SHERIFFDOM OF LOTHIAN AND BORDERS

Case Number: B865/14

Judgment by

SHERIFF PRINCIPAL
MHAIRI M STEPHEN

in appeal
by

B G, named person for the patient J.G.
Applicant/Appellant

against

THE MENTAL HEALTH TRIBUNAL
FOR SCOTLAND
First Respondents

MARK McILWRAITH, Mental Health
Officer, West Lothian Council
Second Respondent

Act: Party Appellant (named person for patient)

Alt: Hunter, solicitor for the Mental Health Tribunal for Scotland

Alt: McEachran, solicitor for the Mental Health Officer

EDINBURGH, 1 August 2014

The Sheriff Principal, having resumed consideration of the appeal, refuses the appeal; adheres to the decision of the Mental Health Tribunal for Scotland dated 4 June 2014 and makes no order on expenses.

(signed) *Mhairi M Stephen*

NOTE:

1. This appeal relates to the patient J.G. (date of birth 17 March 1933). The patient has severe debilitating dementia. Physically she is frail with mobility difficulties which have been exacerbated following fractures sustained at the end of last year. She has osteoporosis. The appellant is her son and named person B.G. He has been the patient's carer and interim guardian until recently.

2. On 10 April 2014 the patient was admitted to St John's Hospital, Livingston and detained under a short term detention certificate (STDC). The appellant disagrees strongly with the patient's detention and made an application for revocation of the STDC in terms of section 50 of the Mental Health (Care and Treatment) (Scotland) Act 2003 ("The 2003 Act"). A curator ad litem was appointed to represent the patient's interests. A hearing was fixed for 7 May 2014. The curator ad litem attended and lodged a psychiatric report by Dr Bhatti which was consistent with the opinion of the Responsible Medical Officer (RMO) and Mental Health officer (MHO). The patient did not attend however the patient's advocacy worker and the appellant did attend together with the RMO and MHO. Following that hearing on 7 May 2014 the Mental Health Tribunal for Scotland (MHTS or Tribunal) refused to revoke the STDC.

3. On 14 May 2014 the MHTS, having considered the evidence of those who attended the hearing, including the appellant, together with the written

evidence and submissions decided to make an interim compulsory treatment order (CTO) the effect of which was to authorise the detention of the patient in hospital for a period of 28 days. That interim order was superseded by the making of a full CTO on 4 June 2014 in terms of section 64 of the 2003 Act. It is that decision which is under appeal.

4. Before the MHTS can make a CTO it must be satisfied that the conditions mentioned in section 64(5) of the 2003 Act are met. These conditions are:-

> *(a) that the patient has a mental disorder;*
> *(b) that medical treatment which would be likely to –*
> *(i) prevent the mental disorder worsening; or*
> *(ii) alleviate any of the symptoms, or effects, of the disorder,*
> *is available for the patient;*
> *(c) that if the patient were not provided with such medical treatment there would be a significant risk-*
> *(i) to the health, safety or welfare of the patient; or*
> *(ii) to the safety of any other person;*
> *(d) that because of the mental disorder the patient's ability to make decisions about the provision of such medical treatment is significantly impaired;*
> *(e) that the making of a compulsory treatment order in respect of the patient is necessary;*

5. An appeal against the decision of the Tribunal to make a CTO may be made on one or more of these grounds:-

> *(a) error of law*
> *(b) procedural impropriety*
> *(c) that the Tribunal acted unreasonably in the exercise of its discretion*
> *(d) the decision is not supported by the facts found to be established by the Tribunal.*

Section 324 of the 2003 Act.

6. The appellant appeals by way of summary application lodged on 10 June 2014. The grounds of appeal are firstly, that the Tribunal erred in law by taking insufficient account of the principles set out in section 1 of the 2003 Act in the making of its decision. The second ground of appeal is that the decision was not supported by the facts and the tribunal erred in conducting the "balancing exercise". Subsequently, the appellant proposed further grounds of appeal based on procedural impropriety and bias. At the appeal hearing on 10 July there being no substantial opposition to the additional grounds the appeal proceeded on the basis of these four grounds. The appellant introduced further amendments dated 7 July 2014 and the document "*amended initial writ* (*updated with authorities 7 July 2014*)" is in effect the appellant's submissions.

