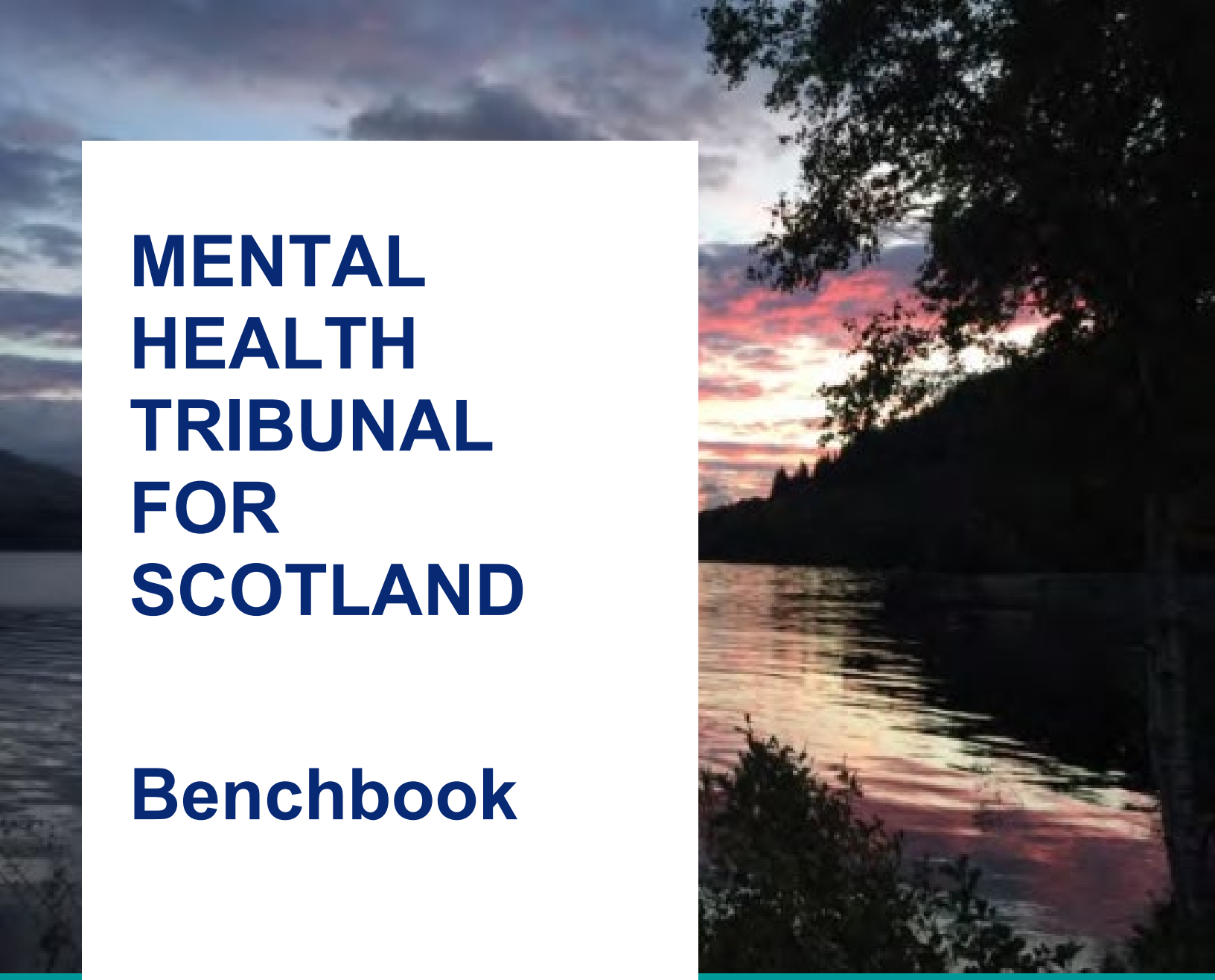

MENTAL HEALTH TRIBUNAL FOR SCOTLAND

Benchbook

FIRST EDITION

September 2025

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Foreword

This Benchbook is the collective effort of a team of people working in and with the Office of the President of the Mental Health Tribunal for Scotland. Those who wrote or reviewed text are listed below. It has taken us a long time, but we hope that what we have produced will be of help to members and others as they engage with the regime set out in the Mental Health (Care and Treatment) (Scotland) Act 2003, which came into effect in October 2005.

Particular thanks are due to Collette Gallagher, who contributed extensively during her time as an in-house convener of the Tribunal, and to Jane Patrick, Kirsty Watson and Jenna Swan, who have written, coordinated and formatted chapter after chapter. I am enormously grateful to everyone for their perseverance and commitment.

The authors have endeavoured to set out any views of the legal position on a particular issue as fully and clearly as possible. We recognise that, on a number of points, an alternative interpretation may be possible. The status of this Benchbook is therefore that of guidance. We welcome contact being made with us to suggest additions or changes in relation to any specific area. It is envisaged that revision and updating will be a continuing process.

Hamilton,
September 2025

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Glossary

AMP	approved medical practitioner
CMS	case management system (the electronic system used by the Tribunal to store case papers)
CO	compulsion order
COP	the code of practice
CORO	compulsion order and restriction order
CTO	compulsory treatment order
DMP	designated medical practitioner
ECHR	European Convention on Human Rights
EDC	emergency detention certificate
FFR	full findings and reasons
FtT	First-tier Tribunal
HD	hospital direction
IHC	In-house convenor
IMR	independent medical report
MHO	mental health officer
MHTS	Mental Health Tribunal for Scotland
MWC	Mental Welfare Commission
PO	President's Office
RMO	responsible medical officer
SIDMA	significantly impaired decision making ability
SCTS	Scottish Courts and Tribunals Service
TTD	transfer for treatment direction
UT	Upper Tribunal

1988 Act	Civil Evidence (Scotland) Act 1988
1993 Act	Prisoners and Criminal Proceedings (Scotland) Act 1993
1995 Act	Criminal Procedure (Scotland) Act 1995
2000 Act	Adults with Incapacity (Scotland) Act 2000

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2003 Act	Mental Health (Care and Treatment) (Scotland) Act 2003
2014 Act	Tribunals (Scotland) Act 2014
2015 Act	Mental Health (Scotland) Act 2015
2005 Rules	Mental Health Tribunal for Scotland (Practice and Procedure) (No. 2) Rules 2005 (SSI 2005 no. 519)

ABSENCE OF A MEMBER, PARTY, WITNESS OR REPRESENTATIVE

1. This chapter deals with the absence of a member, party, witness or representative. The absence of a member or representative is likely only to occur on rare occasions. The absence of a party or witness is much more likely to occur. There are occasions when a party, a representative or a witness can be excluded from a hearing. This is dealt with in **Chapter 30.**

Absence of a member

2. Rule 64 of the 2005 Rules deals with the absence of a member. Any matter which needs to be determined by a tribunal requires all three members to be present at the start of the hearing.[1] If a member is absent before the hearing is due to be convened the hearing cannot start. In the absence of a member the hearing would need to be adjourned, or if the matter was time-critical and needed to be determined on that day, a differently constituted tribunal would need to be convened.

3. There is one exception to the strict rule that three members are required. After a hearing has started, it is possible for the matter to be determined by two members. This situation might arise where a member is taken ill and cannot continue. The conditions which apply to the exception are that one of the remaining members must be the Convener and the parties agree to continue with only two members. Factors which might be relevant to a decision to continue with two members could include the stage that the proceedings had reached, the need for a decision to be reached and the overriding objective. [2]

Party

4. Where a party is not able to attend through illness, age, incapacity or other sufficient cause, the Convener may make such arrangements as may appear best suited in all the circumstances of the case, for deciding the case fairly.[3] A range of options to ensure the participation of a party unable to attend in these circumstances can be considered such as the use of telephone, written statements or other supports such as advocacy or legal representation.

5. A party is entitled to attend a hearing. There are certain circumstances where a hearing may proceed in the absence of a party. Rule 70 of the 2005 Rules provides that if a relevant person is absent from a hearing despite being notified of it and there is no good reason for their absence, the hearing may proceed.

6. There are occasions when a party may choose not to attend a hearing. If the tribunal is satisfied that the party has been given intimation of the hearing date and has chosen not to attend then the hearing can proceed in the absence of that party. A party may instruct a solicitor and/or advocacy worker to attend the hearing on their behalf.

Representative

7. There are occasions when a legal representative may be unable to attend a hearing. It is open to a legal representative to instruct another solicitor to appear on their behalf to represent a party. There may be times when this is not possible, particularly in the case of vulnerable parties. It is a fundamental right that an individual is able to have their legal representative of choice. Therefore it may be necessary to adjourn a hearing to allow for the attendance of a legal representative. However it would be anticipated

[1] Rule 64 of the 2005 Rules
[2] Rule 4 of the 2005 Rules
[3] Rule 71 of the 2005 Rules

that, if a legal representative is unable to attend, they would notify the Tribunal in advance and, where appropriate, request an adjournment.

Witness

8. A party is entitled to call witnesses to give evidence on their behalf. The attendance of witnesses is dealt with in Rule 61 of the 2005 Rules. Where a witness does not attend a hearing without good reason, a party can ask for a citation to be issued to compel attendance, or the tribunal can issue a witness citation on their own initiative. The citation must give five working days' notice of the hearing. In some cases this can be reduced but the minimum must be 48 hours. There are sanctions for non-attendance following a citation and, as a result, citations are used rarely.

In practice

9. In practice where a member is absent before a hearing starts, the hearings clerk would contact the Tribunal Administration to arrange for a substitute member to attend the hearing. This may lead to a delay in the start of the hearing, to allow the substitute member to prepare for the hearing and get to the venue. If necessary, the replacement member could participate by telephone.[4] In these circumstances, the tribunal members will have to decide whether it is fair and just to proceed to make a substantive decision. This will depend on a number of factors and has to be determined on a case by case basis. Advice can be sought from the IHC on duty.

10. In the event that a member is unable to remain for the duration of the hearing the PO should be contacted. This should only arise in very exceptional circumstances. Although the rules do allow for the two remaining members to proceed to make a decision with the consent of all parties, consideration will still require to be given to whether it is fair and just to proceed. Again, advice can be sought from the IHC on duty.

11. In practice it is rare to issue a citation. If this becomes necessary the PO should be contacted.

[4] *MH v MHTS* 2019 SC 527 https://www.mhtscotland.gov.uk/mhts/files/Judgements/MH-v-MHTS

ADJOURNMENTS

1. This chapter deals with adjourning a hearing. This differs from altering the date, time or place of a hearing which is dealt with in **Chapter 5.**

2. Rule 65(1) of the 2005 Rules allows the Tribunal on the request of a relevant person or on its own initiative to adjourn a hearing 'in order that further information or evidence may be obtained or for such other purpose as it sees fit.'

3. As well as being part of the Tribunal's overriding objective, the expeditious and efficient conclusion of cases is in the interests of all involved, in particular the patient. So adjournments should only be granted if absolutely necessary to achieve justice. Each request for adjournment must be considered on its merits and should be considered carefully and judicially, in particular, having regard to the purpose of an adjournment. An adjournment will inevitably mean another hearing, so a delay in the case being determined and perhaps additional stress for attendees. Though there were appeal decisions in 2006 regarding the need for a tribunal to allow the instruction of an independent report, if a motion to adjourn for this purpose is made, the granting of such an application should be the result of consideration by the tribunal, rather than automatic on every occasion when a request is made.[1] Some indication of the basis on which an independent report is thought to be necessary can be sought.

