13. Directions and other pre-hearing matters

INTRODUCTION

Following receipt and disclosure of the responsible authority's statement or that of the Secretary of State, the other formal stages in the proceedings prior to the hearing involve giving notice of the proceedings (**779**); directing that further information or reports be furnished where appropriate (**783**); giving any other directions necessary to ensure the speedy and just determination of the application (**784**); appointing the tribunal members (**788**); conducting the pre-hearing medical examination (**793**); and giving notice of the hearing (**794**). Each tribunal has a legal chairman whose most important functions are to exercise the tribunal's powers under the rules in relation to such preliminary or incidental matters.

FUNCTIONS OF THE REGIONAL CHAIRMAN

The Act provides that one of the legal members of each Mental Health Review Tribunal shall be appointed by the Lord Chancellor as its chairman.[1] Subject to the Mental Health Review Tribunal Rules 1983, the members who are to constitute a Mental Health Review Tribunal for the purposes of any proceedings are to be appointed by the chairman or, if for any reason he is unable to act, by another member of the tribunal appointed for the purpose by him.[2] Where the chairman of the tribunal is included among the persons appointed to consider an application or reference, he shall be president of the tribunal.[3]

PRELIMINARY AND INCIDENTAL MATTERS

Section 78(2) provides that rules made under that section may in particular make provision for enabling a tribunal, or the chairman of a tribunal, to postpone the consideration of applications[4] and for enabling any functions of a tribunal which relate to matters preliminary or incidental to an application to be performed by the chairman.[5] Rule 5 provides that certain powers of a tribunal may be exercised by the regional chairman prior to the hearing of an application or reference. Any functions conferred on the chairman by the Mental Health Review Tribunal Rules 1983 may, if for any reason he is unable to act, be exercised by another member of that tribunal appointed by him for the purpose.[6]

1. Mental Health Act 1983, s.65(2), Sched. 2, para. 3.
2. *Ibid.*, s.65(2), Sched. 2, para. 4.
3. *Ibid.*, s.65(2), Sched. 2, para. 6.
4. *Ibid.*, s.78(2)(a).
5. *Ibid.*, s.78(2)(k).
6. *Ibid.*, s.78(6).

Assessment applications

Rule 5 applies to references, subject to the necessary modifications set out in rule 29,[7] and to assessment applications "in so far as the circumstances of the case permit."[8]

THE CHAIRMAN'S POWERS : MHRT RULES 1983, r.5

Preliminary and incidental matters

5.— As regards matters preliminary or incidental to an application, the chairman may, at any time up to the hearing of an application by the tribunal, exercise the powers of the tribunal under rules, 6, 7, 9, 10, 12, 13, 14(1), 15, 17, 19, 20, 26 and 28.

The preliminary or incidental matters

The "powers" referred to in rule 5 are the powers to send copies of the documents forming the responsible authority's or the Secretary of State's statement to the applicant or patient, excluding any part contained in a separate document;[9] the power to give notice of the proceedings, including to any person who "in the opinion of the tribunal, should have the opportunity of being heard"[10]; the power to postpone consideration of a further application in the circumstances permitted by the rules[11]; the power to appoint an authorised representative for a patient who does not desire to conduct his own case and to direct that a patient or other party may not be accompanied at a hearing by a person of his choice[12]; the power to withhold a document forming part of the responsible authority's or the Secretary of State's statement from a patient or other applicant[13]; the power to give directions to ensure the speedy and just determination of the proceedings[14]; the power to subpoena any witness to appear before the tribunal or to produce documents[15]; the power to direct that further information or documents be provided and to give directions as to the manner in which, and by whom, the information or reports shall be furnished[16]; the power to make arrangements for an application or reference to be heard by members of the tribunal other than those originally appointed or to transfer the proceedings to a different regional tribunal[17]; the power to agree to an application being withdrawn[18]; the power to give notice of the hearing[19]; the power to extend or abridge time limits specified in the rules[20]; and the power to take steps to cure irregularities.[21]

7 Mental Health Review Tribunal Rules, r.29.
8 *Ibid.*, r.33.
9 *Ibid.*, r.6.
10 *Ibid.*, r.7.
11 *Ibid.*, r.9.
12 *Ibid.*, r.10.
13 *Ibid.*, r.12.
14 *Ibid.*, r.13.
15 *Ibid.*, r.14.
16 *Ibid.*, r.15.
17 *Ibid.*, r.17.
18 *Ibid.*, r.19.
19 *Ibid.*, r.20.
20 *Ibid.*, r.26.
21 *Ibid.*, r.28.

Delegation of functions

The Act provides that any functions conferred on the chairman by the Mental Health Review Tribunal Rules 1983 may, if for any reason he is unable to act, be exercised by another member of that tribunal appointed by him for the purpose.[22] Similarly, where the chairman is for any reason unable to act, the members who are to constitute a tribunal in a particular case may be appointed by another member of the tribunal appointed for the purpose by him.[23] Not all of the statutory functions referred to in rule 5 as "powers" exercisable by the regional chairman or his appointee constitute powers in the normal sense of that word. The provision of the authority's statement to the patient and the service of notices under rules 7 and 20 are more in the nature of duties and these routine matters can clearly be undertaken by administrative staff of a tribunal without reference to the chairman or his appointee. The other preliminary and incidental matters do involve exercising a power and making a decision as to whether and how a particular power should be exercised. These decisions may in practice be taken by executive or administrative staff within a tribunal office, either on their own initiative or by way of delegation. However, it is submitted that the Act makes it clear that the powers may only be exercised by the chairman or his appointee and powers exercised by other persons are *ultra vires*.

GIVING NOTICE OF THE PROCEEDINGS

In the case of patients detained under section 2, the usual procedure is abridged. On receiving an application, the tribunal immediately fixes a hearing date and gives notice of its receipt and the hearing date to the responsible authority, the patient, and his nearest relative. The responsible authority must then endeavour to have the necessary reports prepared within the limited time available. In all other cases, a tribunal which receives an application must give notice of its receipt to the responsible authority, to the patient if it was made by his nearest relative, and to the Secretary of State if made by a restricted patient.[24] The responsible authority and the Secretary of State must then furnish their statements to the tribunal during the period prescribed by the rules. Where the proceedings are commenced by reference, the tribunal gives notice of its receipt to the patient and, if a discretionary reference or one involving a restricted patient, to the responsible authority also, since it might otherwise not be aware of the proceedings and of the need for it to prepare a statement.[25] The purpose of the initial notice of application or reference is therefore limited to notifying the patient and the Secretary of State of the proceedings and obtaining reports from the responsible authority. The other persons or bodies with a possible interest in the proceedings are not notified of them until the responsible authority's statement has been received or, in restricted cases, until the Secretary of State's statement has been received by the tribunal, which will be some three weeks later still. Rule 7 sets out who is to be given notice of the proceedings at this stage and it should be noted that the persons or bodies who receive notice thereby become parties to the proceedings.[26]

22 Mental Health Act 1983, s.78(6).
23 *Ibid.*, s.65(2), Sched. 2, para. 4.
24 Mental Health Review Tribunal Rules 1983, r.4(1).
25 *Ibid.*, r.29.
26 *Ibid.*, r.2(1).