7. For the sake of completeness I mention that the appellant lodged appeals against the Tribunal's refusal to revoke the STDC (reference B833/14) and also against the grant of an interim CTO (reference B834/14). I heard submissions from all parties at the commencement of the appeal as to whether there was any live issue to determine in respect of the appeals B833/14 and B834/14. I decided that there was no significant or important point of principle or requirement to clarify the law which may be of public interest. Otherwise, the orders which the appellant sought to appeal were now at an end. The STDC expires after 28 days and the interim CTO has been superseded by the decision to make a CTO which is the subject of this live appeal. Accordingly,

I declined to hear the appeals in respect of the earlier orders which were no longer of any effect.

8. The underlying theme of the appellant's submissions related to his belief that the decision by the MHO and RMO to seek compulsory powers in respect of his mother under the 2003 Act amounted to an abuse of these provisions designed to ensure that he is not allowed to care for his mother and thwarts the court's decision on guardianship in terms of the Adults with Incapacity Act 2010. The appellant had been appointed interim guardian to his mother in November 2013 for six months. The appellant does not believe that there is a real mental health issue to be determined. There is a conspiracy to ensure that he does not look after his mother. The Mental Health Officer is an officer of West Lothian Council. For over a year the appellant has been involved in highly contentious guardianship proceedings involving the Council. There is little or no co-operation between the appellant and the Council due to tension, conflict and mistrust. The appellant is absolutely convinced that only he knows what his mother requires and that he can provide that care. However, he now recognises and accepts the need for assistance. There is no treatment that can be offered to his mother. When able to articulate a view the patient would express a wish to be at home and looked after by the appellant. The patient has an advocacy worker, Barry Stevens, who has conveyed these views to the various Tribunals. The appellant was the interim guardian to his mother until recently. His appointment was recalled by the sheriff at Livingston in May 2014. That decision is also subject to appeal.

This is the background or context to the submissions which I heard on 10 July 2014.

Appellant's Case

9. The appellant presented several written papers in support of the appeal. The document headed "Amended Initial Writ updated with Authorities" together with a paper dated Thursday 10 July 2014 (with background and main issues) and a handwritten paper dated Thursday 10 July 2014 containing seven issues were presented and spoken to by the appellant.

10. Firstly, the appellant argued that the Tribunal had erred by failing to make sufficient findings in fact to support their conclusions and that their reasoning was inadequate. They had failed to state the causal connection between the mental disorder, which is admitted, and the medical treatment which would prevent or alleviate the disorder. There was no treatment for the mental disorder. Although nursing care is stated to be "the medical treatment" the 2003 Act had been used illegitimately with the sole purpose of removing his mother from his care. The only significant risk was the appellant's care. This issue ought to have been dealt with as adult protection proceedings under the Adults with Incapacity Act rather than under the 2003 Act. The CTO, far from alleviating the symptoms, would not assist the patient and would prevent the patient being mobilised in the appellant's care. The Tribunal had simply paid lip service to the requirements of the Act and followed the advice of the RMO and MHO without question. They did not assess the risk

properly. I was referred to the decision of Sheriff Principal Kerr in *Laurie* v *MHTS* [2007] Scot SC 44 and *Scottish Ministers* v *MHTS (re JK)* 2009 SC 398.

11. Furthermore, the appellant argued that the Tribunal had erred in law by failing to take into account the principles set out in section 1 of the Act. In support of this contention the appellant referred to a decision of Sheriff Principal Taylor in *Di Mascio* v *MHTS* 2008 GWD 37-559 together with an article by Adrian Ward "Modern Code for Adults with Incapacity" from the Journal of the Law Society of Scotland in 2001.