4. A hearing may be adjourned either before or after it has started.

5. The tribunal may allow short breaks during hearings. Reasons for such short adjournments include to allow the patient, another attendee or the tribunal to have a break from the hearing, to allow a solicitor to obtain instructions or to allow parties or the tribunal to discuss a particular issue which has arisen during the hearing. At in-person hearings it is necessary that all attendees leave the room taking their possessions with them. This is not a true adjournment as it does not involve putting the case off to another day.

6. A tribunal usually adjourns a hearing to another date either on the request of a party or on its own initiative when further information is required to enable the tribunal to reach its decision, for an absent party or witness to attend or to allow a patient time to instruct a solicitor or for a Curator *ad litem* to be appointed.

7. When adjourning a hearing, the tribunal should always consider:

- the length of any adjournment, having regard to the overriding objective of the 2005 Rules, and what type of hearing the adjourned hearing should be. It should not fix the date of the adjourned hearing but should instead ask those attending the hearing to discuss the date of the next hearing with the Clerk after the hearing to ensure the availability of all attendees.
- compulsory measures and the expiry date of these - to ensure that compulsory measures, if required and appropriate, are put or remain in place and do not expire during the adjournment period; There is specific guidance about an adjournment at the first hearing of a CTO application when sections 68 and 69 of the 2003 Act apply – see paragraph 10 below.
- whether it is appropriate to make Directions under rule 49 of the 2005 Rules. Is further information required to enable the next tribunal to determine the

[1] *Byrne v MHTS* 2006 GWD 10-179, [2007] MHLR 2; *McGlynn v MHTS* 2006 GWD 13-248, [2007] MHLR 16;

case? Try to use the adjournment constructively to give the subsequent tribunal as much help as possible and avoid the need for any further adjournments. For example, the tribunal may direct that a report be lodged by a witness seven days before the next hearing of the case or that a person attend the next hearing; and

- should the same panel sit on the next hearing of the case i.e. is the case part-heard? (This is discussed in **Chapter 53**). If so, specify this clearly in the FFR and advise the Clerk that this should be noted in the case note.

8. The tribunal should make it clear in its written decision why the adjournment has been granted. This will help the next panel hearing the case and explain to the parties why the case could not be concluded. As a decision to adjourn is not a final decision no findings in fact are needed in the written decision.

9. Likewise, a tribunal's decision to refuse a request to adjourn should be stated in the tribunal's written decision with brief reasons for this.

10. Special consideration should be given to adjourning a CTO application at the first hearing where sections 68 and 69 of the 2003 Act apply. Specific guidance has been issued in relation to this and, in particular, in relation to the need either to make an interim CTO or to determine the application.[2] Any tribunal adjourning without making an order would have to explain how it had interpreted and applied section 69. In the situation where the patient was in hospital at the time the application was made (and so sections 68 and 69 apply) but a community-based CTO is now sought, rather than adjourning without making any order, the better course is to make an interim CTO which includes only measure (b). This complies with section 69, ensures the continuation of treatment and avoids any difficulties with section 64(7) of the 2003 Act.

In practice

11. When a case is adjourned, the Clerk will complete a ROHA (Record of Hearing (Tribunal Administration)) form.

12. The ROHA form gives details of when the next hearing should be held, who the tribunal heard evidence from, the reason the case could not be determined, whether an interim order, directions and/or a decision have been drafted and next hearing instructions. The next hearing instructions are important. These are instructions for the caseworker and include advising someone of the next hearing date as soon as possible or any other additional actions which are required now. For example, if a hearing has been adjourned due to the non-attendance of a RMO or MHO, it is important that they are advised of the next hearing date as soon as possible as they will not have been present when this was arranged with the Clerk. Also, it may take some time for caseworkers to send invites to the parties. Members should ensure they highlight all such matters which require action to the Clerk for inclusion in the ROHA.

[2] ***GUIDANCE TO TRIBUNAL MEMBERS No. 3/2023 - Guidance on sections 68 and 69 in appendix***

ADVANCE STATEMENTS

1. An advance statement sets out a person's wishes about future care and treatment, should the person become incapable of making decisions about this in the future.

2. The 2003 Act enables a person to make a written statement, when they are well, setting out how they would like to be treated, or not treated, for a mental disorder should they become unwell and their ability to make decisions about medical treatment become significantly impaired as a result of their mental disorder. This chapter deals with such statements only.[1]

3. Advance statements are an important tool in enabling patient participation as fully as possible and also for the wishes and feelings of the patient to be taken account of with regard to compulsory treatment. They are sometimes incorrectly referred to as 'advanced statements'. This may create the false impression that they are complex, and may even deter people from using this important tool.

Form of advance statement

4. An advance statement can be drawn up at any time, provided the person has the capacity to make it and subject to the other conditions detailed in paragraph 5 below. Unlike nominating a named person, there is no age restriction on making an advance statement.

5. An advance statement is valid under the 2003 Act if:

- the person making it had the capacity to make it;
- it is in writing and is signed by the person who made it;
- a witness certifies in writing that, in his or her opinion, the person making the statement had the capacity to make it; and
- the witness is a registered chartered clinical psychologist, a doctor, an occupational therapist, a person employed in the provision of (or in managing the provision of) a care service, a registered nurse, a social worker or a solicitor.[2]

6. The 2003 Act does not require that the advance statement is dated, although obviously it is preferable that it is.

7. There is no prescribed form of advance statement. In practice advance statements tend to be in the form of Appendix 1 of the MWC's Good practice guide on Advance statements, September 2024, AdvanceStatements-2024.pdf.[3] They usually list what treatments a person would like to receive and those they would not like to receive. An advance statement could also contain information about what treatment a patient has found beneficial in the past and, for information, early changes in symptoms, thinking and behaviour. An advance statement cannot require that a service or medical treatment must be made available to the patient.

8. A personal statement may also be included in or attached to the advance statement but it is not part of the advance statement under the 2003 Act. The personal statement may include details of who should be contacted when the patient becomes unwell,

[1] 'Living wills' or 'Advance directives' are different types of statements which are usually made for physical health conditions. They are not advance statements in terms of the 2003 Act.

[2] The Mental Health (Advance Statement) (Prescribed Class of Persons) (Scotland) (No. 2) Regulations 2004 SSI 2004/429

[3] This provides information on how to write a good advance statement and to help professionals understand their responsibilities in relation to them.

arrangements for looking after a home or pets and information about physical, dietary, communication or spiritual needs.

9. There is no requirement to register the advance statement (or withdrawal of advance statement) with any particular body or organisation. In order for those involved in providing medical treatment to be aware of an advance statement it is good practice for the advance statement to be given to professionals involved in the care and treatment of a person and a copy placed with the person's medical records. Where a Health Board receives a copy of an advance statement from the person making it or someone acting on their behalf, they must place a copy with the person's medical records and inform the MWC that they have it and how it may be accessed.[4] The MWC is obliged to retain a register of advance statements to be available for inspection by the maker of an advance statement, an individual acting on their behalf or, in order that they may make decisions with regard to the treatment of that person, their MHO, RMO or the relevant Health Board.[5]

10. Health Boards also have a duty to support and promote the making of advance statements.[6]

11. An advance statement may be withdrawn at any time by the person who made it provided the person has the capacity, at the time of withdrawing it, to do so and the other conditions detailed in paragraph 5 above are met.[7] This would be the best way of a person updating an advance statement i.e. withdrawing the previous one and making a new one.

Effect of advance statement – the role of the tribunal

12. Section 276(1) and (2) of the 2003 Act cover what the tribunal must do if a person has an advance statement. It should be noted that the tribunal or any person giving medical treatment are not bound by the terms of the advance statement but it must be taken account of.

13. The tribunal must have regard to the advance statement if it is satisfied that:

- due to mental disorder, the person's ability to make decisions about the ways they wish to be treated, or not treated, for mental disorder is significantly impaired i.e. the person has become unwell and no longer has the ability to make the decision(s) they made and included in their advance statement;
- the advance statement complies with requirements detailed in paragraph 5 above;
- any measures or treatment that will be authorised or no longer be authorised by any decision of the Tribunal correspond to those stated in the advance statement;
- and, since the advance statement was made, there has been no change of circumstances which, were the person to be considering making the statement at the time of the hearing, would be likely to cause them not to make the statement or make a substantially different one.[8]

[4] Section 276A of the 2003 Act
[5] Section 276B of the 2003 Act
[6] Section 276C of the 2003 Act
[7] Section 275(3) of the 2003 Act
[8] Section 276(2) of the 2003 Act

14. For the purposes of section 276 of the 2003 Act, there is a presumption that an advance statement and the withdrawal of an advance statement comply with the terms of section 275 of the 2003 Act.[9]

15. In circumstances where a patient has made an advance statement and the tribunal makes a decision authorising measures or treatment which conflict with wishes specified in the statement, the tribunal has to record in writing the circumstances in which they were authorised, or not as the case may be, and state the reasons why. This means that the tribunal should set out clearly in its written decision the reasons why measures or treatment have been authorised contrary to the wishes stated in an advance statement i.e. justifying why the tribunal has overridden the advance statement. The principles of the 2003 Act will be relevant to this. A copy of the tribunal's decision must then be sent to the patient, the named person, any guardian or welfare attorney and to the MWC and placed with the patient's medical records.[10]

Effect of advance statement – the role of others providing medical treatment

16. Those who give medical treatment under compulsory measures are obliged to have regard to wishes specified in an advance statement provided that, due to mental disorder, the person's ability to make decisions about the ways they wish to be treated, or not treated, for mental disorder is significantly impaired.[11]

17. A DMP must have regard to the wishes specified in an advance statement when making a decision that giving medical treatment under section 236(2)(c), 239(1)(c) or 241(1)(c) of the 2003 Act to a patient who is incapable of consenting, or who refuses to consent to treatment, is in that patient's best interests.[12]

In practice

18. In 2017 the Scottish Government provided interim informal guidance on patient representation which included guidance on advance statements - Mental+health+act+-+advance+statements+-+interim+guidance.pdf

19. The tribunal should also record the position about the advance statement in the order form. For example, part 5c of the CTO order asks whether the patient has made an advance statement. When either no advance statement has been made or where an advance statement has been made and the tribunal's decision is not in conflict with it, box A should be shaded. Where an advance statement has been made but the treatment authorised by the order conflicts with this, then box B should be shaded, and a short narrative provided in the text box. The tribunal should provide the clerk with the narrative to be inserted in this text box. Please ensure that you complete part 5c of the CTO order, as this shaded box is the only means the MWC has of analysing patient uptake of advance statements, and thereafter of analysing the extent to which they are capable of being complied with.

[9] Section 276(5) of the 2003 Act
[10] Section 276(8)(b) and (c) of the 2003 Act
[11] Section 276(3) of the 2003 Act
[12] Section 276(4) of the 2003 Act

ADVOCACY

1. Under the 2003 Act, every person with a mental disorder has a right of access to independent advocacy regardless of whether they are subject to the provisions of the 2003 Act.[1]

2. It is the duty of each local authority, health board and the State Hospitals Board, in collaboration, to secure independent advocacy services in their area and to take appropriate steps to ensure that these services are used. [2]

3. The 2003 Act requires that the advocacy services are independent of a local authority, Health Board, a NHS Trust or a member of any of these organisations.[3] Independent advocacy is structurally and financially separate from service providers and other services. Such independence helps to ensure that there is no possibility of any conflict of interest arising in relation to any other services accessed by a patient.