GIVING NOTICE OF THE PROCEEDINGS: MHRT RULES 1983, r.7

Notice to other persons interested

7.—(1) On receipt of the authority's statement or, in the case of a restricted patient, the Secretary of State's statement, the tribunal shall give notice of the proceedings—

(a) where the patient is liable to be detained in a mental nursing home, to the registration authority of that home;
(b) where the patient is subject to the guardianship of a private guardian, to the guardian;
(bb) where the patient is, or will upon leaving hospital be, subject to after-care under supervision, to the person who appears to be the patient's nearest relative, and the persons who are, or will be, the patient's supervisor and community responsible medical officer and in the case of a patient who has not yet left hospital, the person who has prepared the medical report referred to in paragraph 1 of Part F of Schedule 1 to these Rules;
(c) where the patient's financial affairs are under the control of the Court of Protection, to the Court of Protection;
(d) where any person other than the applicant is named in the authority's statement as exercising the functions of the nearest relative, to that person;
(e) where a health authority *or National Health Service trust* has a right to discharge the patient an under the provisions of section 23(3) of the Act, to that authority *or trust;*
(f) to any other person who, in the opinion of the tribunal, should have an opportunity of being heard.

Mental Health Review Tribunal Rules 1983, as amended by the Mental Health Review Tribunal (Amendment) Rules 1996, r.5.

Necessary information provided in the authority's statement

It is, of course, impossible to give notice of the proceedings to bodies such as a registration authority or the Court of Protection unless the tribunal is aware of their involvement in the patient's case. A tribunal therefore relies on the information given to it in the responsible authority's Part A, C or E statement, which is designed to elicit such details **(663, 671)**.

Giving notice to the nearest relative

Rule 7(d) provides that where any person other than the applicant is named in the authority's statement as exercising the functions of the nearest relative, that person must be given notice of the proceedings. The paragraph can easily be misread as referring only to a person authorised by the county court, or by the nearest relative himself, to exercise those statutory functions — the more so since the new paragraph (bb) refers to the person who appears to be the patient's nearest relative. In fact, as the definition of a nearest relative in rule 2(1) makes clear, the person referred to in rule 7(d) is the patient's actual nearest relative if he is personally exercising his statutory functions. However, where a county court order under section 29 is in force, or the nearest relative has authorised some other person to act for him, that person is the person entitled to notice under paragraph (d). In which case, unless the proceedings involve after-care under supervision (see below), the tribunal then has a

discretion to give the actual nearest relative notice under paragraph (f), as a person who ought to be heard.

Cases involving after-care under supervision

In cases involving supervision applications, rule (bb) literally provides that the person appearing to be the nearest relative must always be given notice. Because rule 7(d) already provided that the nearest relative is a party unless a county court order has been made, paragraph (bb) is superfluous in this respect unless it's intended effect is that a displaced nearest relative is always a party. Whether or not that is so, the nearest relative being a party as of right is inconsistent with the statutory framework, because he may not be entitled under the statute to be notified of the existence of the supervision application. Because the rule has the consequence that the patient cannot prevent the nearest relative from being informed about the supervision, and from participating in the proceedings, the *vires* of the rule is questionable **(679)**.

Restricted cases

A restricted patient does not have a nearest relative for the purposes of the Act and the person who would be entitled to notice under paragraph 7(d) if no restrictions existed must therefore rely on being given notice by the tribunal under paragraph (f), as a person who ought to be heard.[27]

Supervision applications and paragraph (bb)

Although the professionals who provide the medical and social reports which constitute the main part of the responsible authority's statement have hitherto been viewed simply as persons involved in presenting the authority's case, generally giving oral evidence on its behalf as well, the rules now depart from that approach where the proceedings involve after-care under supervision. While the responsible authority is a party from the outset, the persons whom it asks to prepare its case by writing the necessary reports then receive personal notice of the proceedings and become parties in their own right. The new provision must partly reflect the pivotal and personal nature of the community responsible medical officer's and supervisor's statutory functions. Where the patient is not yet subject to the supervision, making the doctor in charge of his treatment a party presumably serves the purpose of giving him a continuing status in the proceedings if the patient leaves hospital before the hearing takes place.

The rights of a party to the proceedings

The rights of a party to the proceedings are more limited than they are in most legal proceedings and not all of the parties are on the same footing. The rights of persons with some interest in the proceedings fall into three categories. In the first category are the patient, any nearest relative applicant, the responsible authority and, although not a party, the Secretary of State in a restricted case. They have all the rights of a party but they also have a general right to receive copies of all documents and reports concerning the patient, to hear each other's evidence, to call witnesses, and to questions persons attending the hearing. In the second category are persons who are parties by virtue of the fact that, once reports have been filed, they are entitled to notice of the proceedings under rule 7. However, the rules do even allow the tribunal a

[27] The exceptions and modifications of Part II of the Act mentioned in Sched. 1, Pt. I, para 1 may be compared with these listed in Sched. 1, Pt. II, para 1. Sections 26–28, which define who is the nearest relative, apply to unrestricted hospital order patients but not to those subject to restrictions.

discretionary power to disclose reports about the patient to them [illegible], in consequence, they have no right to make observations about them. They are entitled to notice of the hearing and notice of any step taken which affects whether and where the hearing will take place. They also have the right to be represented, to attend the hearing (subject to the tribunal's general power to exclude persons), and to be notified of the decision and the reasons for it. However, they have no general right under the rules to hear the evidence, to put questions, or to call witnesses. In the third category are persons who are not parties but who have some interest in the proceedings, legitimate or otherwise. They may merely with the tribunal's permission appear at the hearing and take such part as the tribunal thinks proper, subject again to the tribunal's power of exclusion.