12. The appellant argued procedural impropriety by failing to give appropriate weight to the appellant's evidence compared with that given by the RMO and MHO. In so doing the Tribunal had allowed the RMO and MHO to become judges in their own cause contrary to the rules of natural justice. They had failed to act independently as a Tribunal and fulfil their inquisitorial role. Again, reference was made to *Scottish Ministers* v *MHTS (JK)* and *City of Edinburgh Council* v *The Secretary of State for Scotland* 1998 SC(HL) 33. The appellant was critical of the involvement of the RMO and MHO in the Adults with Incapacity proceedings and referred to the Adult Protection Case Conference Minutes of May 2014. This together with the Tribunal's acceptance of the opinions of the RMO and MHO without critical examination was evidence of bias. It was contended that the proceedings under the 2003 were an abuse of power and process simply designed to circumvent the AWI proceedings and remove JG from the appellant's care.

Response on behalf of the Mental Health Tribunal for Scotland

13. Mr Hunter set out briefly the background to the ongoing dispute regarding the care of the patient and whether that be 24 hour nursing care in hospital or care by the appellant at home. This had been hotly disputed.

14. The Tribunal being a statutory Tribunal required to act in accordance with the powers conferred on them by the statute and required to decide the application for the CTO which was before them. They required to apply the statutory rules. In that context medical evidence was extremely important. There was no counter balancing medical evidence before the Tribunal. That said the Tribunal took account of the evidence given by the appellant himself who had informed the Tribunal that the medical evidence in his possession did not support his position and that was why he did not propose to introduce medical evidence.

15. The Tribunal considered the evidence and were entitled, understandably, to give significant weight to the medical evidence given by the RMO and also any other medical evidence available. This was a medical issue. Indeed, the appellant's own evidence supported the view that special care arrangements were required. It is incorrect to say that the appellant's evidence was dismissed without explanation. The Tribunal took account of the appellant's evidence. The weight the Tribunal gave to the RMO reflected the issue they required to determine and the statutory function of the RMO. In this regard I

was referred to the case of *JK*. To give due weight to the RMO's evidence was no any indication of bias or impropriety.

16. Mr Hunter addressed the matter of the section 1 principles. He presented a bundle of authorities dealing with the role of the appellate court; the weight to be given to a specialist Tribunal and the correct approach to the case of *Laurie (supra)*.

17. I was urged to reject the appellant's submissions and refuse the appeal. The appellant, in effect, is suggesting that his own evidence unsupported by any medical evidence should have been accorded sufficient weight to counter balance the medical evidence presented in support of the application. This was simply untenable and the appeal should be refused.

Response on behalf of the Mental Health Officer

18. Mr McEachran who appeared on behalf of the Mental Health Officer referred to the answers lodged on behalf of the MHO. Mr McEachran adopted the arguments presented by Mr Hunter and referred to the answers lodged in response to all three appeals.

19. Mr McEachran addressed me on the factual matters surround the appellant's decision to take his mother home from hospital against medical advice at the beginning of April this year. The patient was then found on the living room floor when the social work care team called on 4 April 2014. This was further

evidence of the risk to the patient which was already evident from the earlier falls which had caused fractures to the patient whilst in the care of the appellant at home. The appellant had refused to allow his mother to be taken back into hospital notwithstanding she had been lying on the floor on the living room having suffered a fall.

20. The appellant's submissions with regard to the role of the expert witness had been misinformed and misguided. The appellant had conflated the role of the expert witness in court giving opinion evidence with the designated duties of the RMO and MHO. In other words, the appellant had not raised any matters which pointed to the Tribunal having erred in law or that they had approached their statutory function in an improper or irregular manner. Mr McEachran did not seek expenses of the other appeals in which there was no live issue however considered that the normal rule with regard to expenses following success should be applied with regard to this appeal.

DECISION

21. An application to the Tribunal for a CTO may be made by, and only by, a Mental Health Officer – section 63(1) of the 2003 Act. Indeed, the MHO comes under a duty to apply for a CTO where two medical practitioners carry out examinations and are satisfied that the patient has a mental disorder; that there is medical treatment available which would either prevent the disorder worsening or alleviate any of the symptoms or effects of the disorder; that due to the mental disorder the patient's ability to make decisions about

medical treatment is significantly impaired; that if the patient were not provided with such medical treatment there would be a significant risk to the health and safety or welfare of the patient and that the making of a CTO was necessary.

