OUTER HOUSE, COURT OF SESSION

[2011] CSOH 193

P341/10

OPINION OF LORD STEWART

in the Petition of

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Petitioner;

for

Judicial Review of (1) a decision to return him to hospital dated on or about 8 December 2009 by Dr Ian Mitchell and (2) a decision by the Mental Health Tribunal of Scotland dated 4 November 2009

Petitioner: Leighton, advocate; Balfour + Manson LLP for Peter J Woolfson & Co, Glasgow; First and Second Respondents and Fourth Interested Party: MacGregor, advocate; NHS Scotland Central Legal Office
Third Respondents: Springham, advocate; Mental Health Tribunal for Scotland

22 November 2011

[1] This Petition raises further challenging questions about the interpretation of the Mental Health (Care and Treatment) (Scotland) Act 2003 [*cf. Scottish Ministers* v *Mental Health Tribunal for Scotland (MM)* 2010 SC 56; *Sherrit* v *NHS Greater Glasgow & Clyde Health Board* 2011 SLT 480]. I find the most difficult of these questions to be: if a psychiatric patient detained under a hospital-based Compulsory Treatment Order [CTO] is given leave of absence during a number of discontinuous

periods of, say, a few weeks at a time and days here and there, how do you calculate the cumulative period of "9 months in the period of 12 months" ending with the expiry of the latest leave period, which is the maximum total amount of leave allowable in terms of section 127(2) of the Act?

[2] The answer is that you cannot calculate it, or that you cannot calculate it with certainty, which may come to the same thing. At least none of the Counsel who appeared in this case could explain how to do it. This is because, I was told, the Interpretation Act, "calendar month" definition cannot apply in the context of section 127 (2); because the 2003 Act itself does not provide an alternative definition; and because, without other definition, "month" is a variable period, 28 days to 31 days in length, depending on the month in question, so that the cumulative period of "9 months" can mean 252 days or 279 days or anything in between.

[3] Consequential questions arise, the first of which is: does section 127(2) meet the standard of legal certainty for Convention Rights-compliance, particularly for compliance with Article 5 ECHR (right to liberty and security); and, if it does not meet the standard, what are the implications? Luckily these interpretative challenges turn out to be, if not entirely academic, then not the most important questions for determination in this case: but there are plenty of other challenging issues arising both from the terms of the Act and from the apparently disjointed management of the Petitioner's mental health regime.

[4] The Petitioner is or has been a psychiatric patient subject to compulsory treatment. He now applies by way of Judicial Review for damages for alleged wrongful mental-health detention. In order to found his claim for damages he seeks to quash various decisions and certificates connected with the management of his treatment, to have it declared that his CTO ceased to be in force and to have it declared that he was

wrongfully detained for a certain period. He is represented by Mr Leighton, Advocate. The Petition is opposed by the psychiatrist who recalled the Petitioner to hospital at a time when the Petitioner claims his CTO was no longer operative, by the managers of the hospital specified in the CTO as the place of the Petitioner's detention and by the Petitioner's Responsible Medical Officer [RMO] at various material times. These parties are respectively the First Respondent, the Second Respondents and the Fourth Interested Party ["the First Respondent *et al*"]. They are represented by Mr MacGregor, Advocate. Ms Springham, Advocate, represents the Third Respondents, namely the Mental Health Tribunal for Scotland [MHTS]. The MHTS made irreconcilable decisions about the Petitioner's CTO and the Petitioner now seeks to have the Court set aside the MHTS decisions which affirmed the existence of the CTO.

[5] Counsel were agreed that the First Hearing, which took place on 5 and 6 May with a continuation on 15 July 2011, should address the merits of the wrongful detention claim with the question of damages being held over for further discussion, if necessary. Having heard the submissions of Counsel and made *avizandum* I have formed the Opinion that there is merit in the allegation of wrongful detention and that damages will have to be discussed.

Background and legislative framework

[6] In 2002 the Petitioner was diagnosed as suffering from paranoid schizophrenia complicated by cannabis misuse. There followed a number of psychiatric inpatient admissions and four short periods of detention under one short-term detention certificate and three interim CTOs. On 16 June 2008 a full, hospital-based CTO was made by the Mental Health Tribunal for Scotland [MHTS], authorising the

Petitioner's admission to Parkhead Hospital, Glasgow for detention and treatment. The pleadings do not disclose the duration of the original order: but a copy is produced by the Petitioner; and the copy order shows the original CTO granted for a period of six months in conformity with section 66 (1) (a) of the Act which gives the MHTS power to grant a first CTO "for the period of 6 months beginning with the day on which the order is made..." Thereafter the power to extend the CTO lies with the Responsible Medical Officer [RMO], subject to safeguards. In terms of section 86(2) (a) the RMO can authorise a first extension for six months. In terms of section 86(2) (b) and (c), second and subsequent extensions are for twelve months. Presumably, in January 2009, a six months extension of the CTO was authorised by the RMO, which carried the detention forward to 15 June 2009. Since the hearing, Counsel have confirmed that this is what happened. Anyway, for most of his first twelve months under detention the Petitioner was actually on leave of absence from the hospital, living in the community (see below). The first twelve months of detention expired on 15 June 2009.

[7] A number of questions arise in relation to what happened at the beginning of May 2009, which is about six weeks before the presumably extended CTO expired. To understand the controversy, we have to go back to the provisions that authorise compulsory treatment. Section 66(1) of the Act lists the measures that may be authorised by a CTO. Depending on the measures specified in the CTO, CTOs may be community-based or hospital-based. Hospital-based orders may subsequently be varied so as to become community-based orders and *vice versa*, all by application to the MHTS. The Petitioner's CTO made on 16 June 2008 was a hospital-based order. The relevant measure for present purposes is measure (1) (a) of section 66 namely

"the detention of the patient in the specified hospital". The hospital specified was Parkhead Hospital, Glasgow.

[8] The RMO has power to suspend the detention element so as to give the patient, effectively, leave of absence from hospital for, it is conventionally said, a trial of community-based care and treatment. The power to suspend the detention element of CTOs is contained in section 127 which provides as follows [*my underlining*]:

"**127 Suspension of measure authorising detention**

(1) Where-

(a) a patient is subject to a compulsory treatment order that authorises the measure mentioned in section 66 (1) (a) of this Act; and

(b) subject to subsection (2) below, the patient's responsible medical officer grants a certificate specifying a period not exceeding 6 months during which the order shall not authorise that measure,

the order does not authorise that measure during that period.

(2) If the sum of-

(a) the period that the responsible medical officer proposes to specify in a certificate under subsection (1) above; and

(b) the period specified in any other certificate granted under that subsection in respect of the same patient,

would exceed 9 months in the period of 12 months ending with the expiry of the period mentioned in paragraph (a) above, the responsible medical officer may not grant a certificate under that subsection. "

Patients on leave of absence are liable to recall to hospital. Recall is effected under the 2003 Act by the RMO taking advantage of section 127(6) to attach a recall condition to the Suspension Certificate authorising leave [*cf.* section 301(2), discussed below]; or by the RMO exercising his or her power under section 129 to revoke the Suspension Certificate. The existence of the power of recall may be an incentive for some patients to stick to their treatment regime in the community.

[9] I found it helpful to learn how the present system had evolved. Before 1995 there was apparently no restriction on the duration of leave of absence other than that it could not be granted for more than six months at a time. Following several high

profile cases in England, the Mental Health (Patients in the Community) Act 1995 introduced, for the whole United Kingdom, Community Care Orders and a twelve-month limit on consecutive periods of leave. There was apparently nothing to prevent further leave being granted almost immediately afterwards, following a few days in hospital. In 1999 the Scottish Executive appointed a committee chaired by the Rt Hon Bruce Millan to review the working of the Mental Health (Scotland) Act 1984 and to report. The Millan Committee's remit included reference to "leave of absence and care outwith hospital". The six-month limit on any single period of leave in the 2003 Act s. 127(1)(b) and the nine-month cumulative limit in subsection (2) come straight from recommendations 6.21 and 6.23 of the Millan Report [*New Directions: Report on the Review of the Mental Health (Scotland) Act 1984*, SE/2001/56 (Edinburgh, 2001)].

[10] Since "leave" from detention sounds like a good thing, it may surprise some readers to find the Millan Report referring to the potential for "abuse" of long-term leave [Ch 6, §§ 30-32, 72-73]. The nature of the abuse is not spelled out. From the context it seems to involve allowing patients to "drift" in the community perhaps - I don't know - without treatment or without proper supervision of their treatment and always with compulsory powers hanging over them. I have subsequently found that the *Code of Practice* states: "A suspension certificate should only be granted under sections 127 or 128 of the Act where it accords with the assessed needs of the patient and not as a means of managing beds in wards which are running at or above capacity" [*Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice*, Volume 2, "Civil Compulsory Powers (Parts 5, 6, 7 & 20)" (Scottish Executive, Edinburgh, 2005), Ch 8 § 42; see also generally S Lawton-Smith, *Community based Compulsory Treatment Orders in Scotland: the early Evidence* (King's Fund, London, 2006)].

[11] Section 127 gives no clue as to what is meant to happen if the statutory limits for leave - six months any one certificate and nine months cumulo in any twelve month period - are exceeded. Counsel for the Petitioner submitted that insight might be offered by the provisions in Part 20 of the Act relating to "Absconding" and "Effect of unauthorised absence". In accordance with the age-old wisdom that someone who can look after themselves is not in need of compulsory measures of care, section 304(3) provides: "Where, in the case of a patient who is subject to a compulsory treatment order, the patient's unauthorised absence has continued for a period of 3 months, the order shall then cease to have effect."

[12] Particularly for the purposes of the argument around the "unauthorised absence" provisions it is important to understand the timescales. The original CTO was made on 16 June 2008 and as first extended lasted for twelve months. During that twelve month period, the Petitioner was in hospital for an initial period of about one month or 28 days, from 16 June 2008 to 14 July 2008, and again from 1 January to 15 March 2009, a period of about two-and-a-half months or 75 days. By my calculation the Petitioner was on leave for 262 days in the original twelve-month detention period to 15 June 2009. No point is taken about this.

[13] Coming back then to what happened at the beginning of May 2009 about six weeks before the expiry of the extended CTO, the Petitioner has produced the following copy documents dated 6 May 2009 relating to authorisation of leave of absence by suspension of detention effective from 16 May 2009, the expiry date of the immediately previous leave period [*my underlining*]:

- Production No 6/4 (vi), Suspension Certificate Form SUS 1A used to notify the Mental Welfare Commission where a responsible medical

officer authorises a suspension of detention, suspending detention in hospital for the period from 00.00 hours on 16 May 2009 to 00.00 hours on 16 July 2009, signed by Dr Rosemary Moore, RMO, on 06/05/2009;

- Production No 6/4 (vii), Suspension Certificate Form SUS 1 used for suspension of compulsory measures relating to a compulsory treatment order, Part 1a suspending detention in hospital from 00.00 hours on 16 May 2009 to 00.00 hours on 16 November 2009, signed by Dr Rosemary Moore, RMO, on 06/05/2009.