RIGHTS OF THE PARTIES UNDER THE 1983 RULES

Rule 2—(1). Unless the context otherwise requires, "party" means the applicant, the patient, the responsible authority, any other person to whom a notice under rule 7 or rule 31(c) is sent or who is added as a party by direction of the tribunal.

	Right	*Rule*
Right to notice	A copy of the written reasons for postponement and period of postponement must be sent to all the parties, although at this stage no notices will have been given under r.7.	9(4)
	Where the proceedings are transferred to another tribunal, notice of the transfer of proceedings shall be given to the parties.	17(2)
	Where an application is withdrawn or deemed to he withdrawn, the tribunal shall so inform the parties.	19(3)
	Where a discretionary reference is withdrawn by the Secretary of State, the tribunal shall inform the parties of this.	29
	The tribunal shall give at least 14 days' notice of the hearing to all the parties, unless all of the parties consent to shorter notice.	20
	Before resuming a hearing adjourned sine die, the tribunal shall give not less than 14 days' notice to the parties unless they have consented to shorter notice.	16(4)
	Where a tribunal wishes to reconvene the proceedings because a recommendation made by it has not been complied with it shall first give all parties not less than 14 days' notice unless they all consent to shorter notice.	25(2)
Representation	Any party may be represented in the proceedings.	10(1)
Hearing	Unless the tribunal otherwise directs, any party appearing before the tribunal may be accompanied by such other person or persons as he wishes, in addition to any authorised representative.	10(6)
	Subject to rule 21(4), which gives the tribunal a power to exclude persons from a hearing, any party may appear at the hearing and take such part in the proceedings as the tribunal thinks proper. The tribunal must in particular hear and take evidence from the applicant, the patient, and the responsible authority who may hear each other's evidence, put questions to each other, call witnesses and put questions to any witness or other person appearing before the tribunal.	22(4)
Decision	The written decision of the tribunal, including the reasons, shall be communicated in writing to all the parties subject to any conditions it may think appropriate as to the disclosure thereof to the patient.	24

Summary

The persons who are parties from the outset have greater rights than other parties, as does the Secretary of State although not a party. In practice, it is worth noting that parties who do not, on receiving notice, express any interest in the proceedings are often not later consulted about the abridgement of notice periods. However, the rules do not permit such a selective approach and all the parties must consent to short notice. Similarly, all of them should receive a copy of the tribunal's decision.

FURTHER INFORMATION AND REPORTS

The Act states that the rules may in particular provide for regulating the methods by which information relevant to an application or reference may be obtained by or furnished to a tribunal and confer on tribunals such ancillary powers as the Lord Chancellor thinks necessary for the purposes of the exercise of their functions.[28] Rule 15 provides that a tribunal may prior to or during a hearing call for such further information or reports as it may think desirable. The power may be used as a way of curing omissions in the responsible authority's statement or that of the Secretary of State or, if the hearing is substantially delayed, as a means of obtaining supplementary, up-to-date, reports. Rule 15 does not correspond to any previous provision in the 1960 Rules. It was added because tribunals considered that they should not need to rely wholly on the reports furnished under what is now rule 6. However, before rule 15 is of any assistance, the reports must first be received. If one or more of the reports is not furnished within the prescribed period, and no application has been made for an extension of the time limit, the tribunal may give a direction under rule 13 **(784)** that the missing report or reports be filed within a specified certain period of time. However, it is exceptional for the tribunal to do this, or to check the adequacy of the authority's statement upon receipt, and the absence of any sanctions means that the rules are frequently not adhered to.

FURTHER INFORMATION, MHRT RULES 1983, r.15

Further information

15.—(1) Before or during any hearing the tribunal may call for such further information or reports as it may think desirable, and may give directions as to the manner in which and the persons by whom such material is to be furnished.

(2) Rule 12(1) shall apply to any further information or reports obtained by the tribunal.

Inadequate medical reports

The standard of medical reports varies markedly in practice. Some are limited to no more than three-quarters of a page, do not include the relevant medical history, and cannot be said to constitute a "full" report on the patient's medical condition.

28 Mental Health Act 1983, s.78(2)(g) and (j).

Although the authorised representative may apply to the tribunal for a [illegible]ection that a further report be provided, the preparation of the patient's case is necessarily hindered by a poor report unless access to his medical records can be agreed. Other reports are not "prepared for the tribunal," being first written for a managers' hearing with the original heading changed and a brief addendum added. Quite often, the report is written by a junior member of the responsible medical officer's team. Although the rules do not prohibit this, the report should ideally be counter-signed by the responsible medical officer, so that it is clear that it accurately reflects his reasons for not discharging the patient.

Inadequate social circumstances reports

The most common fault with the social circumstances report is simply that the writer was obviously unaware of the required content of such reports. Where this occurs, the tribunal may direct that the responsible authority furnishes it with a supplementary report. It is also not uncommon for a previous social circumstances report prepared by some other person to be submitted with an additional paragraph added at the end and the date changed. This is objectionable because the reporter is giving the impression that the views expressed are his own.[29] If the report indicates that no social worker has been allocated to the patient's case, the local authority should be reminded of its obligations under section 117, the National Assistance Act 1948, the National Health Service & Community Care Act 1990, and the relevant departmental guidelines (**745**). In appropriate cases, the representative may wish to consider commissioning an independent social circumstances report.

DIRECTIONS UNDER RULE 13

The Act provides that the rules may in particular make provision for conferring on tribunals such ancillary powers as the Lord Chancellor thinks necessary for the purposes of the exercise of their functions under this Act.[30] Rule 13 confers on tribunals a general power to give directions where that is necessary to ensure the speedy or just determination of an application or reference.[31] By inference, a tribunal direction that a person be added as a party to the proceedings is one given under rule 13.[32] There was no equivalent provision in the 1960 Rules. One of the main aims behind the rule was that it would help to ensure that tribunal hearings were heard within a reasonable time, the European Commission having previously declared admissible a complaint concerning the delay in holding a hearing.

DIRECTIONS UNDER RULE 13

13.—Subject to the provisions of these Rules, the tribunal may give such directions as it thinks fit to ensure the speedy and just determination of the application.

[29] The laziness is normally betrayed by the fact that the stated ages of the patient's relatives are now incorrect and information relating to the current admission is confined to the concluding paragraphs.

[30] Mental Health Act 1983, s.78(2)(j).

[31] Mental Health Review Tribunal Rules 1983, rr.13, 29.

