FIRST DIVISION, INNER HOUSE, COURT OF SESSION

[2015] CSIH 18
XA129/14

Lord Eassie
Lady Smith
Lord Brodie

OPINION OF THE COURT

delivered by LADY SMITH

in the APPEAL

by

BG

Appellant;

against

(FIRST) MENTAL HEALTH TRIBUNAL FOR SCOTLAND and (SECOND) MARK McILWRAITH, MENTAL HEALTH OFFICER

Respondents:

For the appellant: Party
For the first respondent: Springham; Russell Hunter, Solicitor
For the second respondent: MacGregor; Anderson Strathern LLP

4 March 2015

Introduction

[1] This is an appeal by JG's son from a decision of the sheriff principal of Lothian and Borders refusing his appeal against a decision of the Mental Health Tribunal for Scotland ("MHTS"). The decision of the MHTS which he had appealed against was a decision to make a compulsory treatment order ("CTO") in relation to his mother. The appellant is a

named person under the provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act"), Part 17, Chapter 1. He was also, formerly, his mother's carer and interim guardian under and in terms of the relevant provisions of the Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act"). The CTO authorised the detention of JG in hospital and the giving of medical treatment in accordance with Part 16 of the 2003 Act.

Background

[2] It is not disputed that JG suffers from advanced dementia, cannot mobilise without assistance, is doubly incontinent and requires full nursing care. It is not disputed that, due to her mental condition, she becomes agitated and distressed, including during necessary nursing intervention.

[3] Her condition is summarised in a report by Dr Suzanne Roscrow, a medical practitioner approved under section 22 of the 2003 Act ("the RMO") dated 1 May 2014:

> "This lady suffers from advanced Alzheimers Disease, with poor memory and understanding of recent events. No understanding or knowledge of events prior to her admission. She does not have capacity to make decisions regarding her welfare and care needs. She is unable to respond to simple questions. Her mobility is very poor and she sustained a fractured femur in December 2013 and did not regain mobility. Following this she was transferred to a medical unit and was assessed to require nursing home care. She mobilises with the help of 2 people. She requires full assistance with her continence and self care. She becomes agitated and distressed during nursing interventions and currently continues to require 24 hour nursing input and supervision to maintain her safety and self care."

Dr Roscrow considered that, in these circumstances, if JG were not provided with treatment, there would be a risk to her health, safety or welfare. The treatment required is summarised by her, in the same report:

> "She is at risk of falling without 2 people to mobilise her. She needs to have all personal care given in a sensitive manner to minimise distress and to maintain her physical health and hygiene……24 hour psychiatric nursing care – flexible input from staff to manage her distress during interventions relating to her self

> care……Low dose sedative Medication to help minimise distress and improve sleeping pattern."

JG's general practitioner, Dr Fiona Stirrat, in her report dated 1 May 2014, confirmed that JG has marked cognitive impairment caused by Alzheimer's Disease and that she is, due to her mental condition, unable to care for herself or keep herself safe. She explains that JG has osteoporosis, has suffered two fragility fractures because of falls , needs two people to mobilise her and requires regular toileting, day and night: "She needs total care for taking medication, ADL's, feeding and mobility." Dr Stirrat explains:

> "JG can become agitated in changing circumstances and will benefit from staying in the one place with familiar staff. She still gets upset at times with nursing interventions and benefits from being in a setting where staff have the skills, manpower, 24 hour input that she requires. She needs constant supervision as her mobility is poor and she has had serious falls in the past. She is not aware of this risk and has occasionally tried to set off walking on her own. She needs to be encouraged to take her medication and nutrition."

In his report dated 6 May 2014, the second respondent summarised the information obtained from these three doctors. Having made his own enquiries, he provided some additional information including that the frequency with which JG requires to be checked on account of her double incontinence is two hourly and that her ability to engage with physiotherapy was limited due to her cognitive impairment. He referred to it being felt that she had reached her optimum level of functioning on the ward.