[14] Are these two different leave allowances for different periods starting on the same day, or what? Answer 2 for the First Respondent *et al* states: "Suspension of detention was granted . . . from 16 May to 16 July 2009; and thence to 16 November 2009." This is denied by the Petitioner and by the Third Respondents [Article 2 at 6A-B; Answer 2 at 7D-E of the consolidated print]. The Petitioner avers [Article 8 at 11D-E]:

> "On 16 May the Petitioner's RMO purported to suspend his detention until 16 July 2009. Also on 16 May 2009 the Petitioner's RMO purported to suspend his detention until 16 November 2009."

The First Respondent *et al* and the Third Respondents admit these averments without the "purported to" [Answer 8 for the Fist Respondent *et al* 12C-D; Answer 8 for the Third Respondents at 13A-B]. It may be that the RMO inadvertently put different dates in the suspension certificate, Form SUS 1, and in the notification, Form SUS 1A. Counsel for the First Respondent *et al* in oral submissions suggested a "transcription error", by which I understand him to mean an error in transcribing the leave details from the Suspension Certificate Form SUS 1 to the Suspension

Notification Form SUS 1A. This seems entirely possible and would explain why there is no corresponding Form SUS 1A for Production No 6/4 (vii) and no corresponding Form SUS 1 for Production No 6/4 (vi). All this, however, is to an extent speculation. There is actually (and surprisingly) no evidence that I have been directed to explaining the discrepancy. In any event, in the absence of submissions to the contrary, I would venture that the Certificate rules. In other words, on 6 May 2009 detention was suspended and leave was granted for the period of six calendar months or 183 days ending at midnight on 15 November 2009, or purportedly so.

[15] Whatever view you take about how the computation should be done - and this is something all Counsel are agreed about - the six-month Suspension Certificate commencing 16 May 2009 carried the leave allowance beyond the statutory cumulative nine-month limit. If the "9 months" cumulative maximum is converted to days then, as at 16 May 2009, section 127 authorised further leave of absence to, by my calculation, 22 July at soonest and 12 August 2009 at latest. The Petitioner's calculation is that the latest date was 16 August 2009. Looking backwards from the expiry date of the Suspension Certificate, namely 15 November 2009, which is the statutory perspective, during the preceding period of twelve months starting on 16 November 2008, the Petitioner would have had 290 days of leave compared with the statutory maximum of between 252 days and 279 days. Parties, as I say, agree that there was a leave overshoot: but they are in dispute about its consequences.

[16] The other thing that happened on 6 May, according to the pleadings, was that the RMO extended the CTO for a further twelve months with effect from 16 June 2009 to 15 June 2010. Having extended the CTO for a year, the RMO then applied to the MHTS, by application dated 23 June 2009, to vary the CTO from a hospital-based to a community-based order. The application stated [Production No 6/6, page 2]:

> "The nine month period of suspension of the hospital based order is approaching. D.C. has stated that he would not continue with medication if he were not subject to an order. He is attending appointments at the CMHT [*illegible*]. The order has been suspended. A community order would enable ongoing treatment to continue in conditions of less restriction than that of a hospital based order."

Maybe the RMO reckoned that the MHTS would grant the variation of the CTO to a community-based order as a matter of course and that any potential issues about "the nine month period of suspension" would disappear.

[17] It was not to be. When the MHTS hearing took place on 30 July 2009 the Petitioner's solicitor took a preliminary objection in terms of Rule 44 of the Mental Health Tribunal for Scotland (Practice and Procedure) (No 2) Rules 2005. Rule 44 gives the MHTS power to dismiss "misconceived" cases. A case is misconceived if it is *inter alia* "outwith the jurisdiction of the Tribunal". In deciding the objection, the MHTS gave the following reasons:

> "A submission was made by the solicitor for the patient in respect of a preliminary matter. Put shortly, that was that, the periods of suspension of detention having exceeded the periods permitted by s. 127 of the Act, the Compulsory Treatment Order in respect of the patient has lapsed.
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> [...]
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> The Act is silent as to consequences in relation to the failure of the RMO to comply with the terms of the section. Having considered the parties' arguments, and taking cognisance of the principles of the Act and similar provisions of the 1984 Act (where leave of absence was subject to a time limit which, if exceeded, brought about the lapse of the order), the tribunal finds that the application to vary cannot succeed as the order itself if no longer extant. "

The MHTS dismissed the RMO's application, apparently telling the Petitioner that he was "free to go".

[18] The point about "similar provisions of the 1984 Act (where leave of absence was subject to a time limit which, if exceeded, brought about the lapse of the order)" is an opaque one. None of the Counsel in this case, including the Petitioner's Counsel, could explain it. The nearest thing is section 27 of the Mental Health (Scotland) Act

1984 as amended by sections 6 and 7 of the Mental Health (Patients in the Community) Act 1995. The effect was to extend a period of leave of absence, which might otherwise have expired, pending the outcome of an application for a Community Care Order: but these provisions do not bear the interpretation apparently given by the MHTS determination.

[19] I have to conclude that the MHTS was mistaken (see below). The prudent thing for the Petitioner's clinical team to have done would have been either to challenge the MHTS decision of 30 July 2009 by Judicial Review or to accept the ruling and seek a community-based CTO starting again from scratch. Instead, having taken legal advice, the RMO continued as if the original CTO as further extended remained in force. The Petitioner stayed in the community.

[20] On 16 September 2009, the Petitioner was taken into custody by police officers at his home address and conveyed to Parkhead Hospital in handcuffs. This is said to have been following his "recall" to hospital subsequent to his failure to attend for out-patient reviews and to attend for medication [Article 9 at 13C-D of the print; Production No 6/1, page 2 of 28; Production No 6/2 Clinical Notes, Consultant Review 17/09/09 "... now recalled to hospital from suspended detention of hCTO..."; Production No 6/12, page 9, Discharge letter dated 7 October 2009]. I do not know what the warrant or purported warrant for taking the Petitioner into custody and for this "detention" was, if it was a "detention": the pleadings do not explain; and Counsel did not provide clarification. There was no recall condition in terms of section 127(6) in the CTO Suspension Certificate; the Suspension Certificate had not apparently been revoked in terms of section 129 - the copy revocation *pro forma* produced is blank [Production 6/4 (vii), pages 8 and 9 of 9]; and the subsequent Discharge Letter relating to this admission and certain other documents suggest that the Petitioner was

considered by the clinical team to be still on leave [see below]. Were the Suspension Certificate to have been revoked, the revocation should have been notified to the Mental Welfare Commission for Scotland. "Recall" is not a word used in the context of revocation by the 2003 Act: it was used in the much less elaborate provisions of the predecessor legislation, the Mental Health (Scotland) Act 1984 (as amended) s.27(5).

[21] The hospital admission notes state [Production No 6/12 Initial Assessment, page 11, Chronological Account of Care, page 17]:

> "Re-admitted by Dr Moore [RMO] today - picked up from his flat by Police - in order to sort out CTO (has been suspended for longer than 9 mths leading to a question of its continuation)... Brought to ward by Police from own home. Confusion regarding CTO - has been suspended for longer than 9 months. Short admission to re-instate full CTO though according to legal documents can still detained [*sic*]. D.C. has letter to state otherwise..."

The only other clues to the clinical team's thinking about the legal status of the Petitioner are entries recording that the Mental Welfare Commission, the Central Legal Office [*of NHS Scotland*] and the Legal Office of the MHTS had confirmed the continuing effect of the CTO; and that "the CTO stands for another 7 days" [Production No 6/12 pages 14 and 16]. I cannot make sense of the latter entry.

[22] The Petitioner was noted as telling staff [Production No 6/12 page 13]:

> "I don't have to answer your questions. I don't answer to Dr Moore any more... It's illegal that I'm here. I could sue you."

On the morning of 17 September the Petitioner was given "time out" for one hour. He failed to return to the ward. The notes refer to his "abscondment" and he was described as being "absent without leave". The police were contacted but were apparently unable to trace the Petitioner [Production No 6/12 pages 19 and 20]. After four days the Petitioner was discharged. The Discharge Letter recorded the Petitioner's "Mental Health Act Status" as "Discharged on Suspended Hospital Based CTO - absent without leave" [Production No 6/12, page 9]. The words might be

thought to be self-contradictory. The four days "absent without leave" were deducted in a subsequent calculation of the duration of suspension of detention [Production No 6/11, Decision of MHTS 13 April 2010, page 3 of 4; see also the reference to a "computation (updated to reflect the patient's admission on 16th September", Production No 6/1, page 3 of 28].

[23] On the day the Petitioner walked out of the ward, 17 September 2009, the RMO made another application to the MHTS for variation of the CTO to a community-based order. This application was first considered by the MHTS on 21 September 2009. The solicitor for the Petitioner took a preliminary objection in terms of Rule 44. As subsequently developed the objection was on the basis that the CTO had lapsed, that the matter had already been determined by the MHTS decision of 30 July and that the further application by the RMO was an abuse of process and in violation of the Petitioner's Convention Rights [Production No 6/1, Decision of MHTS dated 4 November 2009, pages 3 to 7 of 28]. The hearing was adjourned to 19 October and further adjourned to 4 November. On 4 November the MHTS rejected the preliminary objection, holding that the CTO remained in force and that the application to vary was competent. Written reasons were issued on 10 November [Production No 6/1, Decision of MHTS dated 4 November 2009].

[24] The MHTS continued consideration of the merits to 17 November 2009. By this time of course, as of 16 November 2009, the Suspension Certificate or purported Suspension Certificate of 16 May 2009 had run its course and on any view the Petitioner was in the community without leave of absence. At the hearing on 17 November the MHTS authorised an interim variation of the CTO to a community-based order for a period of fourteen days and (apparently) continued the matter to allow the Petitioner's solicitor to obtain an independent medical report [Answer 9 for

Third Respondents at 15B; Production No 6/7, Interim Variation Order by MHTS dated 17 November 2009].

[25] Assuming the CTO to have been in force, the interim variation regularised the Petitioner's position in the community. Then, on 27 November 2009 the application for variation of the CTO was withdrawn by a Dr Iain Mitchell, Staff Grade Psychiatrist, First Respondent, presumably on the authority of the RMO [Article 2 at 5C-D, Answer 2 for the First Respondent *et al* at 7B-C, Answer 9 for Third Respondents at 15A-B; Production No 6/9, Notice of Withdrawal of Application dated 27 November 2009]. My understanding, again assuming the CTO to have been in force, would be that following the withdrawal of the underlying application for variation on 27 November, the interim variation order fell and the Petitioner's absence from hospital was unauthorised. If the interim variation order continued to be effective until its expiry on 1 December, the Petitioner's absence became unauthorised after that.