4. Advocacy services are defined in section 259(4) of the 2003 Act as "*services of support and representation made available for the purpose of enabling the person to whom they are available to have as much control of, or capacity to influence, that person's care and welfare as is, in the circumstances, appropriate*."

5. In addition to the general right to advocacy contained in section 259 of the 2003 Act, there are other, more specific duties in relation to advocacy services defined in the Act. When a STDC or CTO is being considered, the MHO must advise the patient that s/he has a right to advocacy and assist the person to access advocacy services.[4] Similar duties will apply if a CTO or CO is extended and varied or if the RMO advises the MHO that s/he intends to apply to extend and/or vary the order.[5] If someone is transferred to a hospital from outside Scotland or may move to a hospital outside Scotland, the MHO has a duty to help them access advocacy.[6] Whenever someone becomes subject to a civil or criminal order, the hospital managers should inform that person of the availability of advocacy services and take appropriate steps to ensure they have the opportunity of making use of those services.[7]

6. In essence in tribunal proceedings, an advocacy worker supports a patient or relative and enables them to 'find their voice' and express their views. Unlike the named person, an advocacy worker cannot act independently of the patient. An advocacy worker will have no view on the patient's capacity and should express no personal views.

7. Examples of how an advocacy worker may assist someone in relation to tribunal proceedings are as follows:

<u>Pre-hearing:</u>

- ascertain a person's views on compulsory treatment;
- draft a written statement (which they may lodge with the Tribunal);
- inform decision making around criteria and principles;
- go through application paperwork;

[1] Section 259 of the 2003 Act
[2] Section 259(8) of the 2003 Act
[3] Section 259(1) and (5) of the 2003 Act
[4] Sections 45(1) and 61(2) of the 2003 Act
[5] Sections 85(2), 89(2), 93(4C), 151(2), 155(2) and 159(4C) of the 2003 Act
[6] Regulations 6(2) and 35(2) of the Mental Health (Cross border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005 (SSI2005/467), as amended by 2017/229
[7] Section 260 of the 2003 Act

- provide a practical description of who, what, where etc.;
- assist with obtaining legal representation;
- advise about named person and advance statement;
- seek to reassure and empower participation.

During hearing:

- read a prepared statement;
- provide prompts;
- take notes and record the person's views;
- request short adjournments, if necessary.

After hearing:

- assist with understanding the outcome;
- advise what will happen next;
- follow up points which were not within the remit of the tribunal;
- provide signposting in relation to written decision and potential appeal;
- explain any recorded matters, interim orders or adjournments;
- provide reassurance.

8. The Scottish Independent Advocacy Alliance ('SIAA') is the national intermediary organisation which supports, promotes and advocates independent advocacy across Scotland. It has issued Independent Advocacy Principles, Standards and Code of Best Practice guidelines - SIAA-Principles-Final-2nd-print-run-with-ISBN.pdf. It has also issued a companion guide for independent advocates supporting people through a MHTS process - https://www.siaa.org.uk/information-hub/mental-health-tribunal-advocacy-guidelines/. The MWC has also issued a Good Practice Guide – 'Working with independent advocates.'[8]

9. Non-instructed advocacy is defined by the SIAA as advocating for an individual who may lack capacity, for example, someone in advanced stages of dementia or someone with severe learning difficulties, or for someone who has severe communication difficulties. In such a situation the advocate would take time to get to know the person and their relatives or friends and consider alternative means of communication which might enable the person to express their views. The advocate would then represent what he or she feels a person's wishes would be, if they were able to express them, and also having regard to their rights. The SIAA has produced guidelines in relation to this: SIAA_Non-Instructed_Advocacy_Guidelines.pdf (theadvocacyproject.org.uk)

In practice

10. The Tribunal will usually be notified of the involvement of an advocacy worker by the person who submits the application or other paperwork. The Tribunal will send an invitation to the hearing to any advocacy worker whose details are intimated to it in relation to a case. An advocacy worker is not entitled to receive the paperwork.

[8] A40943 MWC Advocacy Guidance.indd

11. An advocacy worker may provide a written statement of the patient's views prior to a hearing. This will be treated as a production and circulated to all the parties. An advocacy worker may then attend the hearing too or may not appear in person at the hearing.

12. In the event that there is no advocacy worker at a hearing and no mention of the involvement of one, the tribunal should ascertain from those present at the hearing the position in relation to this - in particular, has the patient had the opportunity to engage with an advocacy worker? An advocacy worker may advise the Tribunal in advance of a hearing that the patient has failed to engage with them and so they will not attend the hearing. If this has been done, it will be noted on CMS and the Clerk can advise the members of this.

13. Where an advocacy worker is present at the hearing, the tribunal should clarify, at the outset, their role at the hearing i.e. do they have information to give the tribunal or are they present solely to support the patient or family member? This will inform the process which the tribunal will follow and enable the Convener to explain this process at the start, as required under rule 63 of the 2005 Rules.

ALTERATION OF HEARING DATE, TIME, VENUE OR TYPE

1. Once a hearing date, time, venue or type (i.e. in-person, video-conference or teleconference) has been fixed and intimated in writing to the parties (i.e. the invitation to the hearing sent out) and tribunal members, it can only be altered by an interlocutor under rule 57 of the 2005 Rules. This alteration is different from a hearing being adjourned. This is discussed in **Chapter 2.**

2. Rule 57 allows the Tribunal either on receipt of a written request from a relevant person or on its own initiative to alter the date, time or place of a hearing. In practice, requests for such alterations are often made by a party or attendee after s/he has received notification of the hearing. Usual reasons for requests are that the person is unavailable to attend the hearing or requires further time to obtain an independent medical report.

3. It is worth noting that, except in the most time critical cases, caseworkers seek availability from parties before scheduling a hearing.

4. There is a pro forma form which should be used by any person making a request under rule 57. This is available on the Tribunal's website – https://www.mhtscotland.gov.uk/mhts/files/New_adj_form.docx. Any person submitting a request is asked to advise other parties about the request before they submit it to the Tribunal. The form provides suggested wording for this which includes advising the party that, if they wish to do so, they should inform the Tribunal of their position in relation to the request within 48 hours of receiving notice of it and, if they do not do so, the Tribunal will treat this as consent to the request.

5. Usually such requests are decided by an IHC. In reaching their decision, the IHC will consider the reasons for the request, the position of the other attendees and the overriding objective of the 2005 Rules. The date, time or venue of a hearing should not be altered without a good and valid reason.

6. In terms of rule 57(2) the Tribunal shall not 'without good cause' change a hearing date to a date earlier than the one originally fixed.

7. Rule 57(1) states that the Tribunal shall give relevant persons as much notice as is reasonably practicable of any alteration of date, time or venue.

APPEALS

Appeals to the Tribunal

1. Only a small number of sections of the 2003 Act create an express right of 'appeal' to the Tribunal. Certain other sections use the term 'application' but are often described colloquially as 'appeals'. Both types of process are covered here.

Express rights of appeal

2. Generally, the situations in which there is an 'appeal' to the Tribunal are those where a patient or named person wishes to challenge a decision made about the patient by their treating team or, for restricted patients, by the Scottish Ministers. The following sections set out such rights of challenge:

- Sections 124 to 126: these apply where it is proposed to transfer a patient who is subject to a CTO authorising detention in hospital from one hospital, H1, to another, H2. Section 125 covers appeals against such transfer where H2 is any hospital other than a state hospital. Section 126 covers transfer to a state hospital. In both scenarios, there are provisions for the giving of at least seven days' notice of the proposed transfer to the patient, unless transfer is urgently necessary or the patient consents to the transfer, all as set out in section 124. Where notice is required, it must be given to the patient, their named person and their primary carer. Whether notice is given or not, the patient has a right of appeal to the Tribunal. Where H2 is not a state hospital, the appeal period (under section 125) is 28 days, with different start dates for that period depending on whether advance notice was given or not. The appeal period where H2 is a state hospital is 12 weeks (section 126). In both section 125 and section 126, the patient and their named person have a right of appeal. In both situations, if an appeal is made before the transfer has taken place, the patient is not to be transferred, but an application may be made to the Tribunal for an order that the transfer take place pending the hearing of the appeal. Such an application may be granted if the tribunal is satisfied that the patient should be transferred prior to the determination of the appeal. The application will be decided as an interim matter by an IHC, with an opportunity given to each party to make representations in advance of the decision. Brief reasons for the decision will be provided. When the merits of the appeal come to be considered, the tribunal may make an order that the patient not be transferred or, if already transferred, an order that the patient be returned to H1. If H2 is a state hospital, the tribunal may refuse to sanction the transfer if it is not satisfied that the patient requires to be detained in hospital under conditions of special security which can only be provided in a state hospital, all in terms of section 126(6).
- Section 178: this section applies the above provisions governing inter-hospital transfer to those patients whose detention in hospital is authorised by a CO.

- Sections 201 to 204 deal with certain scenarios occurring after conditional discharge of a patient, and create rights of appeal in these scenarios. Under section 201, variation by the Scottish Ministers of the conditions of discharge may be appealed to the Tribunal by the patient or their named person. The appeal period is 28 days from receipt of notice of the variation. Under section 204, where a patient is recalled to hospital from conditional discharge, they or their named person may appeal to the Tribunal within 28 days of return to hospital.
- Sections 218 to 220 create rights of appeal against inter-hospital transfer for patients subject to a CORO, for those subject to a hospital direction and for those subject to a transfer for treatment direction. As with sections 124 to 126 regarding patients on a CTO, there are provisions requiring the giving of seven days' notice other than in urgent or consensual situations, with analogous rights of appeal to the Tribunal and provision for interim orders. The periods for appeal are the same: 28 days for non-state hospital transfers and 12 weeks where H2 is a state hospital.
- Section 290 deals with the situation where it is proposed to transfer out of Scotland a patient whose detention in hospital is authorised under the 2003 Act or the Criminal Procedure (Scotland) Act 1995. The process for such transfer is set out in the Mental Health (Cross border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005, as amended. Under regulation 13, the patient and their named person have a right of appeal to the Tribunal against transfer, but this is only exercisable prior to transfer.[1]

3. The details of the appeal process in each of the above scenarios are set out in part III of the 2005 Rules. Appeals have to be made in writing and, generally, the respondent will be the person or persons who made the decision under challenge.

Applications equivalent to an appeal

4. The following provisions of the 2003 Act create rights for the patient and their named person to apply to the Tribunal for revocation of a certificate, a determination or an order granted by an AMP or a RMO.

- Section 50: where a STDC has been granted authorising a patient's detention in hospital for 28 days, or an extension certificate under section 47 authorises further detention on a short term detention certificate for three additional days, the patient or their named person may apply to the Tribunal for revocation of the certificate. Such an application is to be granted where the Tribunal is not satisfied (i) that the patient has a mental disorder, (ii) that because of mental disorder the patient's decision-making about treatment is significantly impaired or (iii) that there would be a significant risk to the health safety or welfare of the patient or to the safety of any other person were the patient not detained. The application is also to be granted if the tribunal is not satisfied that the patient's continued detention in hospital is necessary.