[32] See *ibid.*, r.2(1).

Delays in holding hearings

The number of applications made to tribunals tripled between 1984 and 1995, from 4,321 to 13,390. This tremendous strain on their resources has prevented them from making headway in reducing the time taken to hear applications. Indeed, the situation deteriorated in 1995. The majority of special hospital restricted cases took more than 20 weeks to hear and the waiting times in non-special hospital cases, both restricted and unrestricted, increased.

WAITING TIMES FOR TRIBUNAL HEARINGS: 1994, 1995

Restricted cases

	Under 12 weeks		*13–20 weeks*		*Over 20 weeks*	
	1994	*1995*	*1994*	*1995*	*1994*	*1995*
Special hospitals	16	6	77	38	55	51
Other hospitals	46	23	87	95	33	74
Total	62	29	164	133	88	125

Unrestricted cases (excluding section 2 cases)

	Under 8 weeks		*9–12 weeks*		*Over 12 weeks*	
	1994	*1995*	*1994*	*1995*	*1994*	*1995*
Special hospitals	2	0	9	14	20	30
Other hospitals	476	325	266	309	42	78
Total	478	325	275	323	62	108

The figures above are for the last quarter of 1994 and the last quarter of 1995, as given in the Annual Reports of the Mental Health Review Tribunals for England and Wales.

Historical background

Although the waiting times lengthened in 1995, the problem of delays is not a new one. In its First Biennial Report, the Mental Health Act Commission referred to the high incidence of delays and the consequent erosion of detained patients' rights.[33] The Second Biennial Report returned to the theme, observing that the main reason for the delays at that time was a shortage of tribunal staff. Although precise figures were difficult to collate, the average delay between the application and the hearing was said to be over 14 weeks in the Southern region. In the North Western region, 30 per cent. of cases involved delays of between three and six months, and there had been cases where the authority for a patient's detention had expired before the tribunal was able to sit. As to the special hospitals, 42 cases had been pending for more than six months. In the majority of these cases, there was one report outstanding, usually the social circumstances report. The Commission urged that the matter be given urgent attention and that tribunal offices be given the staff necessary to carry out their task promptly.[34] Subsequently, the Commission has been

[33] Mental Health Act Commission, *First Biennial Report 1983–85* (H.M.S.O., 1985), p.29.

[34] Mental Health Act Commission, *Second Biennial Report 1985–87* (H.M.S.O., 1987), para. 18.3.

discouraged from commenting on tribunal issues, although it has a statutory duty to address them. In its various annual reports, the Council on Tribunals has previously identified a shortage of clerks and judicial members as causes of delay.[35]

The Blumenthal Report

In 1992, the Department of Health commissioned research into the area, the result of which was a report written by Blumenthal and Wessely. The report concluded that the pattern of delay primarily reflected the complexity of the cases. The other important factor was the request for an independent psychiatric report.[36] There was also a correlation between the time taken to prepare the medical and social circumstances reports and the time taken to hear the application. The points are not mutually exclusive. If the medical report is submitted late in the day, there may then be insufficient time to obtain an independent psychiatric report. A survey carried out by the Law Society's Mental Health Sub-Committee in 1990 similarly highlighted the problem of the late submission of medical reports by the responsible authority. It also raised the problems arising from the fact that the allocation of judges' time is beyond the tribunal's control.

Delay and the European Convention

Article 5(4) of the Convention provides that, "Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if his detention is not lawful." Lawful in this context includes "substantive lawfulness." In other words, the holding of a hearing concerning the merits of an individual's detention under the statutory provision which authorises that. On 9 December 1981, the European Commission declared admissible an application which alleged that a delay of 18 weeks between the making of an application and its determination by the tribunal contravened Article 5(4).[37] The Government, seeking a settlement from the Commission, suggested 13 weeks as a reasonable target time. It has clearly failed to meet this target, the majority of special hospital restricted cases currently taking over 20 weeks to hear. Put bluntly, it has dishonoured its part of the understanding upon which that case was settled. Subsequently, a number of patients have sought judicial review in relation to delayed hearings but a ruling has been avoided by offering them an earlier date, necessarily at the expense of other patients.[38] In *Koendjbiharie v. The Netherlands*, the European Court of Human Rights recently held that the extension of a patient's detention more than four months after he had lodged an application constituted a breach of Article 5(4).[39] In *Lines v. United Kingdom*,[40] a conditionally discharged patient was readmitted to hospital under section 3 on 27 July 1993. She was formally recalled to hospital by the Secretary of State on 3 December 1993 and her case then referred to a tribunal. The tribunal heard the matter on 23 February 1994, some seven months after her compulsory admission to hospital. The patient complained that the delay was contrary to Article 5(4) of the Convention. The Government opposed the application, submitting that her review had been "speedy." On 17 January 1997, the European Commission unanimously held that the complaint raised serious issues under Article 5(4) which required determination on their merits. Subsequently, the Government has undertaken to amend the 1983 Rules so that when a conditionally discharged patient is recalled to hospital there must be a tribunal hearing within two months of the date on which the case is referred to a tribunal.[41]

Delays involving section 3 cases

The domestic law is particularly vulnerable with regard to delay in the hearing of unrestricted cases. This is because the 1959 Act abolished the previous requirement that the issue of whether a citizen's detention was justified must be determined in advance by a judicial authority, compensating citizens for this loss by enabling them to have the justification reviewed after the event. However, whereas a person could not previously be detained for a prolonged period of treatment unless a judicial order was first obtained, it is now not uncommon for more than half the authorised period of detention to have expired before there is a judicial determination of the merits. Consequently, the detention of many patients is brought to an end before a judicial hearing takes place, the average period of detention in many hospitals being significantly less than six months.

Final note

It has recently been suggested that the frequency with which patients are entitled to have a hearing might be reviewed, including the entitlement of all section 2 patients to a hearing within a fortnight of admission. However, given that some tribunals discharge up to 40 per cent. of patients at such hearings, the price would be unnecessarily prolonged detention in a significant number of cases. Furthermore, the idea that the problem of delayed access to courts should be solved by curtailing access to courts is unacceptable for many people. It has also been suggested that the new power of supervised discharge will significantly contribute to the workload of tribunals, but it must be unlikely that much use will be made of supervision applications.