[26] Dr Iain Mitchell, the First Respondent, then recalled the Petitioner to hospital by undated, hand-written letter in the following terms:

> "I am writing to formally recall you to Parkhead Hospital today under the terms of your current hospital-based Compulsory Treatment Order - The Mental Health (Care and Treatment) (Scotland) Act 2003. This is due to non-adherence with your medication."

The Petitioner was taken into custody by police officers and brought by them to the hospital shortly after midnight on 9 December 2009. The hospital admission note indicates an understanding that the CTO continued in force and that the Petitioner had been recalled because of non-compliance with his care plan, in particular because of his failure to take medication since July 2009 and his repeated non-attendance at clinics.

[27] Again, I am unclear as to the warrant for this "detention", if that is what it was. "Recall" appears to mean "recall from leave" and clearly the Petitioner had ceased to be on leave [*cf.* section 301(2)]. Further, the CTO authorised detention and treatment in terms of section 66(1) (a) and 66(1)(b) of the Act: it did not require the Petitioner to attend for treatment or care in terms of section 66(1) (c) or 66(1)(d); nor did the Suspension Certificate effective from 16 May to 16 November 2009 - during which period the defaults were said to have occurred - contain conditions as to treatment and care while on leave such as might have been imposed in terms of section 127(5) and (6). Compare the Suspension Certificate effective from 14 July to 14 September 2008 which specified "to attend outpatient appts @ [*illegible*]; to get depot [*medication*] at Arran [*Resource Centre*]; to attend CPN [*Community Psychiatric Nurse*] at Arran [*Resource Centre*]" [Production No 6/4 (ii) page 3 of 3]. (I understand the Petitioner's "depot" medication to have been administered by injection and released into the body over a number of weeks.) Reading between the lines, the Petitioner stopped complying with his care plan when he was told by the MHTS on 30 July that his CTO had lapsed. His position seems to have been that the medication did not assist and had unwelcome side-effects. On re-admission he appeared to be symptom-free.

[28] Assuming the CTO not to have lapsed, I think it would have been sufficient reason to take the Petitioner into custody and to detain him thereafter that he remained subject to the hospital-based CTO, which, as extended, bore to authorise detention for another six months until 15 June 2010. There is equivocation on this matter in the pleadings for the First Respondent *et al* which may signify uncertainty as to the warrant for taking the Petitioner into custody, if not for re-detaining him [Article 10 and Answer 10 for the First Respondent *et al* at 15C-E].

[29] On re-admission to hospital the Petitioner appeared to have no symptoms of psychosis. Yet, from 15 December, for one month, he was detained in secure conditions in Intensive Psychiatric Care Units elsewhere. By application dated 18 March 2010 the Petitioner's RMO again applied to the MHTS to vary the CTO to a community-based order. By this stage, apparently, the instant proceedings for Judicial Review had been served or were in contemplation and the Petitioner's solicitor made a motion to the MHTS to stay its process pending the outcome of proceedings in the Court of Session. At the hearing on 13 April 2010, the solicitor stated the Petitioner's position to be that "there was no CTO extant". By its determination of 13 April 2010 the MHTS granted the RMO's application and varied the CTO to a community-based order.

[30] The difficulties created by section 127 in practice, for both clinicians and patients, are well-evidenced by the discussion that took place at the MHTS hearing [Production No 6/11, MHTS Decision dated 13 April 2010, page 3 of 4]:

> "The RMO stated that the Patient was not being allowed overnight or weekend passes as the limit for suspension of hospital detention had almost been reached. The RMO did not have the actual figure available though she estimated it was about 7 days. The tribunal adjourned to allow the RMO to obtain the actual figure from Medical Records. When the Tribunal recommenced the RMO stated the Patient had had suspension certificates totalling 7 months and 22 days, excluding 4 days in 9/09 during which he was recorded as having been absent without leave."

The Suspension Certificate of 16 May 2009 bore to authorise leave until 16 November 2009. Previous to that Certificate the Petitioner had been on authorised leave since well before 13 April 2009. After that, there were no certificates. On that basis my own calculation is that, as at 13 April 2010, assuming all Suspension Certificates *intra vires* to the full extent, the Petitioner had been on authorised leave of absence in the preceding twelve months for 217 days, or, assuming without agreeing a deduction to be appropriate, 212 days after deducting the one day in-

patient admission on 16-17 September 2009 and the four days allegedly "absent without leave". There would remain a minimum of 40 days allowable leave - not far off the RMO's calculation - and a maximum of 67, depending on whether "9 months" means 252 days or 279 days. Clearly the RMO had been playing safe - but not necessarily in the interests of the patient.

Remedies sought by the Petitioner

[31] Counsel for the Petitioner contended that the admitted over-allowance of leave to the Petitioner on 16 May 2009 had invalidated the CTO which was the purported warrant (1) for the Petitioner's recall to hospital for 24 hours on 16 September 2009 and (2) for his recall on about 8 December 2009 and continued detention in hospital thereafter. Alternatively, the Suspension Certificate authorising excess leave from 16 May 2009 was *ultra vires* with the result that the Petitioner became "absent without leave" and, after the statutory period of three months, became no longer liable to detention under that particular CTO. In consequence the Petitioner's recall to hospital and continued detention were unlawful.

[32] Counsel also argued that the ruling by the MHTS on 30 July 2009 to the effect that the CTO had lapsed because of the leave overshoot was *res judicata*; that it was an abuse of process for the RMO to make another application for variation of the CTO; and that the differently constituted MHTS was precluded from reconsidering the matter and reaching the opposite conclusion on 4 November 2009. The remedies sought by the Petitioner in relation to the merits so far as still relevant include:

> (1) reduction of the decision of 8 December 2009 to recall the Petitioner to hospital;
>
> [. . .]

(4) declarator that the CTO dated 16 June 2008 has not been in force since at latest 16 August 2008;

(5) reduction of the decision of the MHTS dated 4 November 2009;

(6) declarator that the Petitioner was unlawfully detained from 16 September to 17 September 2009 and from 9 December 2009 to 13 April 2010;

(7) reduction of the decision of the MHTS dated 13 April 2010;

(8) production and reduction of the certificates of suspension of detention relative to the Petitioner dated 16 May 2009 and 16 July 2009. . .

Effect of the Suspension Certificate bearing to authorise excessive leave

Submissions for the Petitioner

[33] Counsel for the Petitioner's primary submission was that the section 127 Suspension Certificate that granted excessive leave from 16 May 2009 caused the CTO to lapse. In consequence there was no warrant for the Petitioner's re-detention so that the detentions of or commencing on 16 September and 8 December 2009 respectively were unlawful.

[34] Counsel pointed out that the MHTS had accepted the "automatic lapse" argument on 30 July 2009. At that time the RMO had applied to the MHTS to vary the CTO to a community-based order. A particular point recorded in the decision as having been accepted by the MHTS involved comparison with the predecessor legislation, the Mental Health (Scotland) Act 1984. Section 27 of the 1984 Act as amended had provision for extending leave of absence beyond the statutory maximum periods if, on the last day of leave, a community care application was pending. There is no comparable "saving" provision in the 2003 Act. The legislature intended the 2003 Act leave limits to be strictly enforced in order to prevent the abuses that had arisen under

the predecessor legislation. It follows that if a leave limit were exceeded without a community-based variation having been made, the CTO must fall. (Counsel stated that no one had been able to trace the reference made by the MHTS to a provision to the same effect in the predecessor legislation.)

[35] Counsel referred to the Millan Report, Chapter 8, pages 78 and 79. Paragraph 71 proposed the making of the decision *during* the six-month maximum leave period as to whether the patient is to be wholly discharged, placed on a community order or re-admitted to detention. Paragraph 73 recognised the potential for abuse in a system which effectively allowed for indefinite leave. Counsel defined the abuse as holding the threat of re-detention over a patient who was apparently well enough for community-based care and who should really be discharged or subject to a community-based order. Recommendation 6.23 at page 79 stated: "The total periods of leave of absence in any 12 month period should not exceed nine months. "

[36] Chapter 3 of the Report recommended that any new legislation should include a statement of principles. The recommended principles were set out at page 23, Recommendation 3.3. These included:

> "8. Least restrictive alternative
>
> Service users should be provided with any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account where appropriate of the safety of others. "

The "least restrictive" principle is enacted in section 1(4) of the Act to the effect that persons discharging functions by virtue of the Act shall do so "in the manner that appears to the person to be the manner that involves the minimum restriction on the freedom of the patient that is necessary in the circumstances".

[37] Counsel continued to the effect that given the background to the legislation, the terms of the legislation, the common law presumption in favour of liberty and the related principle that measures authorising deprivation of liberty should be strictly construed, the matter is sufficiently imperative to justify classifying the nine-month time-limit as one which, if breached, causes the CTO to lapse.

[38] Counsel asked me to consider the options. First, treat the patient as being on unauthorised absence but not liable to be taken into custody and re-detained nor eligible for time-lapse release from compulsory measures in terms of sections 301 to 304. This is an anomalous, limbo-like status, not recognised by the Act. Yet this Act is supposed to make comprehensive provision. Secondly, treat the patient as an absconder in terms of the Act, liable to be taken into custody and re-detained but also eligible for time-lapse release from compulsory measures all in terms of sections 301 to 304. This is offensive given that as far as the patient is concerned he or she is on authorised leave; and it involves that members of the patient's family or other persons who provide accommodation are at risk of imprisonment for the offence of assisting absconding in terms of section 316. There would also be insurance complications for such persons if any loss, injury and damage were to result.

[39] The third option is to treat the CTO as terminated. This is the simple approach. It avoids the difficult questions that otherwise arise as to the status of a patient released from hospital in breach of section 127. There is no necessary detriment to the patient or risk to the public - *ex hypothesi* this is a patient judged fit to be in the community - because the mental health authorities can immediately use, or apply for, such other compulsory measures, including a community-based CTO, as might be thought appropriate.

[40] The secondary and alternative submission for the Petitioner is that the Petitioner should, contrary to the foregoing, be treated as having been an absconder, liable to be taken into custody and re-detained but also eligible for time-lapse release from compulsory measures all in terms of sections 301 to 304. On this alternative view the section 304 time-lapse provision was engaged from 16 May 2009 and the Petitioner's CTO "ceased to have effect" three-months later on 16 August 2009. The CTO having ceased to have effect, there was no warrant for the Petitioner's re-detention, so that the detentions of or commencing on 16 September and 8 December 2009 respectively were unlawful.

[41] Counsel for the Petitioner submitted that a Suspension Certificate that grants excessive leave of absence is wholly invalid and that the excess element is not severable. Accordingly, from 16 May 2009, which was the end date of the immediately preceding valid leave certificate, the Petitioner's absence from hospital was unauthorised. It was implied in the preceding Suspension Certificate that the Petitioner was required to return to hospital at the specified "end time", namely 12.00, on the specified "end date", namely 16 May 2009 [Production No 6/4 (v) of Process]. If he failed to return he was "liable to be taken into custody" in terms of section 304 as an absconder within the meaning of section 301.

