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(subject to editorial corrections)

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

QUEEN'S BENCH DIVISION (JUDICIAL REVIEW)

IN THE MATTER OF AN APPLICATION BY D H FOR JUDICIAL REVIEW

WEATHERUP J

The application

[1] This is an application for judicial review of the decision of a Mental Health Review Tribunal dated 30 January 2004 directing that the applicant should continue to be detained at Muckamore Abbey Hospital, Antrim under the Mental Health (Northern Ireland) Order 1986.

The legislation

[2] Prior to 14 May 2004 Article 77 of the Order provided that:

> "(1) Where application is made to the Review Tribunal by or in respect of a patient who is liable to be detained under this Order, the Tribunal may in any case direct that the patient be discharged, and shall so direct if it is satisfied –
>
> (a) that he is not then suffering from mental illness or severe mental impairment or from either of those forms of mental disorder of a

nature or degree which warrants his detention in hospital for medical treatment; or
(b) that his discharge would not create a substantial likelihood of serious physical harm to himself or to other persons; or
(c) in the case of an application by virtue of Article 71(4)(a) in respect of a report furnished under Article 14(4)(b) that he would, if discharged, receive proper care.

(2) A Tribunal may under paragraph (1) direct the discharge of a patient on a future date specified in the direction; and where the Tribunal does not direct a discharge of a patient under that paragraph the Tribunal may –

(a) with a view to facilitating his discharge on a future date, recommend that he be granted leave of absence or transferred to another hospital or into guardianship; and
(b) further consider his case in the event of any such recommendation not being compiled with".

[3] Article 3 of the Order provides the following definitions:

"`Mental disorder' means mental illness, mental handicap and any other disorder or disability of the mind;

`Mental illness' means a state of mind which affects a person's thinking, perceiving, emotion or judgment to the extent that he requires care or medical treatment in his own interests or the interests of other persons;

'Mental handicap' means a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning;

> `Severe mental handicap' means a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning;
>
> `Severe mental impairment' means a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned."

The decision

[4] The applicant was admitted to Muckamore Abbey Hospital in July 2002 and detained under Article 13(3) of the 1986 Order by the decision of the Mental Health Review Tribunal dated 30 January 2004 where the applicant's mental disorder was classified as "mental illness and severe mental impairment." The Tribunal directed that the applicant should remain detained for reasons that were set out in the decision.

"The Tribunal heard from the RMO Dr Marriott, the Social Worker, Ms McAuley and the patient. Dr Marriott confirmed her diagnosis of severe mental impairment complicated by recurrent mood disorder and obsessive compulsive symptoms. These complaints impact on one another. The result is that if the patient's mood is low, her obsessive compulsive behaviour becomes more marked. (The applicant) has little insight into her condition and is highly unlikely to continue with her essential medication if discharged. The patient has cirrhosis of the liver which is being treated and her main psycho-trauma medication is Seroxat in a high daily dose to help with her low mood and obsessions. (The applicant's) IQ was tested in 1988 at 67 with an 18 point discrepancy between verbal and performance scores. Dr Marriott conceded that looking at the poor figures alone would take (the applicant) outside the definition of severe mental handicap. However, if one looked at the patient as a whole with her mood swings, her obsessive behaviour and the need for help in her daily living including hygiene, dressing and medication, outside a supervised setting (the applicant) would quickly regress. Dr Marriott

confirmed her view that in the community (the applicant) was at significant risk of serious harm mainly through self neglect.

Ms McAuley confirmed the poor living conditions of the patient on admission and in particular the appalling state of the living room with piles of newspapers and dog faeces. The staff had taken (the applicant) back to her house (for which still pays rent) to attempt a clear out. However, it was clear that this was a very upsetting experience for the patient and the exercise had to stop as she got more upset. Ms McAuley was pleased to report that she had made an application to have the patient admitted to Glenwood Residential Home and she had been accepted. However, that place had not had not yet become available although she was hopeful it would in the next few months.