[4] The nursing care identified by these doctors as being required is, of course, available in a hospital setting without there having to be a CTO. However, the appellant does not agree that his mother needs to be in hospital. On 3 April 2014, he removed his mother from St Michael's Hospital – a geriatric, long stay hospital – without informing staff and against medical advice. He took her home. Home for JG is a house on three levels. No aftercare arrangements had been discussed and none were in place. The appellant did not agree that

she should be returned to hospital; the second respondent, accordingly, applied for a short term detention certificate, relying on a report by Dr Rajitha Jayawardena , dated 10 April 2014 which stated that if JG remained at home, she would, due to her very poor cognitive function, be at high risk of falls and self-neglect. The certificate was granted that day and JG was transferred to hospital.

[5] That was not the first occasion on which the appellant had removed his mother from residential care; he had removed her from a nursing home, against the advice of the social work department, in October 2012.

[6] The second respondent also explained, in his report, why it was considered that JG's needs could not adequately be met by the provision of a 24 hour care package delivered in her home; those reasons included the apprehension that the appellant would, once more, remove his mother from hospital and there being a continuing lack of agreement between him and the relevant health care professionals regarding JG's needs.

[7] In November 2013, JG had been able, for the purposes of the 2000 Act proceedings, to express her views to an advocacy worker. They included that she wished to be able to stay in her own home. However, all three of the doctors who examined her in April and May 2014 reported that she did not have capacity to make decisions regarding her own welfare. The second respondent reported, similarly, that he had attempted to ascertain her views and wishes in relation to the proposed care plan but it had proved impossible to do so, due to her cognitive impairment.

Proceedings before the MHTS

The first tribunal

[8] A hearing took place on 14 May 2014 by which time a curator – Mr Whitten - had been appointed. The appellant was present and he lodged a detailed written submission setting out his opposition to the granting of a CTO. Mr Whitten asked for time to make further investigations and invited the tribunal to make an interim CTO. That motion was opposed so the tribunal proceeded to hear and consider evidence and submissions. After having done so, it granted an interim CTO.

[9] It is clear from its detailed reasons that the tribunal gave careful consideration to all the evidential material available to it – both written and oral - including that which was given by the appellant. The tribunal noted that he held very strong views about mobilising JG - that he could do so without help, that she ought to be walking longer distances more frequently, that she should go up and down stairs, at home, on her own and that overall, he knew his mother's care needs better than others. The tribunal explains that it, however, accepted the evidence of the witnesses relied on by the second respondent, particularly that of the three doctors and explains why, on that evidence, it concluded that the appellant's views could not be accepted given that there would be a significant risk to JG's health, safety and welfare if no interim order were granted. In particular, it identified that JG would be deprived of psychiatric and cognitive assessment, 24 hour nursing care, a safe environment and the availability of two persons for mobilisation.

[10] The tribunal not only granted the interim CTO (for no longer than 28 days) but added that the appellant's past and proposed approach to JG's care was of such concern that the Mental Welfare Commission and the Office of the Public Guardian were to be advised of their decision.

The second tribunal

[11] A hearing took place three weeks later, on 4 June 2014, before a differently constituted tribunal, to consider whether or not a CTO should be granted for a longer period. The curator advised that he had completed his investigations and, having done so, supported the second respondent's application for a CTO. The appellant advised the tribunal, at the start of the hearing, that he had obtained two further medical reports but he was not producing them. That was because they were adverse to his views.

[12] The second tribunal had the same written material before them as had the first tribunal and it was also provided with two written submissions from the appellant. It heard oral evidence from Dr Roscrow, Mr Charles MHO (the second respondent's supervisor) and from the appellant. Having heard and considered all the evidence, documentary and oral, it concluded that that there was no substantial dispute about the facts. Its findings in fact included:

- JG is 81 years old and has severe and progressive cognitive impairment caused by advanced Alzheimer's disease;
- JG fell twice at home in December 2013, fracturing her arm and hip;
- JG had not regained any significant degree of mobility despite having spent a lengthy period in an orthopaedic rehabilitation ward;
- JG's dementia causes significant difficulties in caring for her- she becomes very agitated when her care needs are being met;
- Mobilisation requires the assistance of two members of staff;
- Her behaviour can be challenging even for experienced nursing staff;
- JG has no insight into her illness or her needs for nursing care;
- JG, at an earlier stage, clearly expressed a wish to be cared for at home, by her son;

- JG's care needs are such that a nursing home would not be able to provide a sufficient level of care;
- The appellant genuinely believes that he could safely and effectively care for his mother at home; and
- In the absence of a CTO, the appellant would be likely to try to take JG home.