[1] See **Chapter 22** on cross border transfers

- Section 99: where a patient's RMO has made a determination extending a CTO, a patient or named person may apply to the Tribunal for an order revoking that determination. Under section 103(2), the tribunal has power to revoke the determination, to revoke the determination and the CTO, to confirm the determination or to confirm the determination and vary the CTO.
- Section 100: where a patient or named person makes an application for revocation or variation of a CTO. [2] Under section 103(3) and (4), the tribunal has the power to revoke the order, vary it by modifying the measures or any recorded matter, refuse the application or refuse the application and revoke the order. There are a number of restrictions of this general right to apply to the Tribunal. Firstly, an application under this section cannot be made within three months of (a) the CTO being made, (b) an order made by the tribunal under section 102 or (c) an order made by the tribunal under section 103(1). Secondly, where an application is made during the first six months of a CTO being granted, only one further application can be made under this section within that period. Where the application is made during the second six month period of a CTO (following its extension) only one further application can be made under this section within that second six month period. Where the CTO is being extended on a 12 monthly basis, only two applications under this section can be made within that 12 month period. Thirdly, where a previous application has been made under section 99 and has been refused, one further application under this section can be made before the order is due to expire if not extended. These restrictions apply separately to the patient and named person.
- Section 120: where a patient is subject to a CTO or interim CTO which does not authorise detention in hospital but the patient is not complying with a measure in the order, the patient may be taken into hospital. This is possible only where the RMO considers that certain other steps have been taken without remedying the situation and that there is a risk of deterioration in the patient's mental health (all as set out in section 113). A certificate authorising detention in hospital for 28 days may be granted under section 114 (for a CTO) or 115 (an interim CTO). The patient or their named person may apply to the Tribunal under section 120 for revocation of such a certificate. The application must be granted if the tribunal is not satisfied that it is reasonably likely that there will be a significant deterioration in the patient's mental health if he or she does not continue to be detained in hospital.
- Section 163: where a patient's RMO has made a determination under section 152 extending a CO, a patient or named person may apply to the Tribunal for an order revoking that determination. Under section 167(3), the tribunal has power to revoke the determination, to revoke the determination and the CO, to confirm the determination or to confirm the determination and vary the CO.

[2] See **Chapter 34** on Listed Initiators where there is no named person and that patient lacks capacity in relation to a decision to initiate an application.

- Section 177 applies the mechanisms set out in sections 113 to 122 to COs which do not have a restriction order added. Thus, a patient subject to a CO who is taken into hospital following non-compliance with a measure in their CO and in respect of whom a certificate authorising their detention for 28 days is in place, can apply to the Tribunal for revocation of that certificate using the process in section 120.

5. The details of the appeal process in each of the above scenarios are set out in part II of the 2005 Rules. Appeals have to be made in writing and, generally, the respondent will be the person or persons who made the decision under challenge.

Appeals from the Tribunal

6. Part 22 of the 2003 Act governs appeal against decisions of the Tribunal. Other than in relation to patients subject to a CORO, to a hospital direction or to a transfer for treatment direction, appeals lie to the sheriff principal, as set out in section 320. Section 320 sets out the decisions to which it applies, therefore a decision not listed does not have a right of appeal to the sheriff principal. This means, for example, that a patient who was successful in obtaining revocation of a short-term detention certificate cannot appeal against a finding of fact made by the Tribunal in its decision.[3] In relation to patients subject to a CORO, to a hospital direction or to a transfer for treatment direction, appeals concerning decisions regarding named persons under section 257 also lie to the sheriff principal.[4] Other appeals concerning such patients lie to the Court of Session under section 322. Again, only those decisions listed in the section carry a right of appeal.

7. Under section 320**,** rights of appeal are conferred on a relevant party to the decision appealed against. This includes the person to whom the decision relates, any named person, any guardian of the person, any welfare attorney, the mental health officer and the RMO. If the decision relates to a patient subject to a CORO, to a hospital direction or to a transfer for treatment direction, the Scottish Ministers also have rights of appeal. If a decision concerns excessive security in terms of section 320(1)(w), the Mental Welfare Commission also have rights of appeal, as do the relevant Health Board. In relation to an application to the Tribunal under section 291 of the Act (alleged unlawful detention), the managers of the hospital concerned also have a right of appeal to the sheriff principal.

8. The sheriff principal concerned will be the sheriff principal for the sheriffdom in which the person to whom the decision relates is resident or, if he or she is detained in hospital, for the sheriffdom where the hospital is situated.[5]

9. Under section 322**,** rights of appeal to the Court of Session are conferred on the person to whom the decision relates, any named person, any guardian of the person, any welfare attorney and the Scottish Ministers. Where the appeal is against a decision concerning excessive security, the Mental Welfare Commission and the relevant Health Board also have rights of appeal.

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[3] see *JH v MHTS* 2 December 2020

[4] Section 320(1)(u) and (v) of the 2003 Act

[5] Section 320(3) of the 2003 Act

10. Period for appeal: where the appeal is to the sheriff principal, the period within which the appeal must be made is governed by the Act of Sederunt (Summary Applications, Statutory Applications and Appeals etc Rules) 1999. Under rule 2.6, the appeal must be lodged within 21 days after the date on which the decision was intimated to the person appealing. On special cause shown, the appeal may be heard even though not lodged within the required period. Where the appeal is to the Court of Session, the period is also 21 days. This is set out in the Mental Health (Period for Appeal) (Scotland) (no. 2) Regulations 2005. The 21 days runs from the date on which the person appealing was informed of the decision appealed against or, if they have requested a copy of the Full Findings and Reasons of the Tribunal within seven days of the date of being informed of the decision, 21 days after the date on which they receive the FFR.

11. Whether to the sheriff principal or the Court of Session, the grounds of appeal as set out in section 324 are:

- that the Tribunal's decision was based on an error of law;
- that there has been a procedural impropriety in the conduct of any hearing by the Tribunal on the application;
- that the Tribunal has acted unreasonably in the exercise of its discretion or
- that the Tribunal's decision was not supported by the facts found to be established by the Tribunal.

12. The Tribunal may be a party to the appeal. The Tribunal does not, however, have rights of appeal.

13. If the appeal is allowed, the court will set aside the decision of the Tribunal and will either substitute its own decision or remit the case to the Tribunal to consider it anew, all as set out in section 324.

14. In relation to appeals made under section 322, the Court of Session has power under section 323 to suspend the operation of the Tribunal's decision pending the determination of the appeal.

15. Where an appeal has been made to the sheriff principal and decided, there is a further right of appeal to the Court of Session under section 321.

16. Although not expressly a ground of appeal, alleged inadequacy of written reasons is regularly advanced as a basis for challenging a tribunal's decision. It may be presented under section 324(2)(a), (b) or (d) but, whichever subsection is selected, the Court will be prepared to scrutinise the reasoning provided. The words of Lord President Emslie in *Wordie Property Limited v Secretary of State for Scotland*[6] often feature in this context. Lord Emslie said that the decision maker:

[6] 1984 SLT 345 at 348

> ‘must give proper and adequate reasons for his decision which deal with the substantial questions in issue in an intelligible way. The decision must, in short, leave the informed reader and the court in no real and substantial doubt as to what the reasons for it were and what were the material considerations which were taken into account in reaching it’.

In practice

17. All MHTS appeal cases are on the website under “Caselaw”. They are also summarised in the Tribunal’s Case Digest, volume 1 (decisions to 2011) and volume 2 (decisions 2011 to 2021).

APPROVED MEDICAL PRACTITIONER

1. There are some duties set out in the Mental Health (Care and Treatment)(Scotland) Act 2003 which must be performed by a psychiatrist who holds the status of an Approved Medical Practitioner.

Who holds the status of an Approved Medical Practitioner?

2. The status of an Approved Medical Practitioner (AMP) is defined at section 22 of the 2003 Act. An AMP is a medical practitioner included in a list compiled and maintained by Health Boards and the State Hospitals Board for Scotland. To be listed, a practitioner has to be approved. This will occur if they fulfil the requirements of section 22(1)(a) by having the requisite qualifications and experience and are approved under section 22(1)(b) as having special experience in the diagnosis and treatment of mental disorder.

What if a medical practitioner does not appear on the list compiled by the relevant Health Board?

3. There are occasions when due to a time lag or administrative error the name of the medical practitioner does not appear on the relevant list. The President's Guidance to Tribunal Members No 1/2022 Guidance on the Status of an Approved Medical Practitioner deals with this issue. In short, it is the President's view that the inclusion of a name on a Health Board list at any given moment is not determinative of whether an individual is qualified to act as an AMP in terms of the 2003 Act, i.e. what matters is approval, not listing. If a practitioner satisfies the terms of section 22(1), anything that they do in discharging functions under the Act cannot be considered ultra vires.

In practice

4. If there is an argument made about whether a psychiatrist can be treated as an AMP if they are not included on the relevant Health Board list at the time of the hearing it will ultimately be for a tribunal to decide the question, which is a matter of statutory interpretation.

BURDEN AND STANDARD OF PROOF

1. Burden and standard of proof are different. In every case, the burden falls on one party. Sometimes there is more than one burden in a case, borne by different parties on different issues. The concept of burden of proof can be illustrated by asking what would happen if the decision-maker concluded after all the evidence that the answer was 'don't know'? In that situation, the party with the burden of proof would fail. Standard of proof conveys the idea of how convinced the decision-maker must be. In a criminal case, the level of certainty required is beyond reasonable doubt. In a civil case, it is on the balance of probabilities – or 'more likely than not'. Neither burden nor standard of proof will expressly feature in MHTS proceedings other than occasionally. This is because such proceedings are inquisitorial rather than adversarial, and both concepts belong primarily in adversarial processes.[1]

Burden of proof

2. In proceedings before MHTS, the burden of proof is almost always on the authorities and not on the patient. This reflects principles explained by the European Court of Human Rights in a case *Reid v United Kingdom.*[2] The application to the European Court on behalf of Mr Reid mainly concerned the continued mental health detention of someone diagnosed with untreatable antisocial personality or psychopathic disorder. But the Court also examined the issue of burden of proof. In considering Article 5(1) of the European Convention on Human Rights, which provides that deprivation of liberty shall only take place in prescribed situations (including mental ill-health) and in compliance with a process laid down by domestic law, the Court said:

> *…the Court has adopted the approach that both the initial deprivation of a mental patient's liberty and the continued detention could only be lawful under Art.5(1)(e) if it can "reliably be shown that he or she suffers from a mental disorder sufficiently serious to warrant detention", namely that the burden lies on the authorities in both cases.*[3]

3. Under the 2003 Act, this principle is reflected in repeated reference to the need for the tribunal to be 'satisfied' of matters, and provisions dictating what should happen if the tribunal is 'not satisfied'. This will mean in practice that the person seeking to persuade the tribunal that criteria are met will bear the burden of proof on the issue or issues involved.

4. It follows from this that there are a few instances where the burden of proof is on the patient. For example, the set of sections dealing with excessive security (section 264 onwards) require the tribunal to take certain steps if satisfied that the patient does not require to be detained in particular conditions. The burden of satisfaction will lie on the patient.[4] This contrasts with the position where an order has been made in relation to excessive security and its recall is sought – then, the burden of proof is on the Health Board or other party seeking recall.