On behalf of the patient her brother [ ] and a neighbour [ ] spoke. They both have kept in contact with (the applicant) several times a week. To them she appeared content at home but both admitted that it was sometimes difficult to gain admittance to the house. Both seemed to think Glenwood to be a good compromise.

The Tribunal is satisfied that continued detention is really the only option for (the applicant). We accept Dr Marriott's view that one cannot look at IQ figures in isolation. Before her admission, this lady existed in the most squalid, unhealthy and dangerous conditions. Even in the hospital setting, she needs constant coaxing and supervision to look after herself. Her mental impairment combined with her mental health problems means she is at substantial risk of serious harm in the community.

We welcome the opportunity (the applicant) now has of a place in sheltered accommodation and hope she settles at Glenwood".

[5] The Tribunal President set out on affidavit the approach taken by the Tribunal. The President's affidavit states that the views of Tribunal members were (i) to accept the dual diagnosis that the applicant suffered from both mental illness and from severe mental impairment, (ii) to accept that each condition was of a nature or degree that warranted detention in hospital for medical treatment

and (iii) to accept that the applicant's discharge would create a substantial likelihood of serious physical harm to herself or to others. The affidavit then set out reasons for reaching certain conclusions.

[6] A note of caution must be sounded in relation to a statement of reasons in the course of judicial review proceedings. While accepting that affidavit evidence may elucidate the reasons for a decision Butterfield J stated in *R (Lillycrop) v Secretary of State for the Home Department* [1996] EWHC Admin 281 at paragraph 35 –

> "Accordingly we conclude that where evidence is proferred to elucidate correct or add to the reasons contained in the decision letter a Court should examine the proferred evidence with care, and should only act upon it with caution. In particular, a Court should not substitute the reasons contained in proferred evidence for the reasons advanced in a decision letter. To do so would unquestionably raise the perception, if not the reality, of subsequent rationalisation of a decision that had not been properly considered at the time."

The grounds for judicial review

[7] The applicant's grounds for judicial review resolve to four matters:

(i) Failing to establish under Article 77(1) of the Order that the applicant had severe impairment of intelligence as well as severe impairment of social functioning.

(ii) Failing to establish for the purposes of Article 5(4) of the European Convention that the applicant has sufficient knowledge of the findings and views of the medical member of the Tribunal.

(iii) Failing to establish under Article 77(1) of the Order that the applicant suffered from a mental disorder of a nature or degree which warranted her detention in hospital for medical treatment.

(iv) Failing to give adequate reasons for the decision to detain the applicant.

In addition the applicant objected to the structural position of the medical member of the Tribunal but reserved argument on that issue.

The burden of proof.

[8] In *R (On the application of H) v Mental Health Review Tribunal North and East London Region* (2002) QB 1 the Court of Appeal in England and Wales made a declaration under Section 4 of the Human Rights Act 1998 that Section 72(1) of the Mental Health Act 1983 (and section 73(1) in relation to the power to discharge restricted patients) was incompatible with Articles 5(1) and 5(4) of the European Convention in that, for the Tribunal to be obliged to order a patient's discharge the burden was placed upon the patient to prove that the criteria justifying detention in hospital no longer existed; and that Articles 5(1) and 5(4) required the Tribunal to be positively satisfied that all the criteria justifying the patient's detention in hospital for treatment continued to exist before refusing a patient's discharge. As a result of the decision of the Court of Appeal the Mental Health Act (1983) (Remedial) Order 2001 came into force in England and Wales on 26 November 2001 to remove the incompatibility by amending Section 72(1) of the 1983 Act (and section 73(1)) to provide that a Tribunal shall direct the discharge of a patient if the Tribunal is not satisfied that the criteria justifying detention in hospital for treatment continue to exist.