The tribunal concluded that JG's care needs are such that they can only be safely and effectively provided in a hospital. It did not accept BG's view that he could care for his mother at home. The reasons for that are stated as being:

> "…we accepted the view of the RMO …… and in particular in view of the difficulties in caring for JG caused by her dementia…"

At first sight, that is hardly a satisfactory explanation for preferring the views of Dr Roscrow to those of the appellant. Nor is it helpful that these reasons and the conclusion that JG needs hospital care are included in a section which purports to be a statement of findings in fact. However, the conclusion and the explanation have to be read in context and when that is done, it can be seen that the tribunal had in mind not only Dr Roscrow's views, as expressed in her oral evidence, but also the detailed factual information provided by her (as summarised in paragraphs 1 and 2 of page 3 of their written reasons) which accorded with the information contained in Dr Stirrat's and Dr Jayawardena's reports, both of which were amongst the documentary material before the tribunal, and on which it also expressly founded.

[13] The second tribunal, accordingly, issued a CTO on 4 June 2014, for a period of six months. That CTO was extended for a further six months, on 20 November 2014, under section 86 of the 2003 Act.

The statutory framework

[14] In certain circumstances, the MHO is duty bound to apply to the MHTS for a CTO. They include where (i) two approved medical practitioners have examined a patient and are satisfied that the patient has a mental disorder, (ii) that medical treatment likely to alleviate any of its symptoms or effects is available, (iii) that without such treatment there would be a significant risk to the health, safety or welfare of the patient, (iv) that the patient's ability to make decisions about such treatment is significantly impaired due to the mental disorder, and (v) that the making of a CTO is necessary: see section 57 of the 2003 Act.

[15] "Medical treatment" is listed in the interpretation section of the 2003 Act – section 329 – as meaning:

> "…treatment for mental disorder, and for this purpose "treatment" includes –
>
> (a) nursing;
> (b) care;
> (c) psychological intervention;
> (d) habilitation (including education, and training in work, social and independent living skills); and
> (e) rehabilitation (read in accordance with paragraph (d) above)."

Sec 64(5) sets out a list of conditions:

> "…
> (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; and
> (f) where the Tribunal does not consider it necessary for the patient to be detained in hospital, such other conditions as may be specified in regulations."

If they apply, the MHTS may make a CTO (section 64(4)).

[16] When considering whether or not to grant a CTO, the MHTS is obliged to have regard to the wishes and feelings of the patient, the views of any named person, the views of any carer of the patient, the importance of patient participation as fully as possible, the options available, the importance of providing the maximum benefit to the patient , the need to discharge its function in the way that involves the minimum restriction on the freedom of the patient that is necessary and the needs and circumstances of the carer (section 1(2), (3), (4) and (5) of the 2003 Act).

[17] An appeal lies to the sheriff principal from the MHTS' decision to make a CTO (see section 320), on one or more of the four grounds specified in section 324(2), namely:

(a) error of law;

(b) procedural impropriety;

(c) unreasonable exercise of a discretion; and

(d) decision of the tribunal not supported by the findings in fact.

An appeal lies from the decision of the sheriff principal to this court (section 321).

The appellant's submissions

[18] The appellant is to be commended for his diligence in preparing not only a clear note of argument but also a helpful case summary which he handed up at the beginning of the appeal hearing. Both assisted us greatly in understanding the points he wished to make. The latter also clarified that his motion before this court was to revoke the CTO and order that St John's Hospital release JG back into his care. He presented seven distinct grounds of appeal.

The first ground of appeal

[19] The appellant contended that the conditions for granting a CTO listed in section 64(5) were not met because the proposed care plan did not include treatment for his mother's mental disorder , the significant risk identified was not caused by her mental disorder and it was not necessary for her care to be provided by skilled nurses. He relied on the case of *B* v *Croydon Health Authority* [1995] Fam. 133 as support for the first of these propositions.