5. Finally, in the sections of the 2003 Act dealing with reviews (for example section 102) there is no reference to a need for any party to 'satisfy' the tribunal. The location

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[1] see the comments on the role of burden of proof in a benefits claim in the decision of the House of Lords in *Kerr v Department for Social Development* [2004] 1 WLR 1372

[2] (2003) 37 EHRR 9

[3] Ibid., paragraph 70 of the decision

[4] see *Lothian Health Board v BM and MHTS,* 2007 SCLR 478

of the burden of proof is thus uncertain, and there is no judicial guidance in point. It is reasonable to assume that, in the first instance, if the patient is contending that an order should not have been extended, there is a burden on them to suggest why not.

Standard of proof

6. Proceedings before the Tribunal are civil proceedings. It therefore follows that the standard of proof is on the balance of probabilities. From time to time in civil cases, it is argued that allegations of what would be a criminal offence, made in civil proceedings, should attract the criminal standard of proof. This argument has been rejected multiple times. It was rejected in a case dealing with the predecessor legislation to the 2003 Act, the Mental Health (Scotland) Act 1984. In that case, *B v Scottish Ministers*[5], the Court said:

> *Where an allegation of criminal conduct is made in civil proceedings, the standard of proof is the balance of probabilities; but the nature of the allegations may be such as to call for evidence of quality and weight and for that evidence to be carefully examined and scrutinised in the course of the forensic process.*[6]

7. Thus, an allegation of particularly serious conduct, or of factual matters which are inherently unlikely, may call for particularly careful scrutiny. But the standard of proof in MHTS proceedings will always remain the balance of probabilities.

[5] 2010 SC 472
[6] Ibid., paragraph 42.

CITATION OF WITNESSES

Power to require a witness to attend a hearing and to produce a document

1. In the 2005 Rules, rule 59 empowers the Tribunal to send a citation to any person, requiring that person to attend and produce any document which the tribunal considers it necessary to examine and which is in the custody, or under the control of, that person. The Tribunal may do so on the written request of any relevant person, or on its own initiative.

2. Under rule 59(2)(a) the citation must explain that it is an offence under paragraph 12(3) of schedule 2 to the 2003 Act for a person who is cited to attend the Tribunal

- To refuse or fail to attend; and
- To alter, conceal or destroy or refuse to produce, a document which such person is required to produce for the purposes of the proceedings before the Tribunal.

3. Rule 59(2)(b) requires that the citation must also explain that a person need not produce any document if, were it a document that might be produced in any court in Scotland, the person having that document could not be compelled to produce it in such proceedings.

4. Expenses are to be paid by the relevant person making the request or by the Tribunal, as the President shall direct. No person is required to comply with the citation unless their necessary expenses are paid or tendered to them.

5. Rule 59(4) permits a person receiving the citation to apply in writing to the Tribunal for the citation to be varied or set aside and the Convener may vary or set aside the citation as they see fit.

Power to require a witness to attend a hearing

6. Rule 60 provides that the evidence before the tribunal may be given orally or by signed statement but the tribunal may at any stage of the proceedings require the personal attendance of any witness to give oral evidence. Rule 61(1) goes on to provide that the Tribunal may send a citation to a person for that person to attend to give oral evidence, either on the tribunal's own initiative or on the written request of any relevant person. A request by a relevant person shall give the name and address of each person in respect of whom the request is made.

7. Under rule 61(3) the citation must explain that

- It is an offence under paragraph 12 of schedule 2 to the 2003 Act to refuse or fail, without reasonable excuse, to comply with it;
- A person need not give evidence as a witness if the person could not be compelled to give that evidence in proceedings in any court in Scotland;

8. Rule 61(4) provides that no person can be compelled to attend in compliance with a citation unless given five working days' notice of the hearing or other such period of notice, which must be at least 48 hours' notice, as shall be specified in the citation. Expenses are borne by the relevant person who requested their attendance or by the Tribunal, as the President shall direct.

In practice

9. The provisions in rules 59 and 60 allow for citations in respect of both oral and documentary evidence to be sent to witnesses. Rule 59 sets out powers to require a witness both to attend and to produce a document or documents in their possession or control, whilst rule 60 sets out powers simply to require a witness to attend a hearing. The 2005 Rules do not seem to anticipate the situation where a document is to be produced by someone who is not also required to attend a hearing. Citations issued under rule 60 must provide a minimum notice period of five working days unless otherwise specified, to a minimum of 48 hours. This provision is not specifically replicated in respect of citations issued under rule 59, but it can be assumed that given that rule 59 requires the attendance of the witness as well as the provision of documents, this is implied when the provisions are read together. Similarly, there is no specific provision in rule 61 to permit a person to make a written request for a citation issued under that rule to be set aside or varied.

10. The power to issue a witness citation is rarely invoked. In practice, generally, those who are invited or requested to attend a hearing (and to produce documents) will do so, or will contact the Tribunal Administration to advise of any difficulties. Usually, those who are to attend are invited to do so at the point of scheduling the hearing, or less frequently, by way of a Direction made by the tribunal at a previous hearing of the application. Documents are on the whole, produced when sought.

11. On the rare occasion where a witness indicates that they will not attend or produce a document and does not have a reasonable excuse (for example being overseas or unavailable for other personal or professional reasons) then a citation may be required to secure their attendance. Similarly, where a direction has been made and the witness has not complied with the direction, a citation is generally necessary for any subsequent hearing. It is undesirable for hearings to be adjourned for the absence of a witness or document, but sending a citation is a significant step with legal consequences, and a balance should be struck between ensuring the overriding objective as set out in rule 4 and maintaining positive relationships with the professional groups who regularly attend hearings and facilitate their smooth running.

12. The Legal Secretary to the Tribunal will issue the signed citation in the correct form and with proof of posting. As set out in both rule 59 and in rule 61(2), a citation may be issued by the Tribunal *ex proprio motu* or on the written request of a relevant person. Such a request should be considered by the President or by an IHC. The citation itself may then be issued at the point where a hearing is scheduled, either because a written request from a relevant person has been granted, or a potential witness has intimated their intention to refuse to attend, for example by contacting the Tribunal Administration. Alternatively, it may be initiated by way of a direction made by a tribunal at a hearing which has been adjourned for the attendance of the witness.

13. The failure of a witness to comply with the citation without reasonable excuse may result in a report being made to the Procurator Fiscal. Again, this is done by the Legal Secretary to the Tribunal, who will provide evidence that the citation was properly made and sent to the witness. Once the report is made, the Tribunal has no further duties or powers in relation to the matter, but is not prohibited from sending a further citation to the same individual. Advice should be sought from an In House Convener or the Legal Secretary in this situation.

14. It is for the tribunal sitting to decide as a matter of procedure (the procedure at all tribunals being under the control of the Convener) whether witnesses should be admitted to the tribunal room at the beginning of the hearing or whether they should be kept out until they are actually required to give evidence. The views of parties can be sought in relation to the order and attendance of any witnesses however it is ultimately a matter for the tribunal to determine this.

CLERICAL MISTAKES OR ERRORS IN DECISIONS

1. Rule 72(8) of the 2005 Rules allows 'clerical mistakes or errors' in an FFR to be corrected by the convener by certificate in writing. If a document is corrected in this way, the Tribunal is obliged to notify the parties and the Mental Welfare Commission of the change.

2. The rule does not define or expand the notion of 'clerical mistake or error', though it must arise from 'an accidental slip or omission'. Nor is there any explanation of the difference between a mistake and an error. The purpose of the FFR is to record a full statement of the facts found and the reasons for the decision of the tribunal. It is clear that a typographical error such as calling someone 'John' instead of 'Joan' or attributing an event to '1922' instead of '2022' could be corrected.

3. Sometimes mistakes of a more fundamental nature occur. There is no precise dividing line between a mistake which can be corrected under rule 72 (8) and one which cannot. It may be helpful to remember that the overriding objective of the rules is to ensure that proceedings are handled as fairly, expeditiously and efficiently as possible. In addition, the following extract from the judgement of Lord Neuberger in the Supreme Court case of *Marley v Rawlings*[1] may be helpful:

> *I accept that the expression "clerical error" can have a narrow meaning, which would be limited to mistakes involved in copying or writing out a document, and would not include a mistake of the type that occurred in this case. However, the expression is not one with a precise or well established, let alone a technical, meaning. The expression also can carry a wider meaning, namely a mistake arising out of office work of a relatively routine nature, such as preparing, filing, sending, organising the execution of, a document (save, possibly, to the extent that the activity involves some special expertise). Those are activities which are properly be described as clerical, and a mistake in connection with those activities, such as wrongly filing a document or putting the wrong document in an envelope, can properly be called a clerical error.*

[1] [2015] AC 129 at paragraph 75

CODE OF CONDUCT – JUDICIAL

1. In preparation for the move of the Mental Health Tribunal for Scotland into the First-tier Tribunal, all members took the oaths required of Tribunal members under the Tribunals (Scotland) Act 2014. The oaths concerned are the Oath of Allegiance to the Crown and the Judicial Oath. In taking the latter oath, a member swears that they will 'do right to all manner of people after the laws and usages of this Realm, without fear or favour, affection or ill will'.

2. Some discussion of the principles of judicial conduct is set out within the 'Ethics and Independence' tab of the website of the Judiciary of Scotland. In relation to ethics, reference is made to the Statement of Principles of Judicial Ethics. This key document was framed in 2010 and most recently revised in 2023

3. The principles are intended to be of assistance to all judicial office holders exercising their offices within Scotland.[1] This includes ordinary and legal members of the Scottish Tribunals. It is recognised that there is some difference between what can be expected of full-time salaried judges and the holders of part-time appointments. In reading the Statement, it should be assumed that any particular guidance is applicable to all judicial office holders, unless there is a specific statement to different effect.[2] The guidance is not, in general, intended to be prescriptive. It also acknowledges that there can be a range of reasonably held opinions on some aspects.

4. The Statement begins by quoting the six Bangalore Principles of Judicial Conduct, which were endorsed at the 59th Session of the United Nations Human Rights Commission at Geneva in April 2003. The six principles are:

- Independence;
- Impartiality;
- Integrity;
- Propriety;
- Equality of Treatment; and
- Competence and Diligence.

5. The Statement of Principles for Scotland is written around these six headings. Anyone wishing to gain a fuller understanding of the principles should read the document; attempted summarising risks missing out something important or implying that some principles are more important than others.

6. Related topics are judicial complaints **Chapter 15** and conflict of interest **Chapter 20**.

[1] Paragraph 2.1
[2] Ibid.

CODE OF PRACTICE

1. The Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice ('the COP') runs to three volumes:

(i) Volume 1 deals with a range of issues relating to the general framework within which the 2003 Act operates, including the duties placed on health boards and local authorities; cross-border transfer of patients; and medical treatment. It starts with a discussion of the principles of the 2003 Act and describes two important terms commonly used throughout the 2003 Act, namely 'mental disorder' and 'medical treatment'. This volume also describes the powers and duties of the MWC, discusses the MHTS and examines issues in relation to patient representation, including nominating a named person, making an advance statement and a patient's right to advocacy - Mental Health (care and treatment) (Scotland) Act 2003: Code of Practice Volume 1 - gov.scot (www.gov.scot)

(ii) "Civil compulsory powers" are dealt with in Volume 2, namely matters relating to an EDC; a STDC; an extension certificate; a CTO; an interim CTO; absconding from any of these certificates/orders and transferring patients within Scotland - Mental Health (care and treatment) (Scotland) Act 2003 Code of Practice Volume 2 civil compulsory powers (parts 5, 6, 7 and 20) - gov.scot (www.gov.scot) .