[9] The Mental Health (Amendment) (Northern Ireland) Order 2004 came into operation on 14 May 2004 and amended Article 77(1) as follows:

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

> (a) the tribunal is not satisfied that he is then suffering from mental illness or severe mental impairment or from either of those forms of mental disorder of a nature or degree which warrants his detention in hospital for medical treatment; or
> (b) the tribunal is not satisfied that his discharge would create a substantial likelihood of serious physical harm to himself or to other persons; or
> (c) in the case of an application by virtue of Article 71(4)(a) in respect of a report furnished under Article 14(4)(b), the tribunal is satisfied that he would, if discharged, receive proper care."

[10] The legislation places the burden of proof on the patient to establish the grounds for release from detention. The applicant complains that the decision of the Tribunal did not address the issue of the burden of proof. On affidavit the Tribunal President avers that the Tribunal approached the case by placing the burden on the Trust to establish the grounds for detention and that no burden was placed on the applicant. In so doing the Tribunal was anticipating the amending legislation introduced in Northern Ireland with effect from 14 May 2004. I am satisfied that the Tribunal placed the burden on the Trust and not on the applicant.

Severe impairment of intelligence.

[11] Article 77(1)(a) refers to those suffering from "mental illness" or "severe mental impairment". The definition of severe mental impairment includes severe impairment of intelligence and social functioning. This requires that it be established that the applicant has both severe impairment of intelligence and severe impairment of social functioning. *North and West Belfast Health and Social Services Trust's Application* (2003) NI JB 274.

[12] The applicant contends that there was no evidence of severe impairment of intelligence and accordingly that the Tribunal was not entitled to find that the applicant suffers from severe mental

impairment. It will be noted that Article 77(1)(a) refers to those suffering from mental illness or severe mental impairment. The Tribunal found that the applicant suffered from mental illness.

[13] In relation to severe impairment of intelligence the Tribunal accepted the evidence of the applicant's IQ test in 1988 at 67 with an 18 point discrepancy between verbal and performance scores. As appears from *North and West Belfast Health and Social Services Trust's Application* the British Psychological Society Guidelines refer to an IQ level of 54 and below for "severe" impairment and an IQ level of 55 to 69 for "significant" impairment. On the basis of the IQ test the applicant did not suffer from "severe" impairment of intelligence. The Tribunal noted the RMO Dr Marriott as having conceded that the bare figures would place the applicant outside "severe" impairment. The applicant contends that there is no evidence before the Tribunal other than the IQ test in relation to the issue of severe impairment of intelligence. The respondent contends that there is other evidence on which Dr Marriott and the Tribunal were entitled to conclude that the applicant suffered from severe impairment of intelligence.

[14] Dr Marriott's report of 12 January 2004 was before the Tribunal. That report stated Dr Marriott's opinion that the applicant suffered from mental illness and severe mental impairment. It was stated that her history from early childhood was indicative of severe impairment of intelligence, in particular in the "practical domain". This presented particular difficulty in dealing with problems. Dr Marriott was of the opinion that social/adaptive functioning measures were perhaps the best proxy for elements of practical intelligence. It was stated to be worthy of note that the "performance" aspects of her performance on the WAIS were significantly lower than the verbal aspects.

The Tribunal President has set out on affidavit a summary of the evidence given by Dr Marriott to the Tribunal. He records that she confirmed to the Tribunal that reliance on IQ figures alone was insufficient and masked a poor performance by the applicant in the areas of practical intelligence and her view as a clinician that she had to assess the applicant's intelligence globally.

Dr Marriott's affidavit confirms this approach where she states that intelligence is not limited to the results of IQ and that other aspects of intelligence which impact on a person's capacity, for example to learn

from experience, to make judgments, to appreciate their own limits and to anticipate outcomes, are important. She restates her opinion that the applicant was so severely impaired in these wider aspects of intelligence as to render her severely mentally handicapped.

[15] The applicant objects and that this approach fails to distinguish between the requirement that the applicant suffers from a severe impairment of intelligence as well as severe impairment of social functioning by treating these separate requirements in a cumulative manner. In essence the applicant contends that this is a repetition of the error that occurred in *North and West Belfast Health and Social Services Trust's Application* where there was found to be a failure to recognise the separate requirements for severe impairment of intelligence and severe impairment of social functioning.