22. Two medical practitioners prepared reports in respect of the patient on 1 May 2014. The first was by Dr Roscrow who is the responsible medical officer for the patient. She is a consultant psychiatrist. Separately, but on the same day the patient's general practitioner, Dr Stirratt examined the patient and prepared a report. Independently, they were satisfied as to the conditions which are a prerequisite for a compulsory treatment order. Thereafter, the MHO came under a duty to apply for a CTO and prepare a report. Both medical practitioners identified constant nursing care supervised by skilled nursing staff as the medical treatment available which would be likely both to prevent the patient's mental disorder worsening and alleviate her symptoms and the effects of that disorder. Both recognised the patient's mental disorder; physical frailty and compromised mobility. Both confirmed that the patient was unable to make decisions about her medical treatment due to her mental disorder and both considered that the making of a CTO was necessary as treatment on a consensual or voluntary basis could not be secured due to the appellant's opposition to medical treatment in a hospital and his determination that he could care for his mother at home. Accordingly, both medical practitioners, independently of each other, came to the view that the patient required constant supervision and nursing; that she

was at high risk of falling and self-neglect. They referred to two fragility fractures suffered by the patient in the past six months due to falls in the domestic setting. The patient had also fallen whilst at home in the care of the appellant at the beginning of April 2014. That briefly sets the context against which the Tribunal required to consider the MHO's application for a CTO in respect of the patient.

23. When the Tribunal determine an application for a CTO under section 63 of the 2003 Act its powers are circumscribed by the Act and in particular Part 7 of the Act which deals with compulsory treatment orders. In determining the application the Tribunal exercise a judicial function and the decision they make is a discretionary one. The function of the Appellate Court in appeals against the exercise of judicial discretion is well settled. It is conveniently set out in *Macphail in Sheriff Court Practice (paragraphs 18.110 to 18.112).* The House of Lords case of *G* v *G (Minors: Custody Appeal)* 1985 1WLR 647 is an important decision. The principle laid down in that case is that the appeal court should not intervene unless it is satisfied that the judge exercised his discretion on a wrong principle or that the decision was so plainly wrong that he must have exercised his discretion wrongly. That authority recognises that it is of the essence of judicial discretion that on the same evidence two different minds might reach widely different decisions without either being appealable or wrong. *G* v *G* was adopted in Scotland in *Britton* v *Central Regional Council* 1986 SLT 207.

24. Accordingly, the Tribunal have a wide discretion in their approach to the evidence before them subject always to the provisions of the 2003 Act and the practice and procedure rules.

25. The core purpose or intention of the 2003 Act is the provision of care and treatment to persons with a mental disorder whether that be in hospital or in the community. Part 7 of the Act and, in particular, section 64 sets out the conditions which the Tribunal must be satisfied on before a CTO can be made. (See paragraph 4). There is no dispute here that the patient has a mental disorder. Thus condition (a) of section 64(5) is met. Therefore, the conditions which must be met before a CTO can be granted have as their purpose "medical treatment" – firstly that medical treatment is available which would be likely to prevent a mental disorder worsening or which alleviates any of the systems or effects of the disorder. Another essential requirement involves consideration of the effect on the patient if she were not provided with the medical treatment available. There must be a significant risk to the health and safety and welfare of the patient. These are clearly matters of utmost importance to the patient. It also must be shown that the patient's ability to make decisions about medical treatment is sufficiently impaired because of the mental disorder. That is not disputed. Finally, the making of the order must be necessary.

26. The appellant argued that the Tribunal had paid insufficient regard to the principles which they require to follow when discharging their function.