[20] Counsel for the respondents submitted that the task for the sheriff principal was not to decide herself whether or not the conditions for granting a CTO were met but to decide whether there was any basis on which she could interfere with the tribunal's decision. It was clear that she had understood the statutory test which the tribunal required to apply and, given the material that was before the tribunal, she was entitled to conclude that there was sufficient evidence to support its conclusion. There was a substantial body of evidence all pointing in the same direction and it was, further, supported to some extent by the fact that the appellant had obtained two independent reports but was not producing them because they were adverse to his views. Further, the case of *B* v *Croydon Health Authority* was not in point.

Decision on first ground of appeal

[21] This ground of appeal raises the issue of whether or not the proposed care plan amounts to "medical treatment" as referred to in section 64(5) of the 2003 Act. We have no doubt that it does. "Medical treatment" is defined in section 329 as treatment for mental disorder including nursing and care and such treatment falls within section 64(5) if its purpose is to alleviate the symptoms or effects of the disorder. The proposed care plan qualified on both counts. It is, we consider, clear from the information provided to the

tribunal that the proposal was that JG would, in hospital, receive specialist nursing care directed towards alleviating the symptoms and effects of her dementia. Whilst we can understand why the appellant thought the case of *B* v *Croydon HA* might be of assistance, the analysis and concerns discussed in it are in fact not relevant; they related to the application of different criteria in differently worded legislation (the Mental Health Act 1983). We are, accordingly, not persuaded that this ground of appeal is well founded.

The second ground of appeal

[22] The appellant's second ground of appeal is that the sheriff principal erred in deciding that only medical evidence was relevant; his non-medical evidence had not been given appropriate weight. He, like the RMO in the case of *Scottish Ministers* v *Mental Health Tribunal for Scotland (JK)* 2009 SC 398, had extensive personal knowledge of his mother and his evidence was, accordingly, important.

[23] Counsel for the respondents submitted that weight was a matter for the tribunal; the sheriff principal had been entitled, given the facts, to consider that the tribunal's approach was entirely understandable and logical and nothing relied on amounted to an error on her part.

Decision on second ground of appeal

[24] Insofar as this ground was stated by the appellant as being that the sheriff principal decided that the only relevant evidence was the medical evidence, we consider that he misunderstood matters. Neither the tribunal nor the sheriff principal regarded his views as irrelevant nor, we consider, is there any indication of them failing to appreciate that he had detailed experience of his mother's needs. Neither of them, however, required to prefer his

views. The *Scottish Ministers* case relied on by the appellant is not authority for the proposition that where a person has long-term experience of a patient, that, of itself, entitles their views to be determinative or to be afforded any special weight. We are, accordingly, not persuaded that this ground of appeal is well founded.

The third ground of appeal

[25] The appellant's third ground of appeal is that the sheriff principal erred in deciding that she did not need to examine the factual bases for the opinions of the MHO, the doctors who examined JG or those of the curator. He is critical of the tribunal for having adopted the medical opinions without questioning their factual bases. Also, he had, at the appeal hearing, relied on authorities which stressed the need to examine the factual basis for opinion evidence and they had not been considered by the sheriff principal. He referred to *National Justice Compania Naviera SA* v *Prudential Assurance Company Limited* [1993] 2 Lloyds Rep 68 ("The Ikarian Reefer") in support of this ground.

[26] The respondents' counsel submitted that it is not necessary for a court to examine every authority put before it provided it deals with the substantial issues in an intelligible way (*Moray Council* v *Scottish Ministers* 2006 SC 691*; Eagil Trust Co Ltd* v *Pigott-Brown* [1985] 3 All ER 119, *English* v *Emery Reimbold & Strick Ltd* [2002] 1 WLR 2409) and it was not for the sheriff principal to carry out a full review of the evidence.