[42] Section 304(3) of the Act provides: "Where, in the case of a patient who is subject to a compulsory treatment order, the patient's unauthorised absence has continued for a period of 3 months, the order shall then cease to have effect. "

Section 301 provides:

"**301 Absconding etc. by patients subject to compulsory treatment order**

(1) A patient who is subject to a compulsory treatment order authorising detention in hospital and who-

(a) absconds from-

(i) any place where the patient is kept pending removal to hospital under the order; or
(ii) the hospital in which, under the order, the patient is being detained; or

(b) while being removed to hospital under the order or transferred under section 124 of this Act, absconds,

is liable to be taken into custody and dealt with in accordance with section 303 of this Act. "

Counsel submitted that "absconding" includes a failure to return to lawful detention [*cf.* the Bail Act 1976 s. 6(1) "Offence of absconding"].

Submissions for the First Respondent *et al*

[43] Counsel for the First Respondent *et al* submitted that the issue is one of ascertaining the intention of the legislature: the Act being silent as to the consequences of an over-long suspension of detention, the Court should be slow to conclude that a radical result, namely invalidation of the CTO, as argued for by the Petitioner, was intended. Counsel made a comparison with section 304 which contains express provision for CTOs to lapse in the event of unauthorised absence for three months.

[44] Counsel submitted that the approach proposed in the case of *Soneji* to construing statutory time limits should be adopted in the interpretation of the section 217 limits. It is not useful to discuss whether the "9 months" limit is mandatory or merely directory: the proper approach is a flexible one focusing on the consequences of non-compliance, and posing the question, taking into account those consequences, whether the legislature intended the outcome to be total invalidity of the CTO [*R* v *Soneji and Anr* [2006] 1 AC 340 at §§ 14-17, 23, 24 *per* Lord Steyn; also at §§ 65 and 67 *per* Lord Carswell].

[45] Counsel referred me to two Sheriff Court cases in which the *Soneji* test has been applied in a mental health context. These are *Paterson* v *Kent* 2007 SLT (Sh Ct) 8 especially at 8I-L and §§ 24, 27, 29-35 and *JG* v *Mental Health Tribunal for Scotland* 2010 WL4737734 (14 October 2010) especially at §§ 2, 8, 9 and 11. In *Paterson* Sheriff Principal Dunlop held that the failure of the MHTS to comply with the "5 working days" time limit specified in sections 68 and 69 of the Act did not render incompetent the proceedings of the MHTS to decide whether to make a CTO. In *JG* the issue was whether failure to give notice in compliance with section 60 of the Act invalidated the subsequent application for, and granting of a CTO. Sheriff Principal Taylor held that the notice provision was directory and in any event that the deviation was trivial, that there was no prejudice to the patient and that, in such a situation, the subsequent proceedings were not rendered invalid.

[46] Counsel asked: can it be said that the legislature intended that a *bona fide* arithmetical error should invalidate the Petitioner's entire treatment in terms of the CTO including his treatment in the community? The purpose of the legislation is to provide care and treatment for the mentally disordered. Taking a purposive view there is no good reason why such an error should require the whole process to start again with an application for a fresh CTO. What was the prejudice to the Petitioner in continuing his treatment without a fresh application?

[47] Counsel drew attention to the fact that the RMO had extended the CTO for one year as recently as 6 May 2009. She had not yet reached the stage of being satisfied that it was appropriate to vary the CTO to a community-based order; and the clear indications were that she did not think that the CTO should be revoked. While it is not clear why there is a nine month restriction or why the nine month period should be cumulative or indeed what "9 months" means, it could not readily be thought that the

legislature intended something as important as a CTO falling away in its entirety to happen by implication. Counsel could find no assistance as to the meaning of the word "months" in this context, either in the Act, or in the Interpretation Act 1978 as amended, or in the predecessor legislation. The phrase "9 months" could be meaningless, or it could be impressionistic. This is another indication that the provision is not intended to be mandatory.

[48] The likely purpose of the "9 months" limit is to encourage the RMO to apply his or her mind to the question whether a hospital-based order continued to be appropriate. This was precisely what the RMO was doing at the time. (I take this to be a reference to the fact that, almost seven weeks later, on 23 June 2009, the RMO made application to the MHTS for variation of the CTO to a community-based order giving as her reason, among others: "The nine month period of suspension of the hospital based order is approaching ...").

[49] In relation to the alternative submission for the Petitioner, namely that the Petitioner was an "absconder", Counsel for the First Respondent *et al* submitted that the Petitioner did not come within either branch of section 301(1)(a): he had not (i) "absconded from a place where he was liable to be kept pending removal to hospital"; and he had not (ii) "absconded from the hospital in which, under the order, he was being detained". The situation did not meet the dictionary definition of "abscond", primarily "to depart secretly or suddenly" [B A Garner, ed, *Black's Law* Dictionary, 9th edn (1995), "abscond"; B A Garner, ed, *A Dictionary of Modern Legal* Usage, 2nd edn (1995), "abscond"]. The Petitioner did not have the intention of an absconder. It would be difficult to say that someone required by the Certificate of Suspension to live at his home address, as the Petitioner was, had absconded while he continued to live there.

[50] In any event, Counsel submitted, the excess period is severable so that, if the Petitioner were found to be an absconder, any absconding did not start until the end of the allowable "9 months" cumulative period. Counsel did not offer his own computation of when the allowable period might have expired and when being absent without authorisation in terms of section 304 might have started.

Submissions for the Third Respondents

[51] Counsel for the Third Respondents submitted that though the MHTS decision of 30 July 2009 (to the effect that an over-allowance of leave automatically invalidated the CTO) was mistaken in law - no party to the present proceedings really supported it - equally, no party suggested that the decision should be quashed. Even though the decision was wrong, it was not *ultra vires*. Power was clearly conferred on the MHTS to dismiss the RMO's application to vary the CTO by Rule 44. The differently-constituted tribunals, on 30 July and 4 November 2009, were entitled to make different decisions. Counsel drew my attention to the fact that the section 304 issue relative to the alternative submission for the Petitioner was not before the MHTS and was not decided in the determination of 4 November 2009. The MHTS did not have power in terms of the statute or the rules to declare the CTO invalid. There was no basis for quashing the decisions of the MHTS.

[52] Counsel continued to the effect that the method of computing time varies with context [*Pacitti* v *Jones* 2006 SC 616 especially at § 8]. Counsel agreed with Counsel for the First Respondent *et al* that the uncertain meaning of the phrase "9 months" in section 127 is an argument in favour of a non-mandatory interpretation. A breach of the "9 months" requirement might result in a flaw in the certificate suspending detention otherwise authorised by the CTO. A flawed suspension of detention cannot

"unauthorise" detention or invalidate the CTO. There was a remedy available to the Petitioner, namely to apply to the MHTS in terms of section 100 for variation of the CTO to a community-based order. Alternatively he could have sought a reference to the MHTS by the Mental Health Commission for Scotland for the purposes of seeking a variation in terms of sections 98 and 104.

[53] Counsel for the Third Respondents continued to the effect that it is misconceived for the Petitioner to rely on section 1(4) in connection with the meaning of section 127. The principle of the "least restrictive alternative" is relevant to the discharge of functions: it does not contain principles of interpretation. Other provisions of section 1 arguably militate against the Petitioner's interpretation: section 1(3)(f) is about "providing maximum benefit to the patient"; and section 1(6) imposes a requirement to "have regard to the importance of the provision of appropriate services to the person" subject to a CTO. On the basis of these principles automatic termination of a CTO is ruled out. For the rest Counsel adopted the submissions of Counsel for the First Respondent *et al.*

Discussion

[54] I do not accept the primary submission of Counsel for the Petitioner that the Suspension Certificate granting leave of absence from 16 May to 16 November 2009 caused the CTO to lapse. In saying this, I do not exclude the possibility that there are situations in which a rule, ruling or order otherwise valid can be invalidated or terminated by an *ultra vires* derogation, condition or qualification: but I am confident that this is not one of them. Counsel for the Third Respondents was correct to say that no party really supported the MHTS reasoning of 30 July 2009 leading to the

conclusion that the CTO had lapsed. Counsel for the Petitioner presented his own, different case for the lapsing of the CTO.

[55] While detention and leave from detention may complement one another in the treatment plan, my view is that leave is not integral to detention in such a way that a flawed allowance of leave must, in the absence of clear direction in the statute, vitiate the CTO authorising detention. I accept everything that Counsel said about the merit of a simple solution and so on, but I remain unpersuaded that the points made, good points though they may be in themselves, add up to rendering the CTO invalid or revoking it by implication. I am not persuaded, in other words, that this was the intention of the legislature; and as Counsel for the First Respondent *et al* correctly submitted, it is a question of legislative intention.

[56] In ascertaining that intention, I do not find the consequentialist test articulated in *Soneji* and applied in *Paterson* and *JG* helpful. The issue in those cases was whether non-compliance with the statutory time-scale for one step in, and integral to, a judicial or *quasi*-judicial process might be excused or whether non-compliance invalidated the whole process. In *Soneji* the issue was about the maximum permitted interval between a criminal conviction and the making of a confiscation order; in *Paterson* the issue was about the maximum permitted interval between the expiry of a detention certificate and the determination of an application for an interim CTO; in *JG* the issue was about the time-scale for giving notification of an application for a CTO.

[57] The common feature in all those cases was that the statutory time-scales were held to have been inserted for the purpose of securing a fair or efficient process. Trivial non-compliance was properly, if I may say so, with respect, excused on the basis of lack of prejudice. The issue in this case is not about process but about substance. The legislature apparently accepted that over-long allowances of leave are

potentially abusive, may occur for ulterior, resource-driven motives and risk prejudicing both patient interests and - going back to the reasons for the 1995 Act - public safety. Clearly any time limits have to be, to an extent, arbitrary: but the legislature having made that judgement, then in my view the limits have to be complied with and enforced to the letter.

[58] When I say "arbitrary", I do not mean that the leave limits do not have a functional justification, because they clearly do. A patient who can cope in the community for six months at any one time and for nine months in any twelve-month period must be a candidate for treatment within the community as the norm rather than the exception, if not for discharge from compulsory measures altogether. The function of the nine-months limit, according to Counsel for the First Respondent *et al*, is to "encourage" the RMO to consider community-based management. According to Counsel for the Petitioner, in response, it is to "require" the RMO to discharge the patient, failing which to institute community-based management, unless there are good reasons to the contrary, always bearing in mind the "least restrictive" principle. I agree with Counsel for the Petitioner.