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35 As to this, the answer must lie in re-examining whether it is always necessary for a judicial member to hear restricted cases. There are many ways in which such cases could be graded. For example, one might provide that tribunals dealing with the cases of conditionally discharged patients could be presided over by a non-judicial member, leaving it to judicial members to determine whether patients should be released into the community. Or one could distinguish cases according to the type of index offence, whether the case had ever been before the Aarvold Board, or the type of hospital in which the patient is detained (maximum or medium secure units and open wards). Alternatively, one could provide that the Regional Chairman is to determine whether a judicial member is necessary but the Home Secretary may, when filing his statement, require that the case be so allocated. A further option would be for non-judicial members to preside in section 74 cases where the tribunal's power is limited to making a recommendation — this was considered acceptable to the public prior to 1983. Yet another approach would simply be greater flexibility, allowing the Lord Chancellor to authorise suitably experienced non-judicial members to hear restricted cases. Finally, the volume of cases could be reduced by conferring a power of discharge on Mental Health Act Commissioners (the Board of Control had such a power and the Mental Welfare Commission for Scotland still does), by requiring the managers to consider exercising their power of discharge once a tribunal application has been made, and by at least occasionally making use of rule 9.

36 S. Blumenthal and S. Wessely, *The pattern of delays in Mental Health Review Tribunals* (H.M.S.O., 1994).

37 *Barclay-Maguire v. United Kingdom*, App. no. 9117/80. See L. Gostin, "Human Rights, Judicial Review and the Mentally Disordered Offender" (1982) C.L.R. 777.

38 See *e.g.* the judicial review applications made in *R. v. Mental Health Review Tribunal, ex p. Hudson* (unreported, 1986) and *R. v. Mental Health Review Tribunal, ex p. Mitchell* (unreported, 1985). In the latter case, a hearing had been fixed for the day after the expiration of the authority for the patient's detention.

39 *Koendjbiharie v. The Netherlands*, Judgments of the European Court of Human Rights, Series A, Case No. 185–B.

40 *Pauline Lines v. United Kingdom* (App. No. 24519/94), European Commission of Human Rights, First Chamber Decision as to admissibility, 17 January 1997 (**364**).

41 See App. No. 27560/95, which was resolved in 1997 on the basis of this undertaking and upon the Government agreeing to pay the applicant £2000 by way of compensation, plus costs. On 12 March 1997, The NHS Management Executive circularised the proposals for comment.

APPOINTMENT OF THE TRIBUNAL MEMBERS

The Act provides that, subject to the rules, the members who are to constitute a tribunal for the purposes of any proceedings (or class or group of proceedings) shall by appointed by the chairman or, if for any reason he is unable to act, by another member of the tribunal appointed for the purpose by him.[42]

CONSTITUTION

Of the members so appointed, one or more shall be appointed from the legal members[43]; one or more from the medical members[44]; and one or more from members who are neither legal nor medical members.[45] Where the chairman of the tribunal is among the persons appointed, he is the president of the tribunal.[46] In other cases, the legal member is the president or, if more than one has been appointed, the legal member nominated by the chairman.[47] It is, however, extremely rare for more than three members to hear a particular case. The present rule derives from rule 8 of the 1960 rules.

APPOINTMENT OF TRIBUNAL MEMBERS : MHRT RULES 1983, r.8

Appointment of the tribunal

8.—(1) Unless the application belongs to a class or group of proceedings for which members have already been appointed, the members of the tribunal who are to hear the application shall be appointed by the chairman.

(2) A person shall not be qualified to serve as a member of a tribunal for the purpose of any proceedings where—

(a) he is a member or officer of the responsible authority or of the registration authority concerned in the proceedings; or
(b) he is a member or officer of a health authority *or National Health Service trust* which has the right to discharge the patient under section 23(3) of the Act; or
(c) he has a personal connection with the patient or as recently treated the patient in a professional medical capacity.

(3) The persons qualified to serve as president of the tribunal for the consideration of an application or reference relating to a restricted patient shall be restricted to those legal members who have been approved for that purpose by the Lord Chancellor.

Mental Health Review Tribunal Rules 1983, as amended by the Mental Health Review Tribunal (Amendment) Rules 1996, r.6.

42 Mental Health Act 1983, s.65(2), Sched. 2, para. 4.
43 *Ibid.*, para. 4(a).
44 *Ibid.*, para. 4(b).
45 *Ibid.*, s.65(2), Sched. 2, para. 4(c).
46 *Ibid.*, s.65(2), Sched. 2, para. 6.
47 *Ibid.*

Restricted cases

The rules may provide for restricting the persons qualified to serve as members in relation to proceedings of a specified class[48] and make provision for restricting the persons qualified to serve as the president of a tribunal dealing with the case of a restricted patient.[49] Rule 8(3) provides that, "The persons qualified to serve as president of the tribunal for the consideration of an application or reference relating to a restricted patient shall be restricted to those legal members who have been approved for that purpose by the Lord Chancellor." The reasons given in Parliament for this restriction were summarised by Lord Belstead. The Government believed that the power to release restricted patients who might have been convicted of very serious crimes carried with it a "formidable responsibility." It was "essential" that the exercise of the power was vested in those who had the "confidence of the public and of the judiciary" — the latter being responsible for the imposition of restriction orders. Accordingly, it was felt that the tribunals making these decisions should be chaired by lawyers with "substantial judicial experience in the criminal courts."[50]

Persons disqualified from serving

Rule 8(2) *inter alia* provides that a tribunal member shall not be qualified to serve in a particular case if he is a member or officer of the responsible authority, has a personal connection with the patient, or has "recently" treated the patient in a professional medical capacity.[51] The rules do not define what constitutes having "recently" treated the patient. In any case involving a patient who is liable to be detained in a mental nursing home, a tribunal member is also disqualified if he is a member or officer of the Health Authority responsible for registering and inspecting the home or of a Health Authority or NHS trust which has contracted with the home for the patient to be treated there.

The rule against bias

Where application is made that a tribunal's decision should be quashed on account of the alleged bias of one or more tribunal members not disqualified from serving by virtue of rule 8, the proper test is whether there was a real danger of injustice having occurred as a result of the alleged bias. The test is one of real danger rather than real likelihood so as to ensure that the issue is approached in terms of the possibility rather than the probability of bias: *R. v. Gough (Robert)*.[52] In *ex p. Mackman*, objection was made to the appointment of a president who had presided at a recent tribunal involving the same patient.[53] The ratio of the case is often said to be that a president who has dealt with a patient's case may preside at a subsequent tribunal. However, the issue is the danger of bias and it is possible that a president would be disqualified if his conduct of the earlier hearing had been exceptional.