[16] I am satisfied that Dr Marriott and the Tribunal assessed the severe impairment of intelligence by reference to wider matters than IQ tests; that it was recognised that this is an exercise of clinical judgment and that it was Dr Marriott's clinical judgment that the applicant suffered from severe impairment of intelligence; that the Tribunal accepted Dr Marriott's clinical judgment; that Dr Marriott and the Tribunal recognised the distinction between severe impairment of intelligence and severe impairment of social functioning; that there are practical matters that bear on social functioning that may also bear on the assessment of intelligence; that Dr Marriott concluded that there was severe impairment of intelligence and severe impairment of social functioning and that there was evidence for that conclusion.

[17] The applicant engaged Dr Colin Preshaw whose letter dated 3 June 2004 was exhibited in this judicial review although the evidence was not available to the Tribunal. If applicants wish to challenge medical evidence they should do so at the Tribunal hearing or if necessary apply to adjourn the hearing to make available their own medical evidence or re-apply to the Tribunal with the benefit of their own medical evidence. Dr Preshaw expressed interest in the sub-test results of the IQ tests and was surprised that further tests had not been requested both generally and in relation to an issue about references to the age level at which a patient might be functioning.

Dr Preshaw states -
"Normal psychiatric practice however does not use IQ tests as much more than support for clinical impression. This assessment usually involves various behavioural and social assessments, use of language and communication skills and general functioning".

This appears to be precisely the assessment carried out by Dr Marriott and accepted by the Tribunal.

The applicant further objects that in making the assessment of severe mental impairment the Tribunal took into account the findings and views of the medical member. That issue will be considered below.

The medical member of the Tribunal

[18] The applicant contends that the medical member of the Tribunal made findings and formed views that were not disclosed to the applicant. Rule 11 of the Mental Health Review Tribunal (Northern Ireland) Rules 1986 provides:

> "At any time before the hearing of the application, the medical member or, where the tribunal includes more than one, at least one of them shall examine the patient and take such other steps as he considers necessary to form an opinion of the patient's medical condition; and for this purpose the patient may be seen in private and all his medical records may be examined by the medical member, who may take such notes and copies of them as he may require, for use in connection with the application."

[19] In *McGrady's Application* [2003] NI 250 Kerr J considered the role of the medical member of Mental Health Review Tribunals. Kerr J noted that the medical member does not reach a final view on the question of whether the applicant is suffering from the specified form of mental disorder; the role is confined to a determination on a provisional basis of the patient's mental condition; the medical

member does not consider whether any mental disorder is sufficiently serious to warrant detention in hospital; the conclusion reached should be disclosed in the course of the hearing (para.24). Before the medical member of the Tribunal has formed any views on the basis of his or her interview with the patient the substance of those views should be communicated to the patient and/or those who are representing him per Dyson LJ in *R (On the application of H) v Ashworth Hospital Authority* [2002] EWCA CIV 923 at paragraph 84.

[20] In *DN v Switzerland* [2001] ECHR 27154/95 a medical member of an Administrative Appeals Commission also acted as Judge rapporteur for the Commission. The medical member interviewed the patient and informed her that he would recommend that she should continue to be detained. The ECHR held that there was a breach of Article 5(4) of the Convention as the circumstances taken as a whole served objectively to justify the applicant's apprehension that the medical member sitting as a Judge in the Commission lacked the necessary impartiality. In *McGrady's Application* Kerr J contrasted the role of the medical member of Mental Health Review Tribunals on the basis that the medical member did not form a final opinion on the single issue that is the subject of examination, namely the mental condition of the patient, and did not make a recommendation as to the disposal of the patient (para.28).

[21] The Mental Health Review Regional Tribunal Chairmen have issued Guidance that provides that medical members must be very careful not to disclose in the preview their own opinion as to the discharge of the patient and must retain an open and judicial mind on the question of discharge until all the evidence has been heard. Further the Guidance provides that Tribunals must make absolutely sure that any significant findings by the medical member and any actual differences between the RMO and the medical member are laid open for the patient's representatives to explore and this must be done at the start of the Tribunal hearing. Kerr J found, in *McGrady's Application* that if the advice contained in the Guidance were to be followed no violation of Article 5.4 would arise (para. 29).