[59] And when I say that the section 127 time limits have to be "complied with and enforced to the letter", I am aware that this is paradoxical, given the uncertainty about how to calculate the cumulative limit. The six-month limit for any one period of leave is capable of being complied with. The three-month limit in section 304(3) is capable of being enforced in terms. The likelihood is that the imprecision in relation to the "9 months" cumulative limit is unintentional, the result of a drafting oversight. I do not think I have to "correct" it in this case and with luck the legislature will resolve the problem by expressing the matter in days or weeks before a more pointed challenge

arises [*cf. Inco Europe Ltd and Ors* v *First Choice Distribution and Ors* [2001] 1 WLR 586 at 592 *per* Lord Nicholls of Birkenhead].

[60] The straightforward reading of section 127 is that the RMO simply has no power to grant a Suspension Certificate that results in a leave overshoot - the words are [*my underlining*]: "if the sum of [*past leave periods together with the period of leave proposed to be certified*] would exceed 9 months in the period of 12 months ending with the expiry of the period [*of leave proposed to be certified*] the responsible medical officer may not grant a certificate." Neither Counsel for the Respondents contested the proposition that a Suspension Certificate granted contrary to the "prohibition" must be *ultra vires*.

[61] This brings us to the secondary and alternative submission for the Petitioner, namely that the Petitioner should be treated as having been an absconder eligible, after three months, for time-lapse release from compulsory measures in terms of section 304(3). Before deciding the legal consequences of staying away on the basis of an *ultra vires* leave certificate, I would want to know the consequences of being a leave-overstayer on the basis of an *intra vires* leave certificate. I would want to know in particular whether the CTO *simpliciter* is warrant for re-detention once leave expires. This is not a straightforward issue.

[62] Section 304(3) cannot be triggered unless the patient is on "unauthorised absence". In terms of section 304(1), being on "unauthorised absence" means "being liable, under section 301 of this Act, to be taken into custody and dealt with under section 303 of this Act." As Counsel for the First Respondent *et al* submitted there are two branches to section 303(1)(a) and the question is whether the Petitioner's situation fitted with either of them (see above). In reality the only branch that has any potential applicability to the Petitioner's case is section 303(1)(a)(ii), so that the question is:

"did the Petitioner abscond from the hospital in which, under the CTO, he was being detained, all within the meaning of the Act?"

[63] I cannot address this question without confronting the "dog that did not bark", namely section 301(2) and the silence of all Counsel on the subject. Section 301(2) provides:

> "(2) A patient who is subject to such an order and in respect of whom-
>
> (a) a certificate under section 127(1) of this Act has effect; and
>
> (b) a condition under subsection (6) of that section requires-
>
> (i) that the patient be kept in the charge of an authorised person or reside continuously or for or at specified times at a specified place; or
> (ii) that the patient, on being recalled or on the expiry of a specified period or on or after the occurrence of a specified event, return to the hospital in which the patient was detained under the order or go to such other place as may be specified,
>
> and who absconds from the charge of that authorised person or otherwise fails to comply with the condition is liable to be taken into custody and dealt with in accordance with section 303 of this Act.
>
> [.....]"

This means that a CTO patient on leave by virtue of a section 127 Suspension Certificate is "liable to be taken into custody and dealt with in accordance with section 303" if - an important "if"- the patient fails to comply with what might be called a "special condition" in the Suspension Certificate in terms of section 127(6) requiring the patient to return to the hospital "on being recalled or on the expiry of a specified period or on or after the occurrence of a specified event". The expressions "specified period" and "occurrence of a specified event" could be read as referring back to section 127, which provides for the suspension of detention for a specified period which "may be expressed as the duration of an event".

[64] A possible inference from the terms of section 301(2) together with the absence of specific provision elsewhere in section 301 for leave-overstayers to be "liable to be

taken into custody etc" is that, absent the special condition requiring them to return, "mere" leave-overstayers are not to be treated as "absconders".

[65] I would have expected Counsel to refer to section 301(2) if only to interpret it away: the fact that they did not do so leads me to suppose that, in different respects, it causes all of them difficulty; and that it does so because the Petitioner's Suspension Certificate does not contain a special condition in terms of section 127(6) requiring the Petitioner to return to hospital at the end of his leave. The interpretation hypothesised above would undermine the secondary case that the Petitioner has now advanced, which is that he *was* an "absconder"; and it would render unlawful the position apparently argued for by the Respondents that, though the Petitioner *was not* an "absconder", the hospital, all the same, took him into custody and re-detained him on 9 December 2009, after his Suspension Certificate had expired, simply by virtue of the underlying CTO.

[66] Still, it is deeply counter-intuitive to suppose that a detained patient who fails to return from leave cannot be taken into custody and re-detained unless there is a special condition stipulating return at the expiry of the leave period. I could not support an interpretation of the Act to that effect unless compelled to do so by the clearest indications of legislative intention. Did the legislature intend, for example, that the patient who fails to live at the specified address should be treated as being liable to be taken into custody in terms of section 301(3), while the patient who fails to return to the specified place of detention should not?

[67] Again, section 112 authorises the taking into custody of any CTO patient required to attend for treatment who fails to attend; and section 113 authorises the taking into custody of community-based CTO patients who fail to comply with *any* measure authorised in their CTOs. Given these provisions, it is not easily conceivable

that the legislature meant there to be no power, absent a special condition in the Suspension Certificate, to take hospital-based leave-overstayers into custody and to re-detain them. Further, section 129 empowers the RMO to revoke a Suspension Certificate on grounds of patient interests and public protection: did the legislature mean revocation to be ineffectual to authorise the patient's apprehension and re-detention unless there were a special condition about recall in the Suspension Certificate? I would find that difficult to accept.

[68] Since the hearing I have read the *Code of Practice for the Mental Health (Care and Treatment) (Scotland) Act 2003*, volume 2, "Civil Compulsory Powers". The *Code* supports the view that a patient who fails to return from leave on time is an absconder and someone who is liable to be taken into custody. Chapter 7, states:

> "45. Where the duration of the suspension certificate is fairly lengthy (for example, for more than 28 days), it would be best practice for the patient's RMO to issue a written reminder to the patient to return to hospital shortly before the period of suspension is due to end. If the patient does not return on time, then he/she can be said to have absconded and may be dealt with in terms of Part 20 of the Act. "

That is all good sense: but as a matter of law the view that a leave-overstayer is an absconder has to be based on a sound interpretation of the statute.

[69] I think it possible to construe section 301(1) and (2) in a manner consistent with the view expressed in the *Code of Practice*. The special conditions of leave referred to in section 301(2) are conditions which, in terms of section 127, are thought appropriate by the RMO to serve the patient's interests or to protect other persons, as I understand it, during the intended period of leave, not after it.

[70] This understanding is reinforced by the fact that some of the conditions referred to in section 301(2) have clearly nothing to do with the expiry of the specified leave period. For example, a condition that the patient return to hospital on being "recalled" must be a condition applicable during the currency of the intended leave period

because there is no power in the Act to terminate leave simply by recalling the patient [*cf.* section 129]. Equally a condition that the patient return to hospital "on the *occurrence* of a specified event" must be something different from the expiry of a period of leave expressed as "the *duration* of an event or a series of events" [*my emphasis*].

[71] Most importantly, in the present context, a condition that the patient return to hospital "on the expiry of *a* specified period" would seem to be something different from, or else would be a very odd way of signifying, the end of "*the* period specified" in the certificate, referred to in section 127 [*my emphasis*]. There might be a number of reasons for a patient on leave to be recalled and it is easy to envisage the RMO inserting a recall condition in the certificate as a precaution. Equally it is possible to envisage foreseeable non-health events, such as loss of a tenancy, as well as health events, which the RMO might reasonably wish to make the subject of leave conditions. Finally it can be envisaged that the RMO, judging it best for the patient to return for review, examination or treatment at the hospital after a specified period, might well insert a leave condition to that effect.

[72] I think it possible, therefore, to assign distinctive content to section 301(2) that has nothing to do with what the legislature meant to happen when the leave period specified in the Suspension Certificate expires and the patient fails to return. This opens the way for consideration of the question whether leave-overstayers are "absconders" within the meaning of section 301(1)(a)(ii). In this connection I give no weight to the argument that the Petitioner did not evince an "intention to abscond": in the context of mentally disordered including delusional patients *mens rea* has no bearing; and a purely objective meaning has to be given to the concept of "absconding". There is support for this approach in the fact that, while there is a

criminal offence of inducing and assisting absconding, it is not an offence to abscond [section 316].

[73] On this understanding I take "absconding" to mean simply being absent from the location or situation where the individual is required to be at the time when, under the authority of the Act or any authority derived from it, he or she is required to be there. For the foregoing reasons, negative and positive, I am satisfied that the legislature intended section 127 leave-overstayers to be classed as absconders within the meaning of section 301(1)(a)(ii) and to be liable to be taken into custody and dealt with in accordance with section 303 of the Act. I am satisfied too that the guidance given in the *Code of Practice* to this effect is sound. Clearly, if my interpretation of section 301(2) is correct, namely that patients may be taken into custody and re-detained for failing to comply with leave conditions, this reinforces the argument for understanding section 301(1) to mean that patients may also be taken into custody and re-detained if they stay away after their period of leave has expired.

[74] The next question is whether persons absent from detention on the basis of an *ultra vires* Suspension Certificate are in the same "unauthorised-absence-absconder" category as leave-overstayers. The answer has to be "yes" in my view, partly because no other status can sensibly be assigned. When do they become absconders? The straightforward reading of section 127 is that a certificate that does not comply with the cumulative limit is wholly flawed from the outset. There is nothing to indicate that the legislature intended the overshoot to be severable; and no submission, beyond assertion, was presented to that effect. It follows that where leave is taken on the basis of an *ultra vires* Suspension Certificate the patient who absents himself or herself from detention is in law, from the start of the purported leave period, on "unauthorised absence" and an "absconder", liable to be taken into custody.

[75] During the hearing Counsel for the Petitioner drew my attention to the fact that this view appears to have been shared by the Director of the Mental Welfare Commission for Scotland, Dr Donald Lyons. By letter dated 28 August 2009, Dr Lyons wrote to the RMO as follows [Production No 6/2/6]:

> ". . . Technically, we consider that the person is on unauthorised absence from hospital. Where the patient is not "absconded" as such, there appears to us to be no other proper legal status. Of course, after a further 3 months of unauthorised absence, the Order ceases to exist."

Counsel pointed out that this was also the understanding of the solicitor for the RMO, Mr Stefano Rinaldi, Senior Solicitor, NHS Scotland Central Legal Office, as submitted to the MHTS on 4 November 2009 [Decision of MHTS dated 10 November 2009, page 15 of 28]:

> "(e) It is acknowledged that the status of the Patient where a suspension of detention exceeds the 9 Month Rule is not clear from the Act. However, the logical reading of the Act is that the Patient's absence is unauthorised and is therefore subject to sections 301 and 310. It is accepted that it may seem wrong to say that the Patient has absconded in these circumstances, but it is my submission that the patient is liable to be returned to hospital, if necessary by the police."

I note that in its "Reasons for our decision" the MHTS implicitly accepted that the failure of the RMO to comply with the section 127 cumulative time limit resulted in the Petitioner's "unauthorised absence in terms of section 304" [Production No 6/1, page 25 of 28, paragraph (b)].