These are set out in section 1 of the 2003 Act. Of course the requirement to have regard to the principles is qualified by the words "*in so far as they are relevant to the function being discharged"*. The principles are distinct from the purpose of the Act and are guiding principles which should be taken account of when decisions are being made under the Act. There is no hierarchy of principle however some principles will carry more weight than others depending on the function under consideration and the circumstances of the patient. The principles set out in section 1(3)(e) and (f) underpin the purpose of the Act that is to have regard to the range of options and importance of providing the maximum benefit to the patient. The Tribunal require to take account of the present and past wishes and feelings of the patient. Clearly, they did so. The advocacy worker, Mr Stevens, attended the Tribunal as he had on previous occasions. The Tribunal acknowledge that the patient had in the past expressed a clear wish to be cared for by her son at home. Likewise the appellant and named person conveyed that view to the Tribunal. The appellant is and continues to be of the view that the patient should be cared by him at home. He now acknowledges the difficulties in doing so and would accept additional care assistance at home. Thus the Tribunal are well aware of the patient's stated wishes and the appellant's position. A curator ad litem had been appointed by the court. He is an experienced solicitor in West Lothian. He supports the application. Thus, the Tribunal's decision making function is focussed centrally on the patient. As I have noted the Tribunal require to have regard to the principles in so far as they are relevant to the application. For example, clearly the patient is unable to participate

directly in the proceedings. To address that a curator ad litem had been appointed by the Tribunal to act on behalf of the patient and represent her interests. In deciding the range of options available principle (e) *"the range of options"* and principle (f) *"the importance of providing the maximum benefit to the patient"* carry much weight. Further and overall the Tribunal requires to have regard to the principle articulated in section 1(4) – *"the minimum restriction"* principle. In the penultimate paragraph of the decision the Tribunal discuss their approach to that principle, against the context of where the medical treatment can be provided and the consequences and significant risk if the patient is not treated in hospital. In the absence of compulsion the appellant's stated wish would be to look after his mother at home. Accordingly, I am satisfied that the Tribunal did take account of the principles and gave reasons why, notwithstanding the need for minimum restriction, it is necessary to require that the patient receive compulsory medical treatment in hospital.

27. The case of *Di Mascio* v *Mental Health Tribunal for Scotland* was cited by the appellant in support of this ground of appeal. I cannot readily understand in what way that decision assists. *Di Mascio* is a decision of Sheriff Principal Taylor in 2008. Sheriff Principal Taylor refers to the correct approach by a Tribunal in section 63 applications. If the conditions in section 64(5) are satisfied then a CTO is necessary. However, in determining the measures that the Tribunal should authorise (section 66) they should have regard to the principles which apply. In the two main paragraphs of page 4 of the Tribunal's decision this is what the Tribunal did. The first full paragraph

deals with the section 64(5) requirements and the following paragraph deals with why the measures applied for are necessary (ie a CTO is hospital) notwithstanding full consideration of the principles. The principle set down in section 1(3)(f) (maximum benefit to the patient) is plainly one which prevails over many others including the past wishes of the patient standing her lack of insight and her medical condition; standing the view of the curator ad litem and of course the unchallenged medical evidence as to the patient's mental and physical condition. Accordingly, I do not consider that it can be argued that the Tribunal erred in law by failing to take account or by taking insufficient account of the principles in section 1 of the Act in the making of its decision.

28. Turning to the remaining grounds of appeal. In this case medical opinion was not divided as occurred in *Laurie*. There was no medical opinion which contradicted the view of the RMO and GP and, indeed, the MHO. The dispute related to conditions (b), (c) and (e) of section 64(5). Otherwise there was no significant dispute as to the facts. The patient's medical condition is not in dispute. The appellant was candid with the Tribunal with regard to medical opinion. He stated that he did have medical opinion which was supportive of the RMO and which did not assist his argument. It is the appellant's own view which conflicts with that of the RMO and other medical witnesses. Dr Bhatti prepared a report on the instruction of the curator ad litem which is consistent with the view presented by the RMO and the GP. In the absence of medical opinion which challenged or contradicted the medical