[22] Accordingly it is necessary to establish whether there were any "significant findings" by the medical member or any "factual differences" between the RMO and the medical member and to

determine whether such findings or differences were laid open at the start of the Tribunal in order for the applicant's legal representative to explore such findings or differences.

[23] The applicant refers to the Tribunal President's affidavit to identify three matters which it is contended ought to have been disclosed to the applicant at the hearing. First the medical member had spoken to the applicant's nurse. The nurse had stated that the applicant was quite timid; the applicant needed encouragement in matters of personal hygiene and clothing; the applicant's wardrobe was mostly filled with old newspapers; the applicant had been upset when her Christmas cards had been put in the bin and she wanted to go to the dump to retrieve them. Secondly, the medical member reported that she had formed the view that the applicant has arrested intellectual development with a mental age of a child of about 8 years. This is stated as a provisional finding. Thirdly, the medical member reported that she had tested the applicant's ability for abstract thought by asking her the meaning of some sayings and proverbs and she gave the examples to the Tribunal members which were said to demonstrate the applicant's limited ability for abstract thought and what was described as concrete thinking, that is the applicant interprets what she is told in a literal and rigid fashion.

[24] As to the first matter, namely the interview with the nurse, the first three items referred to were repeats of what otherwise appeared in the reports and evidence before the Tribunal. The fourth item concerning the Christmas cards was a further example of the applicant's reaction to the removal of any of her possessions.

[25] As to the second matter, namely a medical member setting the applicant's mental age at 8 years, it is stated in the medical member's affidavit that the IQ of 67 would more equate to a mental age of approximately 9 years 4 months. In any event the medical member had used a mental age comparison in order to convey to lay persons an estimate of the applicant's capacity to function independently. Dr Preshaw stated that the use of terms like "functioning at an 8 year old level" is not currently in favour because different aspects of social and economic development mature at different rates and even 8 year old children rarely function at all the 8 year old parameters. He stated therefore that he was not really in tune with the medical

member's description of the applicant as having a mental age of a child of about 8 years. Dr Marriott stated that she did not use the term "mental age" except when attempting to explain varying capacities or deficiencies to lay persons, including carers, in order to enhance their understanding of a person's strengths and weaknesses or what to expect from them in the context of their mental handicap. It appeared to Dr Marriott that the medical member had used the terminology in the same way and for the same purpose. I do not consider the medical member's reference to mental age as amounting to a "significant finding" or as involving any "factual difference" between the RMO and the medical member.

[26] The third matter concerns abstract thought and concrete thinking. Dr Marriott in her report of 12 January 2004 referred to the applicant interpreting events and conversation in a very "concrete" manner and that her understanding of language was less than her apparent verbal fluency implied. The medical member gave the Tribunal two examples based on her interview with the applicant. Dr Preshaw states that this exercise has absolutely nothing to do with intelligence or intellectual functioning. The medical member does not agree.
The issue of concrete thinking was raised in Dr Marriott's report. Had the applicant's representatives wished to call evidence to challenge the relevance of such a reference then they might have done so or sought an adjournment to enable them to do so or might have make a further application based on such a challenge. However the issue was raised in the evidence that was before the applicant, and the medical member only introduced two further examples. I do not consider that those examples amounted to "significant findings" by the medical member or "factual differences" between the RMO and the medical member.

[27] Accordingly I am satisfied that none of the matters raised by the applicant on this second ground can be sustained.