[76] Despite these previously-stated positions, the Respondents' current stance is a purely negative one, to the effect that the Petitioner was not an absconder. This handicaps their respective cases. Counsel for the Petitioner submitted, and I think correctly, that the problem with not treating the Petitioner as an absconder is that he then has an anomalous status or no status recognised by the Act. An advantage of treating patients in the Petitioner's predicament as absconders is that it brings them within section 304(3) and offers a way of re-integrating them with the mental health regime which is consistent with the section 127 prohibition on over-long periods of

leave. Section 304(3) can be seen as giving the RMO a period of grace, while the CTO continues in forces, to put other measures in place, without the necessity of actually re-detaining the patient.

[77] On the foregoing interpretation, which in my opinion is the correct one, by 16 August 2009 the Petitioner had been on unauthorised absence for three months and, in terms of section 304(3), the CTO had ceased to have effect. The CTO having ceased to have effect, there was no warrant for the Petitioner's re-detention, so that the detentions of or commencing on 16 September and 8 December 2009 respectively were unlawful. It follows too that the MHTS was not empowered to entertain applications in relation to the CTO, which had ceased to have effect, and that its determinations of 4 November 2009 and 13 April 2010, among others, were *ultra vires*.

[78] I have to consider an alternative scenario, namely that the over-limit part of the Suspension Certificate is severable and that the Petitioner did not commence on unauthorised absence until the *intra vires* part had run its course. The first difficulty is that the Respondents, who contend for this scenario, are not in a position to tell me the date when *intra vires* absence became *ultra vires*, as it were. This could be fatal to their contention, above all in a context to which Article 5 ECHR applies: it would involve an assertion that the Petitioner was liable to be detained without specification of the date when he became liable.

[79] If the leave overshoot started after 16 June 2009, then the unauthorised absence might possibly have been interrupted by the re-detention on 16 September 2009. There would then not have been the continuous period of three months unauthorised absence in terms of section 304(3) before the Petitioner was again re-detained on 8 December 2009. I take the view that there is a fatal lack of clarity in the position of

the First Respondents *et al* on this point. The Petitioner has, I think rightly, called on the First Respondent *et al* "to specify what power was used to return him to hospital on 16 September 2009 and on 9 December 2009". The call has not be answered [Article 15, page 21D; Answer 15 for the First Respondent *et al*]. The stated position of the First Respondent *et al* is that the Petitioner was not an absconder: if so, I cannot see that there was warrant for taking the Petitioner into custody and re-detaining him on 16 September. In the absence of a satisfactory explanation, what happened on 16 September has to be disregarded. Thus I would conclude that any *ultra vires* absence which commenced three months or more before the Petitioner's eventual re-detention on 8 December 2009 constituted the continuous period for the purpose of section 304(3) with the same legal consequence as regards the re-detention on 8 December 2009.

[80] None of the foregoing should be taken to imply criticism. Everyone connected with this saga has had to confront novel and complex interpretational challenges, myself included. At least I have had the benefit of excellent submissions from three well-prepared Counsel. It is no surprise to find that parties have changed their positions over time. This includes the Petitioner. The Petitioner's own case, until he came to this Court was that he was *not* an absconder. No plea of personal bar has been taken against him but, without prejudging matters, the question may arise whether the Petitioner's earlier opposition to the legally correct solution has a bearing on causation and *quantum* of damages.

The MHTS decisions of 30 July 2009 and 4 November 2009

Submissions for the Petitioner

[81] The Petitioner's complaint is that the MHTS decision of 4 November 2009 was flawed because it incompetently re-determined the issue of the existence of the Petitioner's CTO which had already been determined by the MHTS decision of 30 July 2009. Counsel for the Petitioner submitted that the decision of the MHTS of 30 July 2009 to the effect that the Petitioner's CTO had lapsed was *res judicata* as regards any subsequent determination of the same issue by a differently-constituted MHTS. Counsel said that there are no compelling and substantial reasons in the mental-health context to depart from the general principle that matters should not be endlessly re-litigated. The principle serves the interests of certainty and of expediency. In addition, there are positive and compelling reasons to apply the principle in the context of mental-health detention: you cannot have a "limping" CTO which one day does not justify deprivation of liberty and the next day does, depending which particular tribunal considers the issue.

[82] Counsel submitted that the principle of *res judicata*, if not the terminology, has application to administrative tribunals [*British Airways Plc v Boyce* 2001 SC 510 at §§ 3, 4, 6-8]. The principle applies to relevant decisions of the MHTS. The decision made by the MHTS on 30 July 2009 was a decision that the application to vary the CTO was "misconceived" for the reason that the application was "outwith the jurisdiction of the Tribunal" in terms of Rule 44. The basis was a finding that the CTO had lapsed. Applying this logic the Tribunal had no jurisdiction to exercise any of its powers in terms of section 103 either to vary the CTO, or to refuse the application on its merits or even to revoke the CTO. The MHTS decision of 30 July 2009 conclusively determined the issue of the continuing existence of the CTO as between the Petitioner and the First Respondent *et al*, subject only to challenge by way of Judicial Review. The RMO did not challenge the decision.

[83] The principle that compulsory mental health measures should be subject to periodical review is intended to safeguard patient interests by determining whether mental disorders persist and whether and if so what continuing compulsory measures are justified [*Winterwerp* v *The Netherlands* (1979-80) 2 EHRR 387 at § 39]. The issue of the validity of the warrant for compulsory measures in this case was not one that justified repeated review: the relevant facts were fixed, historical and unchangeable. Could the RMO litigate the point again and again? Any exception to the *res judicata* principle in the mental health context should not be broader than required to achieve the objects of the legislation. The objects of the legislation were not defeated by treating the decision on jurisdiction as conclusive. It was open to the RMO, if appropriate, to apply for a fresh CTO through the Mental Health Officer. The merit of a fresh application from the point of view of patient interests is that it involves more intense scrutiny: in terms of Part 7 of the 2003 Act the application has to be supported by reports from two medical practitioners and a report by the Mental Health Officer.

[84] The decisions on *res judicata* under the Social Work (Scotland) Act 1968 are not in point [*McGregor* v *D* 1981 SLT (Notes) 97; *Kennedy* v *S* 1986 SC 43]. These decisions vouch the limited proposition that earlier incidents of child neglect or cruelty supporting an earlier ground of referral to a Children's Hearing, which the Sheriff has found to be not established, may be relied on in support of further grounds of referral based cumulatively on the earlier incidents and on subsequent incidents.

[85] The test is: "what was litigated and what was decided?" The question is about the substance and not about the applicability, or use of, technical litigation terms such as "*media concludendi*" or "*absolvitor*" [*Short's Trustee* v *Chung* 1999 SC 471; *British Airways Plc* v *Boyce* above]. Rule 44 does not use "dismissal" in a technical sense.

Once the MHTS had determined that it had no jurisdiction because the CTO had lapsed, the determination was or ought to have been conclusive as between the parties such that it could not be re-opened in subsequent MHTS proceedings [*Munir* v *Jang Publications Ltd* (CA) [1989] ICR 1 especially at 11C-D *per* Staughton LJ].

[86] Counsel for the Petitioner continued to the effect that Article 5 ECHR requires that fundamental procedural guarantees must be available in the MHTS system since deprivation of liberty is at issue: the procedure applicable should provide guarantees that are not inferior to those existing in criminal proceedings [*De Wilde, Ooms and Versyp* v *Belgium (No 1)* (1979-80) 1 EHRR 373 at §§ 76, 79]. It is particularly important that the general principle of legal certainty is satisfied. Any deprivation of liberty must be "in accordance with law" in the sense that it accords with domestic law and in the sense that domestic law itself has the requisite quality. The law must be sufficiently accessible, precise and foreseeable in its application in order to avoid all risks of arbitrariness. The adoption by the MHTS in its conflicting determinations of 30 July and 4 November 2009 of inconsistent and mutually exclusive positions fell short of the "quality of law" required [*Mooren* v *Germany* (2010) 50 EHRR 23 at § 76; *Nasrulloyev* v *Russia* (2010) 50 EHRR 18 at §§ 71 and 77].

[87] Further, in terms of Article 6(1) the principle of legal certainty requires that where courts have finally determined an issue, their ruling should not be called into question. The right of access to a fair and impartial procedure remains illusory if final and binding decisions are allowed to be unenforced [*Ryabykh* v *Russia* (2005) 40 EHRR 25 at §§ 50-52, 55; *Hornsby* v *Greece* (1997) 24 EHRR 250 at § 40].

[88] Counsel for the Petitioner continued to the effect that, in case the re-determination of the issue of jurisdiction and the existence of the CTO should be deemed to fall short of *res judicata,* the RMO's repeat application for a section 95

order to vary the CTO ought to have been treated by the MHTS as an "abuse of process" and struck out again under Rule 44. Counsel referred to the English case of *Bradford & Bingley Building Society* v *Seddon* (CA) [1999] 1 WLR 1482. Although the second MHTS purported not to be engaged in a review of the first MHTS decision, that is what they were doing. The second MHTS reasoned that because the first MHTS did not address the merits of the application and did not make any order in relation to the application under section 103 of the Act, there had been no "final and binding decision" and there could not be an abuse of process. The logic was spurious [Production No 6/1, page 26 and 27 of 28, paragraphs (f) to (j).

Submissions for First Respondent *et al*

[89] Counsel for the First Respondent *et al* submitted that there are no shades of *res judicata* or different types of *res judicata* for different types of subject-matter; that the concept of *res judicata* has to be approached with caution in the public law field; and that while the concept clearly has application in relation to the proceedings of some types of tribunal its application to others is not so clear. The principle has application to Employment Tribunals because those tribunals are like industrial courts; and it also applies to disciplinary proceedings because such proceedings are akin to litigation [*R* v *Secretary of State for Transport ex p. Richmond upon Thames LBC* [1995] Env LR 390 at 395-396; *British Airways Plc* v *Boyce* 2001 SC 510 especially at 512B-D, 512I, 514B-I; *Munir* v *Jang Publications Ltd* (CA) [1989] ICR 1; *R (Coke-Wallis)* v *Institute of Chartered Accountants in England & Wales* (SC(E)) [2011] 2 WLR 103].

[90] In *Short's Trustee* the focus of the discussion was on adversarial litigation [*Short's Trustee* v *Chung* 1999 SC 471 at 476H-F]. In children's proceedings the plea of *res judicata* is not available [*McGregor* v *D* 1977 SC 330; *McGregor* v *D* 1981

SLT (Notes) 97] Children's proceedings are *sui generis*. Part III of the Social Work (Scotland) Act 1968 is or was intended to secure the well-being of children in need and to be operated without legal assistance [*Kennedy* v *S* 1986 SC 43].

