) found by the Tribunal (unless previously discharged by the Secretary of State under section 42(2)) to be someone who, although not requiring for the time being to be detained in hospital for medical treatment (sections 72(1)(b), 73(1)(a), 73(2)(a)), should nonetheless remain liable to be recalled to hospital for further treatment: section 73(2)(b).

57. It is against this background that the exercise by the Tribunal of its powers under section 75(3) takes place. Accordingly the Tribunal when exercising these powers will need to consider such matters as the nature, gravity and circumstances of the patient's offence, the nature and gravity of his mental disorder, past, present and future, the risk and likelihood of the patient re-offending, the degree of harm to which the public may be exposed if he re-offends, the risk and likelihood of a recurrence or exacerbation of any mental disorder, and the risk and likelihood of his needing to be recalled in the future for further treatment in hospital. The Tribunal will also need to consider the nature of any conditions previously imposed, whether by the Tribunal or by the Secretary of State, under sections 42(2), 73(4)(b) or 73(5), the reasons why they were imposed and the extent to which it is desirable to continue, vary or add to them.

58. As Mr Ward [counsel for the Secretary of State] submits, in exercising the powers under section 75(3) questions as to the patient's mental health, his safety and questions of public safety are evidently relevant. They are, unsurprisingly, the very questions which the Tribunal considered in the present case. And they are moreover, as Mr Ward says, directed to the evidently legitimate policy aims served by the existence of the broad discretion which is conferred by section 75(3). I agree with Mr Ward that this broad discretion serves to ensure that the Tribunal can respond flexibly and appropriately to the varied and potentially complex situations which may arise when a restricted patient has been conditionally discharged. This enables the Tribunal to ensure that both the interests of the patient and the interests of public safety which arise in the case of a restricted patient are adequately served. In practice, as he says, such an exercise is fact-intensive and strongly dependant upon the clinical details of each particular case – as, indeed, the decision of the Tribunal in the present case illustrates.

59. …[A]s Mr Ward points out, section 73 also points the way to a crucial question which the Tribunal will need to consider when exercising its powers under section 75(3). The consequence of an order under section 75(3)(b) is that the restriction order ceases to have effect; in other words, that what was previously only a conditional discharge becomes in effect an absolute discharge. But, as section 73 demonstrates, the difference between the two is the difference between the patient who is, and the patient who is no longer, liable to be recalled to hospital for further treatment. So, in effect, one of the key questions that the Tribunal will wish to ask itself when considering how to exercise its powers under section 75(3) is whether it is – as section 73(1)(b) puts it – "satisfied that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment." If the Tribunal is not so satisfied, then it is difficult to see that it could be appropriate for it to make an order under section 75(3)(b).

60. Mr Pezzani [counsel for the patient, the claimant] correctly points out that section 73 "shall not apply" to an application under section 75(2). But this, with respect to him, does not mean, as he puts it, that the matters which are referred to in sections 72(1)(b)(i) and 72(1)(b)(ii) are "excluded" by section 75(3) from the Tribunal's consideration of an application under section 75(2).

> Nor, specifically, does it mean that there is "explicitly excluded" from consideration by section 75(3), as Mr Pezzani submits, the question of whether it is appropriate that the patient remains liable to be recalled. As Mr Ward rightly submits, the effect of section 75(3) is not to *preclude* the Tribunal from considering the kind of factors which fall for consideration under section 73. Rather, as he puts it, the effect is that the Tribunal, when exercising its discretion under section 75(3), is not constrained by the mandatory terms of section 73, which bind the approach of the Tribunal when considering the exercise of its powers under section 73."

16. The FtT opened its Reasons by directing itself by reference to the test in para 57 of *SC*, set out above. It said that it was setting out its conclusions on each of the matters identified there. The FtT expressly accepted the evidence of the Responsible Clinician and by implication the other witnesses, subject to a degree of clarification of the evidence given by the proposed future Responsible Clinician. The acceptance (express or implied) of the evidence makes it somewhat easier to construe what might otherwise be viewed as reciting evidence as making findings.

17. The FtT addressed the submission from the second respondent that the very significant risk history, the importance of abstinence from cannabis, the nature of the index offence and the risk to the appellant and the public when he was mentally unstable necessitated the current restrictions to ensure he remained compliant with the conditions of his conditional discharge. It specifically found there was no evidence to support the second respondent's submission that

> "There is some indication that [the appellant] might not remain compliant with his conditions in future."