Detention in hospital for treatment

[28] The applicant contends that in January 2004 the applicant was not suffering from mental illness or severe mental impairment "of a nature or degree which warrants (her) detention in hospital for

medical treatment" as provided by Article 77(1)(a). The applicant contends that as the mental illness that had warranted detention in July 2002 was controlled by medication and there was no mental illness in January 2004 warranting the applicant's detention in hospital for medical treatment. The concern that the applicant would not continue her medication and thereby regress to her July 2002 condition did not, the applicant argues, satisfy the statutory ground for detention. Further the applicant contends that her continued detention was merely to await the availability of a placement in residential accommodation, which does not warrant detention in hospital.

[29] The Tribunal's decision states that continued detention was really the only option as even in hospital the applicant requires constant coaxing and supervision to look after herself and that her mental impairment combined with her medical health problems mean that she is at substantial risk of serious harm in the community. The Tribunal President's affidavit states that the applicant's mental illness and severe mental impairment warranted detention in hospital for medical treatment. The nature of the medical treatment in hospital is not stated but it is assumed to relate to the need to maintain the course of medication required for the mental disorder.

[30] The point here taken by the applicant concerns the grounds for detention of the applicant for medical treatment. Detention under Article 77(1)(a) requires in the first place that the patient should be found to be suffering from one of the specified forms of mental disorder and secondly that that mental disorder should be of a nature and degree which warrants in-patient treatment in hospital for medical treatment. In the present case it is apparent that the Tribunal was satisfied that the applicant was suffering from both of the specified forms of mental disorder. Did those forms of mental disorder warrant detention for medical treatment as an in-patient?

[31] In *R v Halstrom ex parte W* [1986] 2 WLR 883 the applicant had been admitted to hospital on many previous occasions for treatment for mental disorders. W was living in a hostel but refusing medication, namely injections. Two medical practitioners signed a recommendation for admission to hospital for treatment and W was admitted overnight and granted leave of absence. It was believed

that W would then be a person "liable to be detained" under the Mental Health Act so that the statutory powers to over-ride a refusal to consent to treatment could be brought into operation. As the doctors considered that W should receive treatment while living in the hostel and did not consider that treatment as an in-patient was appropriate her overnight detention and leave of absence were held to be unlawful. W had been found to be well but would suffer relapse without the medication she was refusing. It was held that "admission for treatment" under the Mental Health Act was intended for those whose condition was believed to require a period of treatment as an in-patient. That was found not to apply to W.

[32] In the present case, unlike W, it was not found that the applicant was well. It was found that the applicant continued to suffer from mental illness and severe mental impairment. However the decision concludes by welcoming the applicant's transfer to Glenwood. The question remains, Did the forms of mental disorder warrant detention for medical treatment as an in-patient?

[33] Article 5 of the European Convention provides for the right to liberty and Article 5 (1) (e) states as follows –

> "Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
>
> (e) the lawful detention …… of persons of unsound mind……"

In *Johnson v United Kingdom* [1997] 27 ECHR 296 a Mental Health Review Tribunal found that the applicant was no longer suffering from mental illness during a period of detention from June 1989 to January 1993. The ECHR found a breach of Article 5 of the Convention. The ECHR restated its established case law in relation to Article 5(1)(e) of the Convention as requiring the following three minimum conditions to be satisfied:

> "First he must reliably be shown to be of unsound mind; secondly the mental disorder

> must be of a kind or degree warranting compulsory confinement; thirdly and of sole relevance to the case at issue, the validity of continued confinement depends upon the persistence of such a disorder." (para.60)
>
> "In (the Court's view) it does not automatically follow from a finding by an expert authority that the mental disorder which justified a patient's compulsory confinement no longer persists, that the latter must be immediately and unconditional released." (para.61).
>
> "In the view of the Court it must also be acknowledged that a responsible authority is entitled to exercise a similar measure of discretion in deciding whether in the light of all the relevant circumstances and the interests at stake it would be appropriate to order the immediate and absolute discharge of a person who is no longer suffering from the mental disorder which led to his confinement. That authority should be able to retain some measure of supervision over the progress of the person once he is released and to that end make his discharge subject to conditions." (para.63)