[91] MHTS proceedings are also unique in their way. It is questionable whether the justifications for the principle of *res judicata* advanced in *Short's Trustee* apply where the purpose of the tribunal is to truly decide what is in the best interests of the patient. As one text book puts it: "In a mental health case there are not really two "sides", as even if the patient opposes the application, any decision made is intended to be for his or her benefit" [H Patrick, *Mental Health, Incapacity and the Law in Scotland*, 2nd edn (Hayward's Heath, 2006), § 23. 31]. There is nothing in the Millan Report to suggest that *res judicata* might be useful in mental health proceedings. What comes across is that patient care is at the centre of the 2003 Act. There is provision for repeated review by the RMO and for repeated applications to the MHTS.

[92] Expedition and informality are keynotes of the MHTS procedure. Rule 4 of the Mental Health Tribunal for Scotland (Practice and Procedure) (No 2) Rules 2005 states: "The overriding objective of these Rules is to secure that proceedings before the Tribunal are handled as fairly, expeditiously and efficiently as possible." Rule 63 authorises informality in the conduct of hearings. Rule 44 gives power to the MHTS to dismiss frivolous or vexatious repeat applications. This is sufficient in the mental health context to deal with the mischief - *nemo debet bis vexari* - without the need for potentially unhelpful application of the *res judicata* principle.

[93] Counsel continued to the effect that, in any event, a finding of no jurisdiction could not be a final and binding decision as to the existence of the CTO. A determination cannot found a plea of *res judicata* unless it is pronounced in *foro contentioso* in relation to the merits of the relevant issue [*Esso Petroleum Co Ltd v*

Law 1956 SC 33]. Even if the principle of *res judicata* applies in proceedings of the MHTS, that in itself is not conclusive because the question remains whether the decision of the MHTS on 30 July was equivalent to "dismissal" or to "*absolvitor*". In litigation, a decree of dismissal does not provide the basis for a plea of *res judicata* [*Waydale v DHL Holdings (UK) Ltd* 2000 SC 172 at 177F-H, 181B, 182I, 184B-D]. The MHTS did not revoke the CTO. The MHTS made a decision in terms of Rule 44 to dismiss "the case". Therefore the matter of the existence of the CTO was not properly *res judicata*.

[94] Counsel for the First Respondent *et al* submitted that the Convention Rights argument advanced by the Petitioner does not add anything to the domestic law points. The Petitioner complained that he had no proper way of deciphering what was happening to him. There was a question as to whether the Petitioner's complaint about "arbitrariness" was about the legislation or the application of the legislation and whether there was a proper contradictor for his allegation. The minimum criteria for mental-health detention had been met in the Petitioner's case [*Ashingdane* v *United Kingdom* (1985) 7 EHRR 528 at § 37:

> "The Court, in its previous case law, has stated three minimum conditions which have to be satisfied in order for there to be 'the lawful detention of a person of unsound mind' within the meaning of Article 5(1)(e) : except in emergency cases, a true mental disorder must be established before a competent authority on the basis of objective medical expertise; the mental disorder must be of a kind or degree warranting compulsory confinement; and the validity of continued confinement depends upon the persistence of such a disorder. "

The proper focus is "lawfulness". A detention which meets the criteria for lawfulness, as the Petitioner's detention did, cannot be described as "arbitrary".

[95] The *Ashingdane* principles had been applied in Scotland. Arguably the principle of legal certainty should not be understood as a subjective one, from the patient's perspective, but as an objective one, having regard to the need to balance public

protection with patient benefit and the need for a flexible approach for a disorder that may be long-term but of fluctuating severity amenable at different times to different treatment regimes [*A* v *Scottish Ministers* 2001 SC 1 at 2D-E; at §§ 48, 56 and 64 per Lord President; §§ 17, 27 and 31 per Lady Cosgrove]. The requirement for flexibility is reflected in the tribunal system, the role of which, like the children's hearings system, is to look for solutions rather than to create winners and losers.

[96] Counsel for the First Respondent *et al* submitted that "abuse of process" is an English concept not readily applicable because of procedural differences [*Wright* v *Paton Farrell* 2006 SC 404 at 412 per Lord President]. Bringing proceedings to an end on the ground of "abuse of process" is an extreme measure justified by extreme situations of a sort from which the present case is far removed [*Shetland Sea Farms Ltd* v *Assuranceforeningen Skuld* 2004 SLT 30 at 31I]. The situation where the RMO makes a repeat application for variation of a CTO to a community-based order cannot be characterised as an "abuse of process" [*cf. Clarke v Fennoscandia Ltd (No 3)* 2005 SLT 511 at § 17 *per* Lord Justice-Clerk; at §§ 35 and 40 *per* Lord Clarke].

[97] There must be a substantial risk to the administration of justice before any question of dismissal for "abuse of process" arises. The power to deal with an "abuse of process" is described as an inherent power, part of the power of the Court to vindicate its procedures and to preserve the administration of justice: it is questionable whether the power exists in a statutory tribunal like the MHTS. [*Hepburn* v *Royal Alexandria Hospital NHS Trust* 2010 SLT 1071 at §§ 17-19 *per* Lord President; at §§ 47, 51 *per* Lord Reed]. There is no need to look beyond the 2003 Act and the Rules to discern the powers of the MHTS. Rule 44 gives the MHTS power to deal with improper applications. There is no need to resort to the concept of "abuse of process".

Submissions for the Third Respondents

[98] Counsel for the Third Respondents adopted the submissions for the First Respondent *et al* and added supplementary points. The principle of *res judicata*, Counsel submitted, is predicated on an adversarial contest, between opposing parties, around a well-defined issue. In contrast an application to the MHTS by the RMO under Rule 9 or by the patient under Rule 10 to extend or vary a CTO can involve input from up to nine other "parties". In terms of Rules 9, 10 and 63 all these persons are entitled to make representations and lead evidence. There is no system of written pleadings to focus the issue. Rule 63(5) expressly authorises an inquisitorial procedure and, in practice, Counsel said, it is not unusual for the Convener to conduct the examination of "relevant persons" and witnesses. There is provision in terms of Rule 63(7) to exclude witnesses but they are often allowed to be present. In terms of the 2003 Act tribunals are constituted by a panel of persons with a variety of professional qualifications.

[99] Further, the concept of *res judicata* is inconsistent with MHTS procedure, which does not have "winners and losers" but "solutions and outcomes" for the purposes of the mental health system. Repeated applications can be made for example by the RMO in terms of section 95 of the 2003 Act for orders varying a CTO. Repeated references to the MHTS are required to be made in respect of restricted patients in terms of sections 185 and 193. There is no authority to the effect that *res judicata* can apply in tribunal proceedings of this kind.

[100] Conversely, there is clear authority for the non-application of the principle in relation to other statutory tribunals. The words of Lord Cameron commenting on the Children's Hearing system established by Part III of the Social Work (Scotland) Act are apposite [*McGregor* v *D* 1977 SC 330 at 339-340]:

> "The procedure introduced by the Statute is novel and without parallel in the familiar course of civil or criminal process. The proceedings are in no sense criminal nor are they governed by the rules of procedure which for long have regulated procedure in the Sheriff Court. Indeed, the plain intention of the legislation is to introduce a simplicity of procedure avoiding, as far as possible, technicalities of legal process which will, on the one hand, enable the requisite action in the interest and for the benefit of the child to be taken by panels of laymen while, at the same time, provide an effective and simple structure within which the purpose of the legislation can be secured. This being so, I do not think it is appropriate or even competent to look outside the Statute or the relevant Rules to interpolate into this very simple procedural scheme the more elaborate and technical rules of formal process in the courts, be they civil or criminal. Once this is realised and accepted the solution of the problems presented in this appeal is to be found within the precise directions and powers set out and conferred in the Statute and in the Rules made thereunder."

Counsel accepted that "legal certainty presupposes respect for the principle of *res judicata*" [*Ryabykh* v *Russia* (2005) 40 EHRR 25 at § 52]: but, Counsel submitted, the rule does not fit well with the role of the MHTS and its subject-matter. Whatever the MHTS is doing, it is not issuing "final and binding judgements". For example, section 291 of the 2003 Act provides a mechanism for voluntary patients to apply to the MHTS for an order requiring their release from detention. The MHTS might grant the application or it might refuse it in the circumstances prevailing: but it would be unthinkable that a refusal could preclude a further section 291 application on the emergence of further evidence or a different diagnosis or prognosis, or on a re-assessment of the risk or on the availability of different treatment or some other change. The Petitioner's submission about "arbitrariness" is an argument against differently constituted tribunals reaching different conclusions on different material. [101] There is nothing equivalent in the MHTS system to the litigation concepts of "decrees in absence", "decrees by default" and "final judgements". There was no question of the MHTS dismissal decision of 30 July 2009 being "enforced" - there was no "operative" part of the decision to be implemented [*cf. Rybakh* at H13 and § 55]. Compare section 103 (4) of the 2003 Act which lists the substantive orders that the MHTS can make when determining an application by the RMO, like the

application in this case, to vary a CTO in terms of section 95. The list does not include power to make a determination as to the existence of the CTO.

[102] Counsel continued to the effect that even if, as a generality, the principle of *res judicata* is applicable to MHTS determinations, the principle did not apply to the MHTS decision of 30 July 2009. This is because the MHTS "dismissed" the RMO's application. This was like upholding a "plea to the relevancy" or a "plea of no jurisdiction" in litigation. No plea on the merits or equivalent was upheld. Accordingly the differently constituted tribunal of 4 November 2009 did not err in law in concluding that *res judicata* did not preclude entertaining the RMO's new application for variation of the CTO.

[103] In relation to "abuse of process" Counsel for the Third Respondents submitted that the concept has no application to tribunals and to the MHTS in particular; that in any event what the RMO did by making a further application under section 95 was not an abuse of process; and that, even if the concept applied in the circumstances, it did not require the MHTS to terminate the process.

[104] Clearly there was no issue of dishonesty: it was a matter of record that the Petitioner accepted the RMO's good faith [Production No 6/1, Decision of MHTS dated 10 November 2009, page 13 of 28, para 4; *cf. Shetland Sea Farms Ltd* v *Assuranceforeningen Skuld* 2004 SLT 30 at 31L-32A]. The situation was not one in which the MHTS was bound to find that it could not properly determine the application because of alleged "abuse of process" by the RMO [*Shetland Sea Farms* at 31I-K, 32A-C].

Discussion

[105] Whether or not the MHTS determination of 4 November 2009 was flawed, it had no juristic effect. Nothing resulted from the determination in a legal sense. The determination of 4 November 2009 was simply a preliminary determination in relation to a repeat section 95 application to vary the CTO. It having been determined by the MHTS that the CTO subsisted, that the application to vary was not misconceived in terms of Rule 44 and that it was competent to entertain the application, Dr Mitchell then withdrew the application. That is all that happened.