48 Mental Health Act 1983, s.78(2)(c).
49 *Ibid.*, s.78(4).
50 See *Hansard*, Vol. 426, cols. 759–764 (25 January, 1982).
51 The disqualification of a medical practitioner who has recently treated the patient in a professional medical capacity was not a feature of the 1960 Rules.
52 *R. v. Gough (Robert)*, *The Times*, 24 May 1993, H.L.
53 It should be noted that the test of bias applied in *Mackman*, which case pre-dated *R. v. Gough (Robert)*, was whether a reasonable and fair-minded person present at the tribunal and knowing all the relevant facts would have a reasonable suspicion that a fair hearing would not be possible.

R. v. Oxford Regional Mental Health Review, ex p. Mackman

The Times, 2 June 1986 — *Q.B.D., McNeill J.*

The patient was detained in pursuance of a restriction order. On 16 January 1985, his case was considered by the Oxford Mental Health Review Tribunal. The tribunal, presided over by His Honour Judge Schindler, did not direct that he be discharged. The reasons for the tribunal's decision stated that it had preferred the responsible medical officer's evidence to that of the psychiatrist instructed by the patient. Although the patient appeared to have made considerable progress since admission, it was "far too early to form a clear picture of his condition and what the prognosis may be." His future progress needed to be very carefully monitored "and it would be beneficial to him if he co-operated with his RMO in the treatment be advises." The patient then made a further application to the Oxford tribunal. The case was due to be heard on 21 November 1985 and His Honour Judge Shindler was again appointed to sit as the president. When the patient was informed of this, he was concerned that he might not receive a fair and impartial hearing. He later deposed that the president had "very recently formed certain unfavourable views about me and my case ... I knew that he had formed an adverse view of my case just ten months ago, and I could not believe that I would have a fair hearing this time round. I felt that he would be bound to recollect my case from the previous hearing, and consciously or unconsciously to be affected by what he knew or remembered of it, and the stance he had taken. He would be bound to know that he had found against me last time." Moreover, the rules required that copies of previous tribunal decisions and the reasons for those decisions be furnished to any later tribunal. It seemed to the patient that his "only chance of winning His Honour Judge Schindler round lay in what had occurred since January 1985." At the hearing, the patient's counsel applied for the matter to be adjourned so that a different president could sit. He pointed out that the hearing would cover a good deal of the ground which had been covered at the last tribunal. Any person who had sat on such a recent tribunal would be bound to hear echoes of matters considered and opinions discussed when the previous tribunal deliberated on its decision. The tribunal refused the application but was willing to adjourn the hearing until later that day, to give the patient and his legal representatives further time to prepare. The tribunal stated that it was differently constituted, in that different medical and lay members had been appointed, and the independent medical report had been furnished by a different doctor from that whose opinion had been rejected in January. The hearing proceeded in the absence of the patient and his counsel.

Decision of the tribunal

The decision reached was again to refuse discharge. The tribunal's reasons for its decision stated that the patient had made further progress since his last tribunal. However, it was concerned that he still refused to undergo psychotherapy and showed little, if any, insight into his condition and the grave index offence. The patient would present a real danger to the public were he to be discharged.

The application for judicial review

The patient applied for an order quashing: (i) the tribunal's decision to hear and determine the application under the presidency of His Honour Judge Schindler; (ii) the decision of the tribunal on the application consequent upon their decision to hear and determine it in the patient's absence.

The tribunal's case

According to the learned judge's affidavit, the tribunal had discussed the matter fully, taking into account the representations made on behalf of the patient, and whether or not it would be unfair, or could be seen to be unfair, for him to continue as president. Although he remembered the patient from his previous hearing, and had consulted the notes which he made at that hearing, the president denied that his consideration of the case was affected by what had previously occurred and been decided. In every case the tribunal had before it the patient's history and details of previous hearings. It was by reference *inter alia* to these documents that a tribunal was able to assess what progress (if any) a patient had made since the previous hearing. The intendment of the Act was simply that each application should receive fresh adjudication, separate and distinct from the determination of any previous applications. However, that did not mean that there should be a new president for each application. It was thus not the case that the president's previous involvement had denied the patient a fair hearing.

McNeill J.

A president who sat on an applicant's case was not statutorily barred from sitting on a later case involving the same applicant. Reference had been made to *R. v. McElligott, ex p. Gallagher and Seal.*[54] That was a case in which one of the stipendiary magistrates had before him applicants charged with loitering with intent who had been before him on previous occasions. The court went out of its way to say that, although it might be desirable in those circumstances for a different magistrate to hear the matter, there was no point of law which disqualified him from doing so. The proper test was whether a reasonable and fair-minded person sitting in court, and knowing all the relevant facts, would have a reasonable suspicion that a fair hearing was not possible. That proposition was most conveniently expressed in the case of *R. v. Liverpool City Justices, ex p. Topping,* in which Ackner L.J. said that "the correct test to apply is whether there is the appearance of bias, rather than whether there is actual bias."[55] At the end of the day, could the reasonable and fair minded person sitting in court and knowing all the facts have a reasonable suspicion that a fair hearing would not be possible? No such person could have formed that view. Indeed, there were arguably certain advantages in a president sitting on the recurring applications of a particular patient, since one of the important features was to monitor the progress of a patient, as happened here. While it was understandable that the patient with his condition might form the view which he did, that was not the appropriate test. It was not his subjective view which mattered. It was the reasonable and fair-minded person's objective view of the situation. It would be quite wrong for the court to lay down that the constitution of the tribunal or the person presiding must as a matter of law be changed each time. That was not the law and it would be quite wrong to put that obligation upon either the approved legal members or upon those responsible for the tribunal's administration. Whether or not that extended to the membership, other than the president, was not for the court to decide in this case. *Application dismissed.*

54 *R. v. McElligott, ex p. Gallagher and Seal* [1972] Crim L.R. 332.
55 *R. v. Liverpool City Justices, ex p. Topping* [1983] 1 W.L.R. 119 at 122G to 123D.