(iii) Volume 3 covers procedures surrounding the compulsory care and treatment of a person with a mental disorder who has committed any form of criminal offence - Mental health (care and treatment) (Scotland) Act 2003: Code of Practice- Volume 3 compulsory powers in relation to mentally disordered offenders - gov.scot

2. The COP is a statutory document which was published by the Scottish Ministers in accordance with section 274 of the 2003 Act. It was brought into force on 5 October 2005.[1] Ministers consulted widely before producing each of the volumes.

3. The COP gives guidance in relation to the provisions of the 2003 Act and identifies and promotes issues of good practice. Section 274(4) of the 2003 Act requires any person carrying out his or her duties under the Act to have regard to the relevant provisions of the COP. The Tribunal is excluded from this (as is any court, a prosecutor and the MWC) but it is a helpful guide for members when considering the discharge of functions by various professionals or bodies under the Act.[2]

4. While there is no binding authority on the legal status of the COP, in the case of *R v Ashworth Hospital Authority ex parte Munjaz*[3] the House of Lords considered the legal status of the Mental Health Act Code of Practice in England and Wales ('the Code'). This case is likely to be highly influential if a case about the COP comes to court.

5. In that case the House of Lords stated that a person to whom the Code is addressed should give clear, logical and convincing reasons if he or she decides not to follow it. Parliament expects people to follow the Code, unless a convincing reason for

[1] The Mental Health (Care and Treatment) (Scotland) Act 2003 (Code of Practice) Order 2005 SSI 2005/417
[2] Section 274(5) of the 2003 Act
[3] [2005] UKHL 58; [2006] 2 AC 148

not doing so can be shown.[4] If human rights are involved, a departure from the Code will be subject to particularly careful and intense scrutiny.[5]

6. In the unlikely event that there is a conflict between the COP and the legislation then the legislation will prevail.

[4] Ibid., Lord Hope, paragraph 69.
[5] Ibid., Lord Hope, paragraph 74.

COMMUNICATION DIFFICULTIES

Patients

1. Generally, if someone's first language is not English or a patient needs help with communication, the hospital should give the person information about his or her legal rights in a form the person can understand. The 2003 Act requires the hospital to make all reasonable efforts to ensure the person understands their rights. [1] The principle of respect for diversity is relevant to this too.

2. More specifically, if a patient has difficulty in communicating or generally communicates in a language other than English, and is detained in hospital or is subject to a specified certificate, order or direction, it is the responsibility of the hospital managers to provide the appropriate assistance. [2]

3. Section 261(2) and (3) provide that the 'appropriate person' shall take all reasonable steps to secure that for the purpose of enabling the patient to communicate during certain events, arrangements appropriate to the patient's needs are made or the patient is provided with assistance, or material, appropriate to the patient's needs.[3] The events for which arrangements are required to be made are:

- any medical examination of the patient carried out for the purpose of assessing the patient's mental disorder;
- any review under the 2003 Act or the 1995 Act of the patient's detention; or
- any proceedings before the Tribunal relating to the patient.[4]

4. 'Appropriate person' is defined by reference to section 260(5) and means:

- the managers of the hospital where the patient is detained;
- where the patient's detention in hospital is suspended, the managers of the hospital where, but for the suspension certificate, the patient would be authorised to be detained; and
- in any other case, the managers of the hospital specified in the order.

5. The managers of the hospital must make a written record of the steps taken as soon as practicable after they have been made. [5]

6. To enable persons with communication difficulties to interact with people effectively, reasonable adjustments should be made to support a patient's needs when identified. The onus is on the hospital managers to ensure these steps are taken. Whenever possible, the patient should be asked which format they prefer. A record should be kept, with the patient's permission, if the patient uses technical aids to support communication or requires information to be interpreted, translated or adapted.

7. Assistance may be provided in the form of interpreters, including BSL interpreters; lip speakers; Makaton; and deaf-blind communicators. It also extends to translation

[1] Section 260(2) of the 2003 Act
[2] Section 261(1), (2) and (5) with 260(5) of the 2003 Act
[3] Section 261(2) of the Act of the 2003 Act
[4] Section 261(3) of the Act of the 2003 Act
[5] Sections 261(2) and 260(5) of the 2003 Act

of tribunal papers. As it is a matter for the hospital managers, the Tribunal has no locus to insist on a particular form of assistance.

In practice

8. Where it comes to the attention of the Tribunal Administration that the patient concerned has a difficulty in communicating, then the Tribunal Administration should bring that to the attention of the person submitting the application/appeal, reference or review. The Tribunal Administration should inform them that it is for the managers of the hospital specified in the order to make the necessary arrangements for the provision of assistance to the patient.

9. If it comes to the attention of the tribunal at a hearing that no assistance has been provided by the hospital to a represented patient in the way of translated papers then, before adjourning, enquiries should be made with the representative as to whether instructions were taken with the aid of an interpreter.

10. If an adjournment is necessary to allow the patient to fully participate, consideration should be given to the making of a Direction to hospital managers to provide assistance in terms of Section 261(2) and (3).[6]

Other persons, including named person

11. In terms of rule 53 of the 2005 Rules, the Tribunal has responsibility to provide assistance to persons, other than a patient, who have difficulty in communicating or generally communicate in a language other than English and who are taking part in proceedings before the Tribunal.[7]

12. This responsibility applies to any person taking part in proceedings before the Tribunal so will apply to an interested person, i.e. a person who has been identified as having an interest in the application and who has been invited to the hearing, as well as to parties or relevant persons.

13. The person requiring assistance to enable them to take part in Tribunal proceedings or a relevant person, who becomes aware of such a person requiring assistance, shall notify the Tribunal of this.[8]

14. The Tribunal is required to take all reasonable steps to secure that arrangements appropriate to the needs of the person who requires assistance are made.[9]

15. There may be hearings where there is more than one interpreter in attendance i.e. one for the patient and one for a named person or primary carer although if the same language is spoken by both this is unnecessary.

In practice

16. Where it is brought to the attention of the Tribunal that a person, other than the patient, requires assistance it is for the Tribunal Administration to arrange this.

17. Before adjourning a hearing to allow assistance for a represented Named Person to be arranged, enquiries should be made with the representative as to whether instructions were taken with the aid of an interpreter.

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[6] See **Guidance Note 1/2023** and practical tips noted in the January 2023 Newsletter. [7] Rule 53(1) of the 2005 Rules
[8] Rule 53(2) and (3) of the 2005 Rules
[9] Rule 53(4) of the 2005 Rules

18. If an adjournment is necessary to allow the Named Person to fully participate, consideration should be given to the making of a Direction to Tribunal Administration to provide assistance in whatever way is appropriate.

COMPOSITION OF TRIBUNALS

1. By the terms of Schedule 2 to the 2003 Act, the MHTS consists of three panels of members. These are legal members, medical members and general members. Regulations specify the qualifications required to be appointed to each panel.[1] Schedule 2 also provides that there shall be a shrieval panel, consisting of persons who hold the office of sheriff principal, sheriff or part-time sheriff.[2] These individuals shall serve as sheriff conveners of the Tribunal. Unlike the other three panels, no specific qualifications are prescribed for membership of the shrieval panel, other than the holding of the identified office.

2. The legislation uses the term 'Tribunal' to refer to the organisation as a whole, and the term 'tribunal' to refer to the sitting together of three members to determine a case. The Tribunal generally follows the same practice.

3. The method for determination of applications is set out in paragraph seven of Schedule 2. The functions of the Tribunal are to be discharged by such number of tribunals as may be determined from time to time by the President. These sit at such times and in such places as may be determined by the President. An individual tribunal shall consist of a convener, who shall be the President or a legal member, sitting with a medical and a general member. If the tribunal relates to a person subject to a CORO, or a HD or TTD, it must be convened by the President or by a member of the shrieval panel. This requirement for a shrieval convener is subject to a qualification in relation to proceedings regarding named persons or for the making of a compulsory treatment order under Schedule 3 to the 2003 Act. Such proceedings are 'excepted proceedings' and will be convened by a legal member or by the President.

4. Interim or preliminary matters arising in an application to the Tribunal, such as the appointment of a curator *ad litem* or the alteration of arrangements for a hearing, may be dealt with by a convener alone, under the 2005 Rules.[3] The question of what would properly be described as 'an interim or preliminary matter' arose in the case of *B v Mental Health Tribunal for Scotland.*[4] The Sheriff Principal allowed an appeal against a decision to declare that an individual was no longer named person for a patient, holding that this was a substantive decision, not covered by the power in rule 43 of the 2005 Rules to determine interim or preliminary matters. He also observed that rule 43 allows decisions to be taken in the context of other proceedings. At the time the decision appealed had been taken by the convener sitting alone, there were no other proceedings before the Tribunal.

[1] These are the Mental Health Tribunal for Scotland (Appointment of Legal Members) Regulations 2004 (SSI 2004/286); the Mental Health Tribunal for Scotland (Appointment of Medical Members) Regulations 2004 (SSI 2004/374); and the Mental Health Tribunal for Scotland (Appointment of General Members) Regulations 2004 (SSI 2004/375).
[2] This does not include the office of Summary Sheriff.
[3] See, in particular, rule 43 and rule 55 of the 2005 Rules.
[4] 2012 SLT (Sh Ct) 71

COMPLAINTS ABOUT JUDICIAL MEMBERS

1. Members of the MHTS are appointed by the Scottish Government, under the provisions of Schedule 2 to the 2003 Act. If a question of their fitness for office arises, a member can only be removed by order of the disciplinary committee constituted under paragraph 5 of Schedule 2. The disciplinary committee will be constituted at the request of the Scottish Government for an investigation into the member concerned. It will be constituted by the Lord President and will consist of a Senator of the College of Justice or a Sheriff Principal (who shall preside), a solicitor or advocate of at least ten years' standing and one other person. The committee can investigate allegations of inability, neglect of duty or misbehaviour.

2. Further detail as to how the disciplinary committee will operate is contained in regulations.[1] At any time during its investigation, the committee may suspend the member from office, under regulation 5 of the Mental Health Tribunal for Scotland (Disciplinary Committee) Regulations 2004. When its investigation is complete, the committee is required by regulation 7 to send to the Scottish Government and to the member a written report of its findings and its decision.

3. For issues that do not raise a question of fitness for office, a procedure exists for making a complaint against a member. The process is similar to the complaints procedure for members of the Scottish Tribunals under the Tribunals (Scotland) Act 2014. The application of the process is supervised by the Judicial Office for Scotland. Details are available at MHTS - Complaints (mhtscotland.gov.uk).

4. The standards of behaviour expected of members of the Tribunal are detailed in the STATEMENT OF PRINCIPLES OF JUDICIAL ETHICS (judiciary.scot).