evidence before the Tribunal it is correct and understandable that the Chairman of the Tribunal would explain that the Tribunal were likely to give great weight to the evidence of the RMO. The RMO is the responsible medical officer, a consultant psychiatrist responsible for the patient's condition and care. As such the RMO acts in accordance with the requirements of the 2003. The RMO gives evidence both of fact and opinion. Likewise the general practitioner who has known the patient for a number of years. Dr Bhatti gives, in effect, opinion evidence never having treated the patient and provides a report based upon the medical records and information from nursing staff. Accordingly, the Tribunal had a sufficiency, if not an abundance of medical evidence in support of the application. They were entitled to have regard to that evidence. The RMO provided a report and gave evidence to the Tribunal. The court in *Scottish Ministers* v *Mental Health Tribunal for Scotland (JK)* [2009] CSIH 9 acknowledge the role of the RMO. At page 416 the court observe *"The Tribunal therefore required to pay close attention to all parts of the Responsible Medical Officer's evidence."*. That case involved a restricted patient and the Tribunal required to consider not only the medical evidence from the RMO but also from a Consultant Forensic Psychiatrist instructed on behalf of the patient. In this case there is no contradictory medical evidence and the Tribunal were indeed entitled to place significant weight on the evidence of the RMO. The RMO is supported in her view by the GP and Dr Bhatti.

29. The appellant's submission with regard to the expert evidence misunderstands the Tribunal's function with regard to an application for a CTO. It is necessary where the RMO is the author of one of the Mental Health Reports for the Tribunal to give careful consideration to that report and the RMO's evidence. The RMO and the author of any other medical report provides evidence to assist the Tribunal decide whether the criteria set down at section 64(5) is met. The duty of the Tribunal in the exercise of its discretion is to evaluate all the evidence before it and give it such weight as it considers proper. In this case there is no contradictory medical evidence and the Tribunal clearly had evidence from both the appellant and the MHO as to the background to the patient's care. There is no dispute as to the occurrence of falls by the patient which have led, in at least two instances, to fractures whilst being cared for at home. Lengthy inpatient hospital treatment followed. There is no dispute that there is fundamental disagreement between the appellant and the MHO and others caring for the patient as to the patient's treatment and care. This has led in the past to the appellant taking his mother home from hospital contrary to medical advice. In the absence of other medical evidence it is not difficult to understand why the Tribunal preferred the evidence of the RMO who is involved in the medical care of the patient.

30. There is no basis for suggesting that the Tribunal allowed the RMO and the authors of other reports to usurp their function. It is clear that the Tribunal evaluated the evidence. Clearly, they gave weight to the evidence of the

RMO and the other medical reports. In an issue which relates to medical treatment and care it is not difficult to understand why that might be so. It is incorrect to say that the Tribunal disregarded the appellant's evidence. The Tribunal are clearly aware of the appellant's position. That is recorded on the first full page of the Tribunal's findings. The Tribunal also had available to them the advice of the curator ad litem, Mr Whitten. He had nothing to say to contradict the application and indeed, was supportive. That is but another factor that the Tribunal were entitled to take account of. As a matter of fact the Tribunal records that the patient:-

> "*needs 24 hour nursing care and support in all the aspects of self-care, with two members of staff whenever she requires to be moved. By reason of her mental illness she becomes very agitated when her care needs are being met to the extent that her behaviour is challenging for experienced nursing staff to deal with safely*".

31. The Tribunal go on to note that the appellant vehemently disagreed with that evidence. Accordingly, not only do the Tribunal accept that past incidents have placed the patient at risk due to injuries she has sustained due to falling but that further attempts to improve her mobility would place her at such substantial risk as to not be in her best interests. This is a clear link between the patient falling and the significant risk to health, safety and welfare of the patient. It is beyond doubt and essentially admitted that the falls have caused the patient to require significant medical treatment in hospital. The provision of medical treatment in the form of 24 hour nursing care would clearly address or minimise that risk in the circumstances of the case the medical treatment specified is nursing care of a specialised and round the clock

variety. In the opinion of the RMO and the GP this care is both necessary and is available. Consistent skilled nursing care in a familiar stable surrounding will benefit the patient and reduce her agitation. The patient needs constant supervision as she has no insight into her condition.

32. The Tribunal address the necessity test with reference to the undisputed background that the appellant would intervene in the care plan and attempt to take the patient home in the absence of compulsion. The appellant maintains that the principle of autonomy has been given scant regard and that the patient's needs could be met at home with appropriate support. The appellant pointed to an agreement or contract which he proposed to the hospital authorities. The proposed rehabilitation care plan envisages the appellant having sole care of the patient from time to time contrary to the assessment of her care needs. The proposed plan envisages that either party may decide when the patient is safe to be discharged back into the appellant's care. The fundamental disagreement between the medical witnesses and the appellant suggests that this is likely to lead to conflict and uncertainty for the future care plan for the patient. Accordingly, the Tribunal's decision that *"in the absence of compulsion, that the making of a Compulsory Treatment Order in the terms applied for is necessary"* is a logical conclusion based upon the material available to the Tribunal.