[106] We can speculate about the reasons why the application was made when it was made - and then withdrawn. It may be that the RMO was "testing the water". It may be that the result gave the RMO confidence to "recall" the Petitioner to hospital and then to detain him on the authority of the disputed CTO. But the ruling of 4 November 2009 did not "cause" the Petitioner to be detained. Indeed, if the application had proceeded to a hearing on the merits on the basis of the affirmative preliminary ruling, and if the application to vary had then succeeded, the warrant for the Petitioner's detention would have been cancelled.

[107] To be fair to the Petitioner, Counsel's written Outline Submissions do state [*my underlining*]:

> "Reduction of certain decisions of the Tribunal are [*sic*] sought in an effort to prevent the other respondents seeking to rely upon them as a basis to avoid other orders being granted. The petitioner has no particular interest in seeing that the tribunal decisions are reduced other than to avoid that difficulty. This was considered appropriate given the history in relation to the July Tribunal. "

As a rule the Court does not exercise its supervisory jurisdiction to quash decisions if no practical benefit would result: but the Third Respondents have not taken the point or tabled a plea of "no title and interest" or "no standing" [*Agnew* v *Laughlan* 1948 SC 656; *Cameron* v *Lightheart* 1995 SC 341; *Lennox* v *Scottish Branch of the British*

Show Jumping Association 1996 SLT 353]. I shall therefore consider the merits of the arguments.

[108] One thing I can say at the outset is that, in my opinion, the "abuse of process" argument somewhat faintly presented by Counsel for the Petitioner has no merit, broadly for the reasons given by Counsel for the First Respondent *et al* and by Counsel for the Third Respondents. Before discussing the merits of the arguments in relation to *res judicata* and Convention Rights, I should mention some nuances which are not reflected in the record of parties' submissions above.

[109] One point of interest is that while Petitioner's Counsel submitted that the issue of the subsistence or otherwise of the CTO became *res judicata* by virtue of the MHTS ruling of 30 July 2009, he did not submit that the decision was binding on this Court. That must be right: an issue about the existence of a condition precedent to the exercise of its powers by a tribunal operating within a statutorily defined jurisdiction must as a rule, if not confided to the conclusive determination of the tribunal itself, be open to review by the Court.

[110] Counsel for the Petitioner felt the need to persuade me that, on a proper interpretation of the MHTS order, the MHTS found the application to vary to be misconceived on the basis that it was "out with [*sic*] the jurisdiction of the Tribunal". This is part of the wording of Rule 44 as reproduced in the "Misconceived Case - Rule 44" *pro forma* used by the MHTS to record its decision. The other categories of misconceived case liable to be "dismissed", also reproduced, are "made otherwise than in accordance with these Rules and has no reasonable prospect of success" and "frivolous or vexatious". On the face of the operative part of the order it is not possible to say which of the three stated grounds the Tribunal has found to be established: all of the grounds stand undeleted and none has been highlighted (by

shading the relevant blank bullet point as has been done elsewhere) [Production No 6/3, pages 2 and 3].

[111] Counsel for the Third Respondents submitted that the ground found to have been established was the "no reasonable prospect of success" ground [*cf.* Production No 6/1, Decision of MHTS dated 10 November 2009, submissions for RMO, page 11 of 28]. There is some support for this in the wording of the supporting reasons: "... the tribunal finds that the application to vary cannot succeed as the order itself is no longer extant" - but there is no mention of the rest of the ground: "made otherwise than in accordance with these Rules." I am not sure how much this matters, if at all. It is perfectly possible for there to be overlap between the stated grounds. I suspect that Counsel for the Third Respondents took the view that it was easier to justify the MHTS re-visiting a judgement on prospects than a judgement on jurisdiction.

[112] The rule to which Counsel for the First Respondent *et al* adverted is that in a litigation context a plea to the jurisdiction cannot result in *res judicata* for the reason that, as logic would dictate, the proper disposal where an action fails on the ground of "no jurisdiction" is dismissal [*Pitt* 1864 2 M 1153]. A court that has no jurisdiction to pronounce a judgment *condemnator* has no power to grant decree of *absolvitor* [*Wyper* v *Carr* 1877 4 R 444 at 446 *per* Lord President]. To put it another way, unless there is jurisdiction to entertain the case, the merits are not open for determination one way or the other.

[113] Counsel for the Petitioner submitted that *res judicata* is a plea on the merits [*Macphail's Sheriff Court Practice,* 3rd edn, § 2. 104]. True, but the proposition that *res judicata* is a plea on the merits should not be confused with the question whether a successful plea of "no jurisdiction" is *res judicata*. There is clearly potential for

confusion in this area. A ruling of "no jurisdiction" cannot be *res judicata* as to the merits of the dispute: but that does not mean that it cannot be binding *quoad* jurisdiction. I believe the Petition to have *incorrectly* stated the position where it avers: "The CTO was not in force because of the decision of the Tribunal of 30 July 2009" [Article 17, page 25D-E]. I believe the Petition to have *correctly* stated the position where it avers: "The Tribunal's decision on the issue of jurisdiction is *res judicata* - *Munir* v *Jang Publications* 1989 ICR 1" [Article 16, page 23C]. *Munir* is persuasive authority for the proposition that a decision by a statutory tribunal as to whether or not a matter is within its jurisdiction precludes, *per rem judicatam*, the re-opening of the issue as to jurisdiction.

[114] In *Munir* the preliminary issue was whether the Industrial Tribunal had power to entertain a claim for unfair dismissal by an employee who had been dismissed while on strike. The Employment Protection (Consolidation) Act 1978 s. 62 enacted that "in such a case an industrial tribunal shall not determine whether the dismissal was fair or unfair" unless certain factual pre-conditions were satisfied. The central dispute in the case was whether the findings of fact by the preliminary hearing in relation to jurisdiction were binding at the substantive hearing. The Court of Appeal held that the preliminary decision was not binding as to the merits but that it was conclusive, on the principles of issue estoppel or *res judicata*, of the question whether or not the claim for unfair dismissal was a competent one for determination by an Industrial Tribunal [*Munir* v *Jang Publications Ltd* (CA) [1989] ICR 1 at 9H-10A *per* Dillon LJ; at 11C-D *per* Staughton LJ]. I am satisfied that the on 4 November 2009 the MHTS was led into error as to the meaning of *Munir*; and that in consequence its decision of that date was mistaken in law [Production No 6/1, Decision of the MHTS dated 10 November 2009, page 26 of 28, paragraphs (f) and (g)].

[115] My interpretation of the MHTS order of 30 July 2009 is that it represented a ruling of "no jurisdiction", as submitted by Counsel for the Petitioner and as accepted by Counsel for the First Respondent *et al*. I am satisfied that the MHTS has power to determine issues of its own jurisdiction. Rule 44 puts this beyond question. The jurisdiction conferred by the legislature on the MHTS is in relation to, broadly speaking, compulsory measures for the management, care and treatment of mentally disordered persons in our society. Part of that jurisdiction concerns patients who have become, and continue to be, subject to compulsory measures. The legislature must necessarily have intended that the MHTS should adjudicate on the issue of its jurisdiction in connection with the continued subsistence or otherwise of compulsory measures, particularly CTOs. There clearly are situations where the MHTS may be called on to rule whether or not a CTO has ceased to have effect. I have in mind situations in which section 304(3) is brought in to play. It must have been within the contemplation of the legislature that non-compliance with the section 127 time limits would give rise to jurisdictional issues in terms of section 304 or otherwise.

[116] If the apparent uncertainties of the legislation lead to mental health authorities and patients playing cat-and-mouse with each other, as happened in this case, that is not acceptable. Without certainty the system for mental health detention is arbitrary; and if it is arbitrary it is unlawful. Counsel for the First Respondent *et al* correctly states that the well-known *Winterwerp* criteria are necessary conditions for the lawfulness of compulsory mental-health measures: but these criteria are not of themselves sufficient in terms of ECHR Article 5.

[117] The process must also be, as Counsel for the Petitioner submits, in accordance with law; and the law must achieve the requisite quality [*Winterwerp* v *The Netherlands* (1979-80) 2 EHRR 387 at § 39 cited in *Ashingdane* v *United Kingdom*

(1985) 7 EHRR 528 at § 37 and *A* v *Scottish Ministers* 2001 SC 1 at 2D-E; at §§ 48, 56 and 64 per Lord President; *Mooren* v *Germany* (2010) 50 EHRR 23 at §§ 76-81]. Such being the state of the jurisprudence, I agree with Counsel for the Petitioner that not only is there no reason why Rule 44 decisions of the MHTS in relation to the subsistence of a particular CTO should not be treated as binding: there is a compelling reason why such decisions should be treated as binding.

[118] I reject the argument presented on behalf of the First Respondent *et al* and the Third Respondents that there is something unique about the mental health jurisdiction that permits or even requires the MHTS to re-visit Rule 44 decisions as to whether or not it has the power to deal with particular applications. Binding the MHTS to its own decisions on jurisdiction does not, in my opinion, detract from the necessary flexibility of the system and its ability to respond in a balanced way through a range of measures - emergency, short-term and longer-term measures - to the needs of the public and of patients.

[119] For all of these reasons I conclude that the order of 30 July 2009 and the finding underlying the order to the effect that the CTO in question had lapsed did demand *per rem judicatam* to be respected and to be treated as conclusive of the issue of MHTS jurisdiction in relation to the CTO in question. Accordingly, the MHTS decision of 4 November 2009 was flawed and is open to be reduced on this ground also.

Decision, disposal of the Pleas-in-Law and Further Procedure

[120] My decision is that the Petitioner was unlawfully taken into custody and detained on 16 September 2009 and was unlawfully taken into custody and detained on 8 or 9 December 2009. I have also decided that the determination of the Mental Health Tribunal for Scotland dated 4 November 2009 to the effect that it had power to

deal with the RMO's repeat section 95 application was *ultra vires* (1) in respect that the issue of the Tribunal's power in that regard was *res judicata* by virtue of the decision of the Mental Health Tribunal for Scotland dated 30 July 2009 and (2) on the basis that the Tribunal purported to deal with an application in respect of a Compulsory Treatment Order which had ceased to have effect on 16 August 2009 by virtue of section 304(3) of the Mental Health (Care and Treatment) (Scotland) Act 2003. It follows that the determination dated 4 November 2009 is liable to be set aside. It also follows from my decision that the Compulsory Treatment Order had ceased to have effect that the determination of the Mental Health Tribunal for Scotland dated 13 April 2010 on a further application to vary the Compulsory Treatment Order was *ultra vires* and is liable to be set aside, and I so decide.

[121] Fourteen Pleas-in-Law have been tabled for the Petitioner, nine for the First Respondent *et al* and four for the Third Respondents. Parties are agreed that the case should be put out By Order to discuss the terms of the Interlocutor to be pronounced and to discuss further procedure. I should welcome the assistance of Counsel on these matters and I shall appoint a By Order hearing for this purpose at a date and time to be afterwards fixed. In the meantime all questions of expenses are reserved. This Opinion has been anonymised on the application of the Petitioner, unopposed.