[1] The Mental Health Tribunal for Scotland (Disciplinary Committee) regulations 2004, SSI 2004/402

COMPULSION ORDERS – DISCLOSURE PERIOD

Background

1. A modification of the disclosure regime applicable to a CO was effected by legislation in 2019. This came into force on 30 November 2020, by virtue of a statutory instrument, the Mental Health Tribunal for Scotland (Practice and Procedure) (No. 2) Amendment Rules 2020 (SSI 2020/246), which permitted section 26 of the Management of Offenders (Scotland) Act 2019 to be commenced.[1]

2. The effect of this is to add three new sections to the 2003 Act: sections 164A, 167A and 167B. Taken together, these sections amend the 2003 Act to enable the Tribunal to determine, in certain circumstances, that the period during which the existence of a CO must be disclosed shall end. The provisions do not apply to COs which have a restriction order added (CORO patients).

3. The purpose of these sections is to achieve equity in respect of disclosure of information between mentally disordered offenders and those in the criminal justice system; some offences need not be disclosed under the Rehabilitation of Offenders Act 1974, but this has not previously been the case for those who have been subject to compulsion orders. For mentally disordered offenders whom the Tribunal consider present continuing risk, the application must be refused and disclosure will thus continue until the CO ceases to have effect.

New Legislation

4. The changes to the 2003 Act are set out below. You should update any printed copy of the Mental Health (Care and Treatment) (Scotland) Act 2003 which you may refer to, to show that it is amended as follows:

After section 164 there is inserted—

164A Application to end disclosure period for compulsion order

After section 167 there is inserted—

167A Duties of Tribunal on application under section 164A

167B Duty to notify outcome of applications under section 164A

Notes

5. It is not anticipated that there will be a large volume of applications under these sections. The circumstances in which patients will be in a position to make such an application are limited, but are likely to relate to individuals who are seeking employment, voluntary work and/or housing provision.

6. The application can made by the patient or the patient's named person if they have one. A qualifying "listed initiator" can also lodge an application with the Tribunal if required.

7. As the tests incorporated in the new sections relate to risk, the patient's RMO will be a party to the hearings and is likely to be required to give written or oral evidence.

[1] The Mental Health Tribunal for Scotland (Practice and Procedure) (No. 2) Amendment Rules 2020 (SSI 2020/246)

8. Tribunal Administration should process any such applications by scheduling a hearing as normal, giving notice to the persons named in section 167A. It is noted that such applications may, where no matters are contested by parties, be considered under Rule 58, with no oral hearing necessary.

9. It should be noted in particular that an application may not be made until 12 months after the date on which the relevant CO was made. No further application under these provisions is competent within twelve months of the tribunal's refusal of a previous such application and no hearings should be fixed outwith those timescales.

10. The decision should be issued to the parties in the case when available. There is no requirement at this stage to inform Disclosure Scotland of the outcome of the case.

11. At a later date the Tribunal may be contacted by Disclosure Scotland to seek information as to whether the Tribunal has made an order that the patient's CO should cease to be disclosed, or if the Tribunal has refused such an application from the patient.

12. Amendments have been made to the Tribunal's CMS to permit the necessary data to be captured and stored, and to generate proforma intimation letters to relevant persons.

COMPULSION ORDERS

Making of a CO

1. Unlike a CTO, which is made by the Tribunal under the 2003 Act, a CO is made by a court under the Criminal Procedure (Scotland) Act 1995. It is one of the range of sentencing options open to the Sheriff Court or High Court when a person with a mental disorder is convicted of a criminal offence punishable by imprisonment. The purpose of the CO is to ensure that the offender receives medical treatment by compulsory measures – either in the community or by means of detention in hospital.

2. Section 57A of the 1995 Act deals with COs. They are made on the evidence of two medical practitioners, one of whom must be an AMP, and the criteria for making them are the same as for the making of a CTO, with the exception of SIDMA, which does not need to be present.[1] When a CO is granted, it will authorise the measures specified for a period of six months.[2]

3. The measures which can be included in a CO are almost identical to those authorised by a CTO. The measures are set out in section 57(A)(8) of the 1995 Act. References are to 'the offender' rather than 'the patient' and a requirement to reside at a specified place (measure (e)) can only be imposed in relation to a care home if the court is satisfied that the service provider is willing to receive the person.[3]

4. The sections of the 2003 Act dealing with COs refer to 'relevant compulsion order'. Section 137 of the 2003 Act defines 'relevant compulsion order' as a compulsion order authorising the measures specified in it for the initial six month period made in respect of a patient.

Expiry date of CO

5. The expiry day of COs differs from CTO expiry days. This is dealt with in Chapter 19. In summary, the expiry of the first six months of a CO is at the end of the same day of the month as the day on which the order was made (i.e. a CO made on 15th of month one will last until midnight at the end of 15th of month seven). Thereafter COs expire annually at midnight on the same day of the month on which they were made (i.e. using the example above, at midnight at the end of 15th of month one of the following years).

6. For COs made before 30 September 2017, expiry will be at midnight at the end of the day before making of the order, namely 14th of month one in the example above.

Extending and Varying COs

7. Unlike CTOs (where the first extension can be made by the RMO making a determination to that effect), a first extension of a CO has to be made by the Tribunal. This is the time when a patient who is subject to a CO first enters the Tribunal system. This means that a CO which is close to expiry will lapse if a tribunal adjourns without making an interim order. Once lapsed a compulsion order cannot be revived.

(i) First mandatory review

8. In terms of section 139, the RMO has a duty, during the two month period before the CO will cease to have effect, to carry out a first review. This involves having the patient medically examined. The RMO requires to consider whether the conditions in

[1] Section 57(A)(3) of the 1995 Act
[2] Section 57A(2) of the 1995 Act
[3] Section 57A(8) and (9) of the 1995 Act

paragraphs (a) to (c) of section 139(4) continue to apply and whether it continues to be necessary for the patient to be subject to the CO. The RMO requires to consult with various persons including the mental health officer (MHO). If the RMO wishes to extend the order after the first review then he or she must apply to the Tribunal for this, irrespective of whether this is to extend or extend and vary the order.[4]

(ii) Further mandatory reviews

9. Section 140 deals with further mandatory reviews after the first review. The procedures are broadly the same as section 139, and again each review requires to be carried out within two months of the CO otherwise ceasing to have effect. Subsequent renewals will be for 12 months and on and after the first anniversary of the CO the RMO can extend it by making a determination to that effect (without applying to the Tribunal).[5] However, if a variation is required an application to the tribunal will be necessary.[6]

Applications by patients and named persons

10. Both the patient and the named person have the right, under section 163, to make an application to revoke a determination by the RMO to extend a CO. This provision does not apply where the Tribunal is required to review the RMO's determination to extend the CO under section 165. At review hearings the patient and named person will be parties and so will have the right to make representations in respect of the extension of the CO (including the right to ask the tribunal to revoke the CO).

11. Separately, section 164 gives a right to the patient and the patient's named person to apply to the Tribunal to revoke or vary a CO. Such an application cannot be made during the first six months of a CO; within three months of an order being made by the tribunal on reviewing a determination by the RMO to extend a CO; or within three months of an order being made by the tribunal under section 167 to extend the CO following first review or to determine an application to extend and vary the CO.[7] Where the application is made during the second six month period of the CO following extension, only one further application can be made by that party within that second six month period.[8] Where the application is made after the expiry of the second six month period of a CO and during any subsequent 12 month period following its extension, one further application can be made under this section by that person within any succeeding 12 month period.[9] Where a previous application under section 163 has been made and refused, the person who made the application is only entitled to make one further application under section 164 during these same periods.

12. The Tribunal's powers in such applications are set out in section 167 and are broadly the same as they are for a CTO.[10]

Reviews

13. The circumstances in which the Tribunal, on being notified that a RMO has made a determination to extend a CO, is obliged to review it are detailed in section 165. These circumstances are largely similar to those which apply for CTOs although the

[4] Sections 148 and 156 of the Act
[5] If a restriction order is added to a CO the measures specified in the CO are without limit of time.
[6] Section 161 of the 2003 Act
[7] Section 164(4) of the 2003 Act
[8] Section 164(7)(a) of the 2003 Act
[9] Section 164(7)(b) of the 2003 Act.
[10] See Recorded Matters section in **Chapter 48**

wording of these sections differ. The one notable difference is that for COs a previous review by the tribunal is a relevant decision for the purposes of calculating whether a two year review is due.[11]

14. The powers of the tribunal on review are set out in section 166.

Revocation of COs

15. If, when carrying out a mandatory review of the CO, the RMO is not satisfied that the conditions for the CO continue to exist the RMO has a duty to revoke the CO as soon as practicable.[12] The RMO must consider the views of the persons consulted under section 139(4) of the 2003 Act when reaching their decision on this.

16. The RMO also requires to keep the CO under review and from time to time to consider if the conditions for the CO continue to be met. If the RMO reaches the view that the conditions are not met the RMO must revoke the CO as soon as practicable.[13]

Recorded Matters

17. It is not currently possible to make a recorded matter in either a CO or CORO case. This is likely to change following the successful judicial review *X v MHTS*[14] which concluded that this legislative distinction amounted to unjustified discrimination under Article 14 of the ECHR.

Multiple Orders

18. There have been occasions where COs have been made by the court when the patient is already subject to a CTO. This is competent but it would be expected that one of the orders (usually the CTO) is revoked.[15] Having the two run concurrently would arguably not be in accordance with the Section 1 principles of the 2003 Act.

19. There have also been occasions where patients have been subject to more than one CO and this has only come to light once an application under section 149 to extend the most recent order has been made. As with above, a withdrawal of the application or revocation of the multiple order(s) normally follows.

[11] Section 165(2)(b) of the 2003 Act
[12] Section 141 of the 2003 Act
[13] Section 142 of the 2003 Act
[14] [2022] CSOH 78; 2022 SLT 1234
[15] *D v Procurator Fiscal, Lanark* [2018] SAC (Crim) 2; 2018 SC (SAC) 19

CORO

Introduction

1. The term 'CORO' is used frequently in relation to particular patients subject to compulsory care and treatment. It stands for 'compulsion order and restriction order'. These terms will be explained below. Patients on a compulsion order and restriction order are subject to a distinct statutory regime, set out in part 10 of the 2003 Act. Although used as an umbrella term, the term 'CORO' does not describe 100% of the patients who are subject to a regime of that nature, where the primary feature is the involvement of Scottish Ministers in decision making. A smaller number of patients are subject to an analogous regime because they were made subject to a Hospital Direction ('HD') at the time of their conviction, or because they became mentally unwell while in prison and were transferred to a hospital under a Transfer for Treatment Direction ('TTD'). Hospital Directions and Transfer for Treatment Directions are also dealt with below.

Compulsion Order and Restriction Order

2. A compulsion order ('CO') is made under section 57A of the Criminal Procedure (Scotland) Act 1995 ('the 1995 Act'). A conviction is not necessarily required: under section 57, someone found not criminally responsible or unfit for trial can also be made subject to a CO. Where a CO follows conviction, the preconditions are that the person has been convicted in the High Court or the sheriff court of an offence punishable by imprisonment (other than an offence the sentence for which is fixed by law); or has been remitted to the High Court by the sheriff under any enactment for sentence for such an offence.

3. The criteria for making a CO are similar to those for a compulsory treatment order, save for the criterion of SIDMA, which is not required for a CO.[1] The Court must be satisfied of these criteria on the evidence provided in two medical reports, and also that a CO is appropriate. The latter test must take into account

- a report by an MHO;
- all the circumstances including the nature of the offence of which the offender was convicted and the antecedents of the offender; and
- any alternative means of dealing with the offender.