18. Why then did the FtT decide against absolute discharge? The key passage is as follows:

> "13. The panel found that this case was very finely balanced but ultimately found that it could not, on the totality of the evidence, conclude that it was not appropriate for the patient to remain liable to be recalled to hospital. The panel came to that conclusion on the basis of the extreme risk to the public in the event of the patient becoming mentally unwell again. The panel also considered that the fact that the patient is to be transferred from the Focus team to the CMHT is still, despite liaison and some working together, an untested change which creates the possibility of some uncertainty. The panel considered that it was proper to balance the risk to the public should the patient become unwell in the future with the very slight restriction upon the patient of his being liable to recall. The panel found that it was proper to keep the safety net of liability to recall in place as a proportionate measure, given the severity of the index offence, despite the – probably well placed – confidence of the professional witnesses in the positive prognosis for the future.
>
> 14. Whilst coming to that conclusion the panel considered that, in the light of the evidence being all one way as to the patient's compliance with his care programme, and the assurances of careful monitoring given by the care team,

> that it was proper to remove the conditions previously in place. The panel noted that the victims of the index offences had been approached and had made no representations about the possibility of an absolute discharge and that, in any event, the patient has no intention of going into the area from which he has been excluded. The panel considered that on a future occasion a panel may well be significantly assisted by evidence of compliance with his care plan by the patient, despite there being no conditions requiring this. …"

The grounds of appeal

19. The appeal to the Upper Tribunal proceeded on the basis of the Grounds of Appeal dated 22 December 2020, which were a development of those dated 26 November 2020 on the basis of which permission to appeal had originally been given. The appellant's representatives accepted that the later Grounds should be taken as standing alone.

20. In summary, the FtT's decision was challenged on the basis of:

a. irrationality in lifting all the conditions attaching to the appellant's conditional discharge and retaining the liability to recall him in the circumstances of the case;
b. error of law in assessing the proportionality of what the FtT viewed as a "slight burden" on the appellant of being liable to recall against the severity of the index offence; and
c. inadequacy of the reasons it provided for deciding it was not inappropriate for the appellant to remain liable for recall.

Ground a: irrationality

21. As the Grounds note, the FtT did not accept the submission that there was some indication that the appellant might not remain compliant with his conditions in future. I therefore examine the rationality of the FtT's conclusions on the basis that there was no evidence suggesting the possibility of non-compliance.

22. The Grounds rely on an alleged tension between the FtT's concern relating to an "untested change" in the appellant's care team which "created the possibility of some uncertainty" and its removal of conditions requiring him to engage with the new team. Likewise, the Grounds refer to the FtT's reliance on the likelihood of the appellant's mental health deteriorating due to use of illicit substances while removing the condition requiring him to abstain from them and to submit to random testing. While it was undisputed that use of illicit substances was likely to have such an effect, the evidence indicated that the appellant had not used them since the conditional discharge in 2016 (and, though he might not have had much opportunity, longer) and had considerable insight into the link between cannabis use and his mental health.

23. There is nothing in the legal framework itself which makes the imposing of a conditional discharge, when no conditions are attached, intrinsically irrational. The words "if any" in s.73(4)(b) make clear that there may be no conditions attached at all: see *SH* at [17]. Nor, as noted above, is there any direct sanction attaching to breach of conditions if any are attached: *SH* at [36]. What makes a conditional discharge "conditional" is the liability to recall. I therefore do not consider that

irrationality necessarily arises by retaining a liability to recall while jettisoning conditions previously in force. What matters, rather, are the reasons in the circumstances of the case for retaining liability to recall (on the one hand) and dispensing with the conditions (on the other).

24. The FtT's stated reason for retaining liability to recall was as a "safety net", given the severity of the index offence, because of the extreme risk to the public in the event of the appellant becoming mentally unwell again. That is entirely rational and in accordance with the intended purpose of the power: see the dicta at [13] and [14]. The Ground is, correctly, not put on the basis of no evidence: the evidence of the Responsible Clinician that "it seems a reasonable assessment that recall to hospital is not an imminent likelihood" undoubtedly leaves room for a view on the part of the FtT that unexpected further changes needed to be guarded against.

25. The conditions were removed because of the evidence "all one way" and because removing the conditions would give the appellant the chance to show that he could comply with his care plan despite there being no conditions in that regard. The point has not been fully argued before me and differing views may perhaps reasonably be held as to the utility of that approach when breach of the condition would not lead to a direct sanction and when even without a condition in place an element of compulsion would remain in the form of the liability to recall. Nonetheless, by s.73(4)(b) a patient is required to comply with such conditions as may be imposed and I do not regard the view of the specialist FtT that how the appellant would perform if not subject to conditions would be useful to a future tribunal as an irrational one.

26. I therefore dismiss Ground a.

Ground b.:application of test of proportionality to decision to retain liability to recall

27. The Ground is expressed as follows:

> "The FtT introduced an element of proportionality and appear to weigh the severity of the index offence as against the "slight burden" to [the appellant] of liability to recall in reaching its determination. It is not clear that the psychological impact on [the appellant] was part of the FtT's assessment. The approach of assessing the proportionality of the "slight burden" as against the severity of the index offence, it is respectfully submitted, is erroneous."

28. It is not clear to me whether the Ground is objecting to the introduction of proportionality as a matter of law or to the FtT's view, as part of considering proportionality, that the burden of being liable to recall is "slight", or both.