Decision on third ground of appeal

[27] When considering whether or not an appellate court has adequately scrutinised a decision under challenge, it is, we consider, important to take account of the nature of its source. Where, as here, the decision is one of a specialist tribunal including specialist

members, the level of forensic examination of factual evidence will not normally be as great as, without that expertise, would be required. A degree of prior knowledge is likely to exist; in the case of MHTS there is, for instance, likely to be prior knowledge of the nature of a particular mental disorder. Further, if there are real questions as to the veracity of the underlying factual material or the reliability of the medical opinions expressed or where there is a divergence of medical opinion, it can be expected that the tribunal members will explore them if they are not addressed in evidence in chief or cross examination by parties. To that extent, the MHTS may fulfil an inquisitorial role.

[28] Those were not, however, the circumstances in this case. There were no conflicts in the underlying facts spoken to in evidence or detailed in the reports and there was no divergence of medical opinion. The curator did not dispute that factual basis and agreed with the medical opinions. The appellant did not challenge the underlying facts. He did have two medical reports but he withheld them because they were adverse to his views; it would seem to follow that they agreed with the other medical reports. Where the appellant parted company with the other witnesses and with the documentary evidence was when it came to forming a view as to whether, on the facts, a CTO was required and the sheriff principal took account of that. It is fair to say, as was touched on in oral submissions, that the decision whether or not to grant a CTO is for the tribunal, not for the relevant doctors and also that the tribunal has a discretion; it "may", if satisfied as to the conditions listed in section 64(5), grant the CTO but it does not have to do so. It could, in an individual case, accept that the conditions are met but consider that the imposition of a CTO would not involve the minimum restriction on the patient's freedom that is necessary in the circumstances (see: section 1(4) of the 2003 Act) – if, for instance, there was in fact, a viable alternative. The tribunal must, accordingly, reach its own view and avoid simply "rubber

stamping" the medical views expressed. It should make it clear, in its written reasons, that that is what it has done.

[29] This tribunal's findings and views are, perhaps, economically expressed and greater clarity could have been achieved when it came to distinguishing between findings in fact and conclusions but it is, we consider, clear that it did reach its own conclusions, it is clear that it did so on the basis of the facts which we have listed in paragraph 12 above and we cannot identify any respect in which it failed to explore any relevant matter. We are, accordingly, not persuaded that this ground of appeal is well founded.

The fourth ground of appeal

[30] The appellant's fourth ground of appeal is that the sheriff principal erred in deciding that the tribunal had given adequate reasons for preferring the evidence of the RMO and MHO to his evidence. He relied on the case of *English* v *Emery Reimbold & Strick Ltd* [2002] 1 WLR 2409 in support of this ground although he accepted that it may be possible to infer the tribunal's reasons. That said, he submitted that the inferred reasons – namely that it preferred the medical evidence – were not valid. Some reliance was also placed on the cases of *Moray Council* v *Scottish Ministers*, *LK* v *Secretary of State for the Home Department* 2009 CSIH 53, and *Lutton* v *the General Dental Council* 2011 CSIH 62.

[31] Counsel for the respondents submitted that the sheriff principal's decision on whether or not the tribunal had given adequate reasons for its decisions including its preference for the medical evidence was not a matter of discretion; it was a matter of law and she was entitled to find that the reasoning was adequately explained. The informed reader could not have been left in any doubt.

Decision on fourth ground of appeal

[32] We agree with counsel for the respondents. The written decision of a tribunal does not require to be an elaborate exposition of legal draftsmanship. Its duty is to give reasons; that involves making findings of fact and answering a question (or questions) of law. Where parties are at issue, an adequate explanation is required but reasons do not become inadequate simply because more explanation could have been given. Much will depend on the circumstances of the individual case and the style of the individual drafter.

[33] The appellant's approach was that this tribunal required to give more detailed reasons because they were rejecting a whole body of evidence, namely his evidence. It is, though, important to ask what it was that they were rejecting. They did not, as we understand it, reject any facts about which he gave evidence. What they rejected was his view regarding the predictions that ought, on the basis of the facts, to be made as to the likely outcome if JG were to be returned home. The explanation which, accordingly, the appellant appears to have been looking for was an explanation of why the tribunal did not agree with him.

[34] We are satisfied that that explanation can readily be found within the tribunal's reasons and, moreover, that the tribunal not only agreed with the unanimous medical view but reached its own conclusion, as it had to do. It is, further, not arguable that they were not entitled, on the facts, to conclude as they did. We are, accordingly, not persuaded that this ground of appeal is well founded.