33. I can detect no error in the Tribunal's approach to the evidence and their evaluation of the evidence. This is a matter primarily for the Tribunal. In

their approach to the balancing exercise they have preferred the preponderance of evidence in support of the application to that of the appellant. That does not disclose any failure to weigh up the evidence properly. The polarised position of the parties on the issue of the care of the patient is such that the worthwhile objective of co-operation cannot be achieved. It is not for the Tribunal to make an assessment of risk based on speculation and possibilities surrounding improvements to patient care at home. The Tribunal have to make a decision based on the statutory criteria and based on the evidence before them. This they have done and they have clearly accepted the unchallenged medical evidence in support of the application. This does not point to bias or impropriety. The Tribunal took into account the evidence of the appellant which was diametrically opposed to the evidence given by the MHO and the RMO.

34. Likewise, I do not consider that there is anything improper about the RMO's involvement in adult protection proceedings. The RMO is the medical officer involved in the patient's care. The RMO has a particularly important role when the patient lacks capacity or understanding or insight. It is entirely legitimate for the RMO to be involved in distinct but related proceedings involving guardianship.

35. It is important to recognise that the making of a CTO is not an irrevocable decision. Part 7 of the 2003 Act sets out detailed provisions for review of CTOs. The RMO comes under a duty to revoke the CTO if he or she is not

satisfied that section 64(5) conditions no longer apply. The RMO has a duty to keep the order under review. The making of an order requiring medical treatment in hospital now does not preclude a community based order being made in future. On the other hand, if the RMO is satisfied, following due procedure, that the order continues to be necessary the RMO comes under a duty to extend the CTO.

36. The role of the appellate court is not to carry out a full review of the evidence and submissions and apply its own judgment. It is necessary to consider whether the Tribunal, as constituted on 4 June 2014, correctly addressed the statutory test on the basis of the evidence and submissions before it. Clearly, the Tribunal had regard to the statutory test. I see no misdirection in law. The Tribunal had regard to all the evidence and submissions before it. It does not follow from the Tribunal's rejection of the appellant's evidence that they failed to have regard to his evidence. They clearly did have regard to his evidence. They are aware of the fundamental differences and disagreements between the appellant and the hospital authorities and the local authority. The Tribunal have a discretion as to how they deal with the evidence. How they exercise their discretion in this case is entirely understandable and logical. The preponderance of evidence favoured the conclusions which they drew from the evidence to the effect that it was necessary to grant the order. The judgment of the House of Lords in *AH and Others (Sudan)* v *Secretary of State for the Home Department (United Nations High Commissioner for Refugees Intervening)* [2008] 1AC was referred to particularly the dicta of Baroness Hale

of Richmond and her observations as to the approach of the Appeal Court to decisions of expert Tribunals. Clearly, the MHTS is such a tribunal having discrete jurisdiction under the 2003 Act. In the *Sudan* case Baroness Hale at page 691 had this to say:-

> *"This is an expert tribunal charged with administering a complex area of law and challenging circumstances. To paraphrase a view I have expressed about such expert tribunals in another context, the ordinary courts should approach appeals from them with an appropriate degree of caution; it is probable that in understanding and applying the law in their specialised field the tribunal will have got it right: see Cooke v Secretary of State for Social Security [2002] 3 AllER 279 para 16. They and they alone are the judges of the facts. It is not enough that their decision on those facts may seem harsh to people who have not heard and read the evidence and arguments which they have heard and read. Their decisions should be respected unless it is quite clear that they have misdirected themselves in law. Appellate Courts should not rush to find such misdirection simply because they might have reached a different conclusion on the facts or expressed themselves differently."*

37. Accordingly, this appeal falls to be refused. I do not propose to make any order in respect of expenses.

(signed) *Mhairi M Stephen*

MMS