Commentary

The court left open the question of whether different considerations might apply where it was the medical member who sat on the previous tribunal. The legal issue must still be whether there had been a real danger of injustice. However, the inquisitorial nature of the medical member's role, which involves the taking of other steps deemed *by him* to be necessary to form an opinion, may lend itself more easily to unfairness. The more so because his examination is conducted in private in the absence of the other members, who must rely on him to take all steps necessary to form a medical opinion of the patient's *present* condition. While the evidence presented at the hearing will be heard by a differently constituted tribunal, its constitution for the purposes of the medical examination is necessarily the same as before. There is a difference between a tribunal member who has sat before being able to confine himself to the evidence and arguments presented at the hearing and a medical member not taking those steps to obtain relevant information which he would usually undertake. One can therefore foresee a situation where it is asserted that a medical member did not in any meaningful sense examine the patient, as required by the rules, because he had examined him some months before and had already formed an opinion about his mental condition. While the Act requires a tribunal to consider whether it is satisfied that the patient's condition "then" meets the criteria for discharge, there was a real danger that it was interpreting the evidence according to the same examination and opinion as caused the previous tribunal to reject the medical evidence presented in favour of discharge.

When the members are appointed

Where the proceedings involve a patient who is detained for assessment, the chairman is required to appoint the members upon receipt of the application.[56] In other cases, it is a matter for the chairman's discretion as to when during the proceedings he appoints the members.

Members unable to dispose of the case

The rules provide that where the regional chairman is later of the opinion that it is not practicable or not possible without undue delay for the consideration of the case to be completed by the members appointed, he shall make arrangements for them to be heard by other members of the tribunal.[57]

ARRANGING FOR OTHER MEMBERS TO DISPOSE OF CASE

Transfer of proceedings

17.—(1) Where any proceedings in relation to a patient have not been disposed of by the members of the tribunal appointed for the purpose, and the chairman is of the opinion that it is not practicable or not possible without undue delay for the consideration of those proceedings to be completed by those members, he shall make arrangements for them to be heard by other members of the tribunal.

56 Mental Health Review Tribunal Rules 1983, r.31.

57 *Ibid.*, r.17(1).

THE PRE-HEARING MEDICAL EXAMINATION

The Act states that the rules may in particular authorise the members of a tribunal, or one or more of them, to visit and interview in private the patient.[58] Rule 11 requires the medical member of a tribunal to examine the patient prior to the hearing.[59] It applies to references and assessment applications but, in the latter case, only "in so far as the circumstances of the case permit."[60]

MEDICAL MEMBER'S EXAMINATION : MHRT RULES 1983, r.11

Medical examination

11.— 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 mental 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 *and in the case of a patient subject to after-care under supervision this rule shall also apply to such other records relating to any after-care services provided under section 117 of the Act.*

Mental Health Review Tribunal Rules 1983, as amended by Mental Health Review Tribunal (Amendment) Rules 1996, r.9.

Taking notes and copies of the medical records

Rule 11 provides that the medical member may inspect the patient's medical records and take such notes and copies of them as he may require for use in connection with the application. Rule 12 provides for the disclosure by a tribunal of every document it receives which is relevant to the application. Where the medical member obtains photocopies of medical notes, the question arises whether those documents are thereby received by the tribunal and come within the ambit of rule 12. Where a medical member makes a hand-written note of some entry in the medical records, that note is self-evidently not a document received by the tribunal but one created by a member of the tribunal as an *aide-mémoire*. It may therefore be said that where a copy rather than a note is taken of a document in the case notes, for example a previous medical report or a psychological assessment, the same principle applies. It is no more than a labour-saving device, a way of avoiding the time of making a hand-written record, and the copy does not thereby become a document disclosable under rule 12. The purpose of the rule is to ensure that documents furnished by the parties or the Secretary of State prior to the hearing are seen by the other parties.

58 Mental Health Act 1983, s.78(2)(g).

59 Rule 11 derives from rule 11 of the 1960 Rules, the only material difference being the addition of the final phrase in the present rule ("who may take such notes and copies of them as he may require, for use in connection with the application."). The 1960 rules also provided that a non-medical member could visit the patient prior to the hearing.

60 Mental Health Review Tribunal Rules 1983, rr.29, 33.

This ensures that all the parties have a copy of all the written evidence ...dered to the tribunal and so avoids unnecessary adjournments, as well as helping to define in advance the respective cases for and against discharge. The rules are, however, ultimately less important than the general principles of natural justice. If further copies of reports copied by the medical member are taken for the other members, this can only be because they are considered to be particularly relevant to the decision to be made. Moreover, they are no longer a record made merely for such use as "he requires" but for the use of all the members. It is also difficult to think that a particular report would be copied if its contents were adequately summarised in any medical report previously prepared for the tribunal. There is then a risk that the tribunal's decision may rest on some fact or opinion recorded in the copied document which is not adequately summarised in the reports furnished under rule 6. A point considered in the following case.

Ex p. Clatworthy

In *ex p. Clatworthy*,[61] the Divisional Court quashed a tribunal decision because the reasons given for it did not enable one to see why the medical evidence before the tribunal had not been accepted. Mann L.J. noted that it might be suggested that the tribunal had proceeded on the basis of the medical member's opinion rather than the opinions laid before the tribunal. While there was no explicit suggestion that was the case, His Lordship said that, "Where a tribunal desires to proceed on the basis of some point which has not been put before it and which on the face of the matter is not in dispute, it is in my view in the highest degree desirable that the person whose case is being considered by the tribunal should be alerted to the possibility" (**805**). The same approach must apply if a tribunal has relevant information which is not available to the applicant and which he does not know is in its possession.

GIVING NOTICE OF THE HEARING

Rules 31 (assessment applications) and 20 (all other cases) provide for giving notice of the date, time and place fixed for the hearing.

Assessment cases

Rule 31 provides that on receipt of an application, the tribunal shall give notice of the date, time and place fixed for the hearing to the patient, the responsible authority, the nearest relative (where practicable) and any other person who, in the opinion of the tribunal, should have an opportunity of being heard. Any person to whom such notice is given becomes a party to the proceedings.[62]

Non-assessment cases

Rule 20 provides that the tribunal shall give at least 14 days' notice of the date, time and place fixed for the hearing (or such shorter notice as all the parties may consent to) to all the parties and, in restricted cases, the Secretary of State. The parties are the patient, the responsible authority, any person to whom notice of the proceedings was given under rule 7, and, where relevant, a nearest relative applicant.

[61] *R. v. Mental Health Review Tribunal, ex p. Clatworthy* [1985] 3 All E.R. 699, *per* Mann J.
[62] Mental Health Review Tribunal Rules 1983, r.2(1).

Notice of hearing

20.—The tribunal shall give at least 14 days' notice of the date, time and place fixed for the hearing (or such shorter notice as all parties may consent to) all the parties and, in the case of a restricted patient, the Secretary of State.