The fifth ground of appeal

[35] The appellant's fifth ground of appeal is that the sheriff principal did not examine his contention that JG had been removed from her home because of "adult protection" concerns

about how he cared for her. This was a reference to the ongoing sheriff court proceedings relating to orders under the 2000 Act. His contention was that concerns arising in those proceedings were a major influence on the tribunal particularly because of the central role of the MHO in each set of proceedings; there was an ulterior motive and the sheriff principal ought to have addressed that.

[36] Counsel for the respondents submitted that the matters referred to were not central to the issue for this tribunal and the sheriff principal was not obliged to address them. In any event, the individuals referred to were simply performing their statutory duties.

Decision on fifth ground of appeal

[37] We can deal with this ground of appeal shortly. The appellant has not put forward any basis on which it could properly be inferred that the motives of the RMO and MHO were other than to perform their statutory duties in terms of the 2003 Act. In any event, the decision whether or not to grant a CTO was a decision of the tribunal and, as we have already observed, it is clear that they reached their own view. We are, accordingly, not persuaded that this ground of appeal is well founded.

The sixth ground of appeal

[38] The appellant's sixth ground of appeal is that the sheriff erred in deciding that the tribunal had conducted a proper balancing exercise; it had given insufficient weight to his mother's convention rights to liberty and family life and undue weight to the views of health professionals.

[39] Counsel for the respondents submitted that the issue for the sheriff principal was whether or not the tribunal had exceeded its discretion and she was plainly entitled to

conclude that it had not done so. It was aware of JG's wishes and had considered whether the proposed care plan was the least restrictive option; it had, accordingly, complied with what was required in this case by section 1(2), (3), (4) and (5) of the 2003 Act.

Decision on sixth ground of appeal

[40] We agree with counsel for the respondents. It was not for the sheriff principal to carry out her own assessment of the evidence or to decide what weight to give to the evidence.

The seventh ground of appeal

[41] The appellant's seventh ground of appeal is that the sheriff principal misapplied the guidance about respecting decisions of specialist tribunals given by Baroness Hale in the case of *AH (Sudan)* v *Secretary of State for the Home Department* 2008 1 AC 678. She had not, contrary to the sheriff principal's interpretation, urged restraint when looking for errors or departure from the appellate court's duty to scrutinise the decision of an inferior court impartially and with due diligence in relation to the grounds of appeal.

[42] Counsel for the respondents submitted that the appellant had misunderstood the guidance in *AH(Sudan)* which was that where considering decisions of specialist tribunals, the court should recognise that it is probable that, in understanding and applying the law relevant to their specialist fields, they will have "got it right"; the court ought not, accordingly, to begin with a presumption that the tribunal got it wrong.

Decision on seventh ground of appeal

[43] The issue for this court is whether the sheriff principal erred in law. That involves recognising that the task for the sheriff principal was, in turn, to decide whether or not the tribunal that granted a CTO on 4 June 2014, in doing so, misdirected itself in law. If they did not do so, the appeal cannot succeed; it must be that, in some respect, they have got the law wrong. Even a specialist tribunal may misunderstand the relevant law or fail to apply it correctly but, as a general rule, it is more likely than not that they have got the law right. That is, as we understand it, all that Baroness Hale was seeking to emphasise in the passage in the *AH (Sudan)* case. We are, in these circumstances, not persuaded that this ground of appeal is well founded, either.

Decision on the appeal

[44] In common with the second tribunal, we have no reason to doubt that the appellant genuinely believes he could care for his mother at home and that that is what the tribunal ought to have decided. To that end, he seeks to have his views given greater weight. This court could, however, only interfere if, contrary to the sheriff principal's assessment, one of the grounds specified in paragraph 17 above in fact applied. We cannot, however, conclude that any of them do. On the material before it, the tribunal was entitled to make the findings in fact to which we have referred, it took account of all relevant views, it demonstrably had regard to the relevant statutory principles and the conclusion it reached was one which was, plainly open to it in all the circumstances. Further, we cannot, for the reasons we have explained above, conclude that any of the grounds of appeal are well founded. In these circumstances, the appeal is refused.