[34] It was stated in the penultimate paragraph of the decision in the present case that the applicant had to be detained. The remainder of the paragraph might suggest that the reason for that conclusion related to personal safety concerns. However the Tribunal President's affidavit confirms that the Tribunal was satisfied that the applicant had to be detained for medical treatment. By welcoming the transfer to Glenwood the decision suggests the absence of a need to detain for medical treatment in hospital. The Tribunal had power to direct the release of the applicant on a future date specified in the direction but did not exercise that power. The Tribunal had power to make certain recommendations with a view to facilitating discharge on a future date. It was not considered appropriate to exercise any such power. The applicant asks why she is being detained on the ground that she

requires treatment in hospital when she will be released on a placement becoming available outside hospital. This leads to a consideration of the final issue, namely the adequacy of the reasons for the decision.

Reasons

[35] The applicant contends that the Tribunal failed to give adequate reasons for detention in hospital for medical treatment as well as for a number of other matters arising from the decision. Rule 23(2) of the 1986 Rules provides-

> "The decision by which the tribunal determines an application shall be recorded in writing by the tribunal. The record shall be signed by the president and shall give the reasons for the decision and in particular, where the tribunal relies upon any of the matters set out in Article 77(1) or (3) or Article 78 (1) or (2) of the Order, shall state its reasons for being satisfied as to those matters."

[36] As stated by Dyson LJ in *R (on the application of H) v Ashworth Hospital Authority and Others* [2002] EWCA Civ 923 in relation to the equivalent statutory duty of Mental Health Review Tribunals in England to give reasons (at para 76) –

> "The adequacy of reasons must be judged by reference to what is demanded by the issues which call for decision. What is at stake in these cases is the liberty of detained patients on the one hand and their safety as well as that of other members of the public on the other hand. Both the detained person and members of the public are entitled to adequate reasons."

[37] I return to the issue of the reasons for the finding that the applicant be detained for in patient treatment in hospital. Rule 23(2) makes particular reference to the statement of reasons for being satisfied of matters under Article 77(1), which sets out the grounds

for detention, including detention in hospital in medical treatment. It is assumed that the reason for in patient treatment relates to the need for supervision to ensure that the applicant continues to take her required medication. Yet the applicant is considered ready to be sent to Glenwood where she will no doubt be subject to supervision but will not receive in patient treatment in hospital. The applicant contends that this decision involves the applicant being detained, not for the reason that she requires in patient treatment in hospital, but by reason of the absence of an available placement outside hospital. There is the appearance of an inconsistency between the need to detain in hospital for medical treatment and the desire for release when a placement become available and the position is not fully explained. I am satisfied that there has not been a adequate statement of reasons in this regard.

[38] Further the applicant contends that the decision fails to set out the approach to the burden and standard of proof. By affidavit the Tribunal President states that the Tribunal adopted the view that in respect of each matter on which it had to be satisfied the onus of proof rested on the Trust and that no onus was placed by the Tribunal on the applicant to establish why she should not be discharged. The applicants do not contend that the burden was placed on the applicant but rather that the Tribunal approach was not stated in the reasons. I accept the Tribunal President's affidavit evidence and am satisfied that it contains an adequate statement of the approach adopted by the Tribunal to the issue of the burden of proof.

[39] Further the applicant contends that the Tribunal decision fails to disclose the role and findings of the medical member. As I am satisfied that the medical member did not make any significant findings and that there were no factual differences between the RMO and the medical member for the reasons sat out above, I am satisfied that it was not necessary for the Tribunal to include in its reasons the role and findings of the medical member.

[40] Further the applicant contends that there was a failure to set out the basis for the other findings of the Tribunal. I am satisfied that the decision gives adequate reasons for the findings that the applicant at the relevant time had a mental illness and a severe

mental impairment, and in particular a severe impairment of intelligence. Further, the decision records that the applicant's discharge would create a substantial likelihood of serious physical harm to herself or to other persons. I am satisfied that the Tribunal has given adequate reasons for all its findings, other than in relation to the need for detention in hospital for medical treatment in the light of the proposed transfer to Glenwood. For that reason alone the decision will be quashed.