Assessment applications

31.—On receipt of an assessment application the tribunal shall—

(a) fix a date for the hearing, being not later than 7 days from the date on which the application was received, and the time and place for the hearing;
(b) give notice of the date, time and place fixed for the hearing to the patient;
(c) give notice of the application and of the date, time and place fixed for the hearing to the responsible authority, the nearest relative (wherever practicable) and any other person who, in the opinion of the tribunal, should have an opportunity of being heard;

and the chairman shall appoint the members of the tribunal to deal with the case in accordance with rule 8."

The venue

Hearings usually take place in the board-room or committee room of the hospital where the patient is liable to be detained or, in cases involving conditionally discharged patients, was detained prior to discharge. In guardianship cases, the hearing may be held at the offices of the local authority appointed as the patient's guardian or, where appropriate, at the hostel where the patient resides. In the case of in-patients who are detained on a locked ward, the hearing may occasionally be held in a side-room on the ward. The authorised representative should resist this if the arrangements give a false impression of the patient's mental state and, in other cases, discuss with staff the appropriateness of any arrangements for escorting a patient to a board-room hearing. On the positive side, the holding of ward-based hearings may have the benefit that the non-medical tribunal members, who often have little or no experience of visiting psychiatric wards, are more acutely aware of the loss sustained by a detained person and the limitations of the ward environment. Wherever possible, an ante-room should be provided for the parties and witnesses or, at the very least, chairs set out in the corridor outside the board-room. Not infrequently, the patient and the parties wait standing in the corridor, although this is rarely an appropriate venue for holding final discussions and taking final instructions, and can also cause the patient unnecessary distress.

The time of the hearing

Conventionally, hearings are scheduled to take place at "10.00am for 10.30am" or at "2.00pm for 2.30pm." This means that those attending are to be present and available to the tribunal at the earlier time but the hearing will not commence until the later time. During the half-hour before the hearing, the medical member will inform the other members of his examination of the patient. Procedural matters may also be dealt with and, in section 2 cases, the reports read. In particular, the social

worker attending the hearing will often bring his report with him, rather than send it to the tribunal or responsible authority in advance. The time of the hearing may affect a patient's ability to participate in the proceedings or the manner in which he gives his evidence and so, in practice, also affect the decision made. For example, the mood of many depressed patients is subject to diurnal variation and lifts as the day progresses. In other cases, where medication is due immediately prior to or during the hearing, the patient may be unduly sedated or become aroused as time passes. Similar problems arise if the hearing takes place shortly before or after depot medication is administered.

Failure to give notice of the hearing

The importance of giving notice was emphasised in the *Oxford case.*[63] In that case, the tribunal determined an application by a restricted patient having failed to give notice of the hearing to the Secretary of State. Lord Bridge described the tribunal's omission as "a breach of the most fundamental rule of natural justice, in that the Secretary of State, as a vitally interested party, was denied a hearing ... Such a fundamental flaw as vitiated the proceedings leading to that decision must surely call for a complete rehearing de novo." Previously, in the Court of Appeal, Lawton L.J. had described the tribunal's failure as "a classic case of a failure of natural justice entitling the court to intervene by ordering judicial review," adding that in future "tribunals, before starting to hear any application when the Secretary of State is not represented, should inquire, and note, whether he has been given notice of the application and when."

Failure to give notice to a party

Although it is well established that a tribunal's decision will be quashed if the Secretary of State did not receive notice of the hearing, it is unclear whether a failure to give notice of the hearing to a party listed in rule 7 would have the same consequence. Their role in the proceedings is less fundamental and they have no right under the rules to see the reports or to take a full part at the hearing, in terms of calling evidence and questioning witnesses. The effect of their absence would rarely be so material as to affect the decision reached, although one can never be entirely sure. On the other hand, the main reason for designating them as parties appears to be to entitle them to notice of the hearing, and of any step which affects whether and where a hearing will take place, so the omission is fundamental in this respect. Judicial review being a discretionary remedy, it may be that the court would simply look at any affidavit setting out the evidence which the absent party would have given, compare this with the reasons for the decision reached, and then decide whether the omission may have affected the decision reached and whether the matter is in any case now academic.

63 *R. v. Oxford Regional Mental Health Review Tribunal, ex p. Secretary of State for the Home Department* [1988] 1 A.C. 20.

14. The hearing

INTRODUCTION

Hearings take place at the hospital where the patient is liable to be detained, most often in the board-room or a committee room. That is also the normal venue if the case involves a patient who has been conditionally discharged or who is subject to after-care under supervision. In guardianship cases, the hearing takes place at the offices of a local authority guardian or, if convenient, at a hostel where the patient is required to reside. Rules 21 and 22 set out the basic hearing procedure but, more importantly, the proceedings must be conducted in a way which is fair and accords with the principles of natural justice. From a legal viewpoint, the issues to be considered in relation to the hearing are whether it should or must be held in private or public (**797**); who is entitled or may be required to attend or appear at the hearing (**800**); who may be excluded from the hearing (**801**); the pre-hearing deliberations (**805**); the hearing itself and the taking of evidence (**807**); the effect of irregularities in the conduct of the proceedings, including failure to comply with the rules (**806, 816**); the power of adjournment (**817**); and sanctions (**826**).

ATTENDANCE AT THE HEARING

The rules provide that a tribunal shall sit in private unless the patient requests a hearing in public and the tribunal is satisfied that a hearing in public would not be contrary to his interests.[1] In practice, it is exceptional for a patient to request a public hearing and virtually all hearings are held in private.

THE RIGHT TO A PUBLIC HEARING

The onus is on the patient to satisfy the tribunal that a public hearing would not be contrary to his interests. Persons other than the patient, including a nearest relative applicant, have no right to request a public hearing. Equally, the fact that a public hearing would be contrary to some other person's interests is not a material

1 Mental Health Review Tribunal Rules 1983, r.21(1). The test under the 1960 Rules was different. Rule 24(1) required a tribunal to hold a public hearing if the patient requested one provided it was satisfied that such a hearing "would not be detrimental to the interests of the patient and would not for any other reason be undesirable." This provision was considered in the case of *R. v. Mental Health Review Tribunal, ex p. Royston* (CO517/83), 10 May 1983, in which the court held that "detrimental" did not refer to the patient's relationship with his responsible medical officer and there had been no specific reason why one should not be held.