29. As regards the former, I see no objection. Consideration of whether it is "appropriate" for the patient to remain liable to be recalled remains relevant under s.75(2): *SC* at [60]. Consideration of what is "appropriate" is in my view entirely apt to extend to whether retaining a liability to recall is proportionate, in the somewhat general sense in which the FtT appears to have been using the word. The Ground makes no complaint based on art.8 ECHR.

30. As regards the latter, I believe the ground misquotes the FtT. What it appears to have been balancing was ”the risk to the public should the [appellant] become unwell” with the ”very slight restriction” upon him of being liable to recall.

31. The more subjective word “burden” used in the Grounds appears to have been something raised by the appellant in his evidence: “[he] felt that it was a psychological burden and he did not like having the possibility of recall hanging over him” (FtT Reasons, [11]). I address that when considering the adequacy of the FtT’s reasons below.

Ground c: inadequacy of reasons

32. Ms Curtis relied on *HK v Llanarth Court Hospital* [2014] UKUT 0410 (building, in this jurisdiction, on the foundation of *English v Emery Reimbold & Strick Ltd* [2002] 1 WLR 2409 and on *SLL v Primary Healthcare and Secretary of State* [2019] UKUT 323 (AAC). I do not need to set out those authorities at length but for present purposes note, in particular, that it must be apparent to the parties from the tribunal’s reasons why one has won and the other has lost (*English*). Reasons must be clear and unambiguous (*Llanarth*). Where there are competing views, the tribunal must set out its reasons for preferring one or other of those views *(Llanarth* and other cases).

33. Where in my view the FtT’s decision falls short is in failing to give reasons – or indeed to make findings - as to the likelihood of the appellant becoming mentally unwell again. If he was not unwell, the risks which it was undisputed he might present when unwell would not arise. Having rejected the second respondent’s submission that there was some indication that the appellant might not remain compliant in future as being unsupported by evidence, the only area identified by the FtT as potentially leading to difficulty was the transfer from the Focus team to the CMHT, something which the FtT regarded as “an untested change which creates the possibility of some uncertainty”. Even if it did create a “possibility of some uncertainty”, it is unclear how the FtT considered that might be linked to the appellant becoming ill once again. In any event, evidence had been given by both the current and the future proposed Responsible Clinicians as to how the transfer between teams would be managed; the current Responsible Clinician had offered to retain that role for a period; and there had already been a period of joint working, matters which had clearly been explored in some detail at the hearing (Reasons, [9]) and the Reasons do not indicate why those measures were thought to be inadequate (if indeed they were). So in my view the parties are unable to discern what it was about the transfer between teams which was thought to be a cause of possible uncertainty; nor how the uncertainty was thought to impact on the likelihood of the appellant becoming mentally unwell, a matter falling squarely within the factors identified by *SC.*

34. The same position may additionally be reached via a slightly different route. Although not expressly part of the Grounds as they stand, the Grounds do rely on *SLL*, in which Upper Tribunal Judge Church drew attention at [34e] to the need to make findings

> "(given the "least restrictive [principle] that informs the MHA regime) whether any alternative strategies are available which might manage the risks associated with future deteriorations in the patient's mental health effectively but which place less restriction on the patient's liberty than the patient continuing to be subject to the power of recall".

35. In the present case, the Responsible Clinicians were proposing the least restrictive option of managing the appellant's care following an absolute discharge via the CMHT and there was evidence about the mechanisms to pick up on emerging problems. The FtT does not give reasons why that evidence was rejected.

36. Finally the grounds submit that it is not clear from the reasons that the psychological impact on the appellant was part of the FtT's assessment. Earlier in the Grounds, they include a passage from *SLL* at [33] where Judge Church drew attention to the need for the FtT to assess "the effect which knowledge of the Secretary of State having the power of recall would have on the [patient]". At [30] he does make clear that "what will be relevant will depend on all the circumstances of the particular case" so he may not have been intending to lay down at [33] a rule of general application, as its presentation in the Grounds rather implies. Nonetheless, in the present case there was a thread of documentary and oral evidence that the appellant did indeed find being liable to recall a psychological burden. It may be seen in his oral evidence recorded at Reasons [11] and also in the evidence of the Responsible Clinician (paras.71, 72 and 81). There will be cases where there is a psychological burden, but it has to be borne; but I accept the submission that the reasons do not indicate that the impact on the appellant was addressed.

Concluding remarks

37. My decision is therefore as set out at the head of these Reasons. The appeal has succeeded on a point of law and the appeal will have to be reheard. This carries no implication as to the outcome when the matter goes before a new panel of the FtT, which is entirely a matter for it.

Anonymity

38. The Grounds originally sought an anonymity order, but the appellant's solicitor subsequently agreed that the application of rule 14(7) in accordance with the Upper Tribunal's usual practice in such cases provides adequate protection for the appellant's privacy, given that the substantive part of the decision has been drafted on the basis of anonymity and the front sheet with his name on will go only to the parties who are, of course, already aware of his identity.

C.G.Ward
Judge of the Upper Tribunal
Signed on the original on 23 April 2021