4. A CO can be hospital or community based, with the list of measures being contained in section 57A(8) of the 1995 Act and being almost identical to the measures available in a CTO. The Court can only make a hospital-based CO if the medical treatment concerned can only be provided if the offender is detained in hospital. Detention in a state hospital may be authorised only if it appears to the Court that the offender requires to be detained in hospital under conditions of special security; and that such conditions of special security can be provided only in a state hospital.

5. A restriction order ('RO') can only be combined with a hospital-based CO – it has no freestanding existence. It is made under section 59 of the 1995 Act. The effect of the RO is to make the CO unlimited in terms of duration (sometimes referred to as 'detention without limit of time'). The criterion for

[1] See Chapter 17 on Compulsion orders

imposing a RO is that, having regard to specified factors, the order is necessary for the protection of the public from serious harm. The specified factors are the nature of the offence with which the person is charged; their antecedents and the risk that, as a result of their mental disorder, the person would commit offences if set at large.

6. The restrictions referred to are those contained in part 10 of the 2003 Act. These are not primarily day to day restrictions – it is discharge that is restricted. The Scottish Ministers will be involved in decision-making regarding the person, and will be a party at any Tribunal hearing concerning that person.

Hospital Direction

7. A HD is made by the Court under section 59A of the 1995 Act. Where a person has been convicted on indictment of an imprisonable offence, in addition to a sentence of imprisonment, the Court can send them to hospital to be detained there. As with a CO, the criteria for making the HD are the same as for a CTO, with the exception of impairment of decision-making ability, which is not a criterion. The Court also has to be satisfied as to the availability of a place in a hospital, which is suitable, and that the HD is appropriate. That test requires the Court to have regard to a report by an MHO; all the circumstances including the nature of the offence of which the offender was convicted and the antecedents of the offender; and any alternative means of dealing with the offender.

Transfer for Treatment Direction

8. A TTD is made by the Scottish Ministers under section 136 of the 2003 Act. The effect of a TTD is that, where mental disorder emerges in a person serving a sentence of imprisonment, they may be transferred to hospital in certain circumstances. Those circumstances are, firstly, satisfaction of the same set of criteria regarding the existence of mental disorder, available treatment, risk and necessity as apply in relation to COs and HDs and, secondly, criteria regarding the involvement of an MHO and availability of a place in a suitable hospital. A TTD can also apply to those detained for immigration purposes.[2]

Hearings for patients on COROs

9. There are a number of routes by which a patient on a CO and RO may come to a Tribunal hearing. As with a CTO, the RMO is obliged to keep the CO and RO under regular review, and also to consider the continuing need for the orders on an annual basis. After such a review, if a report sent to Scottish Ministers makes a recommendation, Ministers must refer the case to the Tribunal, and a hearing will take place under section 185 of the 2003 Act. Under section 186, the MWC can require the Scottish Ministers to refer and, under section 187, the Ministers must refer, a patient's situation to the Tribunal. Under section 188, the Ministers themselves must also keep the orders under regular review and, in certain circumstances, must make an application to the Tribunal under section 191. Under section 192, the patient or their named person may also make application to the Tribunal for conditional discharge or for an order revoking the CO and/or RO. Failing a hearing under any of these

[2] See Article 13 of The Mental Health (Care and Treatment) (Scotland) Act 2003 (Consequential Provisions) Order 2005.

provisions, there will be a review hearing under section 189 on a two-yearly basis.

10. Section 193 of the 2003 Act sets out the powers of the Tribunal on a reference or application being made, or a review hearing taking place, in relation to a person on a CO and RO. This is a complex section. In the cases of *Scottish Ministers v Mental Health Tribunal for Scotland*[3] and *Scottish Ministers v Mental Health Tribunal for Scotland*[4] the Inner House gave guidance as to the approach which the Tribunal should follow in applying section 193. In summary, the Court emphasised that the section imposes a series of tests, which must be considered in sequence. Section 193(2) imposes a 'threshold requirement' which must be considered before any other aspect of the section is applied. This subsection is often referred to as 'the serious harm test'. It requires the tribunal to consider whether the patient has a mental disorder and whether it is necessary, in order to protect any other person from serious harm, for the patient to be detained in hospital, whether or not for medical treatment. If that test is met, the tribunal is directed to make no order under the rest of section 193. The Inner House also determined that, in considering whether or not to revoke the RO, the tribunal must ask whether the RO is necessary in order to protect the public from a risk of serious harm. The Court considered that, in answering that test, the tribunal should normally start from an analysis of the reasons why the RO was imposed in the first place. In this analysis, the factors referred to in section 59 of the 1995 Act (the nature of the offence with which the person is charged; their antecedents and the risk that, as a result of their mental disorder, the person would commit offences if set at large) would normally require to be considered.

11. A patient who remains on a CO and an RO may be discharged into the community under section 193(7) of the 2003 Act. This is referred to as 'conditional discharge' and there will be a set of conditions included in the Order. These conditions will be drafted by Scottish Ministers who, for a patient on conditional discharge, retain jurisdiction to vary the conditions, under section 200. The patient has a right to appeal to the Tribunal against such a variation (section 201). Importantly, a patient who is conditionally discharged remains subject to a hospital-based CO and an RO.[5]

12. A patient who has been conditionally discharged from hospital may be recalled to hospital, where Scottish Ministers consider that necessary. Such recall is undertaken using a warrant. A patient thus recalled, or their named person, may appeal to the Tribunal under section 204 of the 2003 Act. On such an appeal, the tribunal will apply the provisions of section 193 afresh.

13 Alternatively to conditional discharge, or for a patient who has already been conditionally discharged, the tribunal may decide to revoke the CO (in which case the RO would fall) or to revoke the RO. If the RO is revoked, the CO becomes a time-limited order and the tribunal may vary the measures contained in it. There are complex provisions for calculating the deemed commencement date of the de-restricted CO. In essence, it will start on the day which is 22 days after the date on which the written decision of the tribunal

[3] 2009 SC 398 (this case is often referred to as 'JK').
[4] 2010 SC 56 (often referred to as 'MM').
[5] I.e. measure (a) isn't varied.

was received by the parties. This is a result of the interaction of sections 196 and 198 of the 2003 Act and the appeal period of 21 days after the decision is intimated. In other words, if the Full Findings and Reasons are received on 1 July, for example, the appeal period is 2 to 22 July inclusive, and the deemed start date of the CO is 23 July.

Hearings for patients on HDs or TTDs

14. These follow a similar structure to hearings for CORO patients. The RMO is obliged to keep the HD or TTD under regular review[6] and also to consider the continuing need for the Direction on an annual basis.[7] After such a review, if a report sent to Scottish Ministers makes a recommendation, then under section 210, Ministers must either revoke the Direction or refer the case to the Tribunal for a hearing to take place. Under section 209, the MWC can require the Scottish Ministers to refer and, under section 211, the Ministers must refer, a patient's situation to the Tribunal. Under section 212, the Ministers themselves must also keep the Direction under regular review and, in certain circumstances, must revoke it. Under section 214, the patient or their named person may also make application to the Tribunal for revocation of the Direction. Failing a hearing under any of these provisions, there will be a review hearing under section 213 on a two-yearly basis.

15. For any hearing held under these provisions, the powers of the tribunal are those set out in section 215 of the 2003 Act.

Additional provisions

16. There are other provisions of the legislation which deal specifically with patients on a CO and RO, or on a HD or TTD. These are sections 218 to 220 of the 2003 Act in relation to transfer of such individuals between hospitals, and rights of appeal against such transfer, and sections 224 to 226 regarding suspension of detention.

17. Finally, on the matter of jurisdiction to determine applications and appeals in relation to patients on a CO and RO, or subject to an HD or TTD, Schedule 2 paragraph 7(4) requires all such hearings apart from those in relation to 'excepted proceedings' to be convened by a sheriff who is on the shrieval panel for the Tribunal. Excepted proceedings are those regarding removal of a named person, or seeking a CTO for someone on an HD or TTD whose sentence of imprisonment is about to end.[8] It follows from these provisions that sheriffs do not have jurisdiction to sit on hearings for patients who are neither on a CO plus RO, nor a Direction (HD or TTD).

[6] Section 208 of the 2003 Act

[7] Section 206 of the 2003 Act

[8] Paragraph 7(4A) of Schedule 2 of the 2003 Act

COMPULSORY TREATMENT ORDERS

1. This chapter focuses on the most common type of order made by the Tribunal, a CTO.

CTO application

2. A CTO application is an application to compel someone to receive care and treatment under the 2003 Act for up to six months. A full CTO application is comprised of the CTO1 form completed by the MHO (the application) plus 2 CTO2 forms. The CTO2s are medical reports completed by two doctors.

Validity of an application[1]

3. Minor failures to comply with statutory requirements of the 2003 Act will not automatically mean that the CTO application etc. is invalid. The Tribunal requires to follow the approach to such failures set out in *R v Soneji*[2] and the mental health appeals which have considered the effect of a failure to comply with a statutory provision, e.g. *JG v MHTS*,[3] *N v Borland & MHTS*[4] and *Paterson v Kent*.[5] There is a sliding scale – some failures will be so serious they will invalidate the application etc., others will not. The question of whether any prejudice has arisen always requires to be considered.

4. It should be remembered that the boxes which require to be shaded in an application for a CTO, for example in relation to measures or in the mental health reports, are boxes in non-statutory forms. The tribunal requires to look at all of the information in the application or mental health report, to discern whether, from that information, it is clear what measures are sought in the CTO application or what measures are specified in the mental health report.

Medical examination

5. The two medical examinations must be carried out by two AMPs or by the patient's GP and an AMP. They should be carried out separately from one another unless the patient or, where they are incapable, their named person, guardian or welfare attorney, has consented to both examinations being carried out at the same time.[6] Where they are carried out separately the second must be completed no more than five days after the first.[7] The application must be submitted no more than 14 days after the date of the last examination.

6. 'Medical examination' is not defined for the purposes of the 2003 Act. The general definition of medical examination is an examination carried out to determine the physical fitness of an individual, for example for a job, life insurance, etc. In some of the definitions there is a suggestion that a medical examination implies a thorough physical examination. This would, of course be appropriate where it was a physical ailment that the patient suffered from. This is not, however, the case in relation to mental disorder where, in an examination, a doctor will not be physically examining the patient's mind. Nevertheless it is important that a detailed interview can be carried out with the patient. The COP provides guidance on medical examinations at paragraphs 17 to 22 of Chapter

[1] See also Chapter 38 (Non-compliance with statutory provisions)
[2] [2006] 1 AC 340
[3] Sheriff Principal Taylor, Glasgow Sheriff Court 14 October 2010
[4] 2011 SLT (Sh Ct) 135
[5] 2007 SLT (Sh Ct) 8
[6] Section 58(6) of the 2003 Act
[7] Section 58(3) of the 2003 Act

three in Volume two. There is also some discussion in the case of *M v Murray* of the operation of the legislation when a patient refuses to engage with a doctor.[8]

7. The mental health reports require to be completed and lodged with the Tribunal at the same time as the application. However, it was held in the case of *N v Borland & MHTS* that a short delay in lodging the mental health reports did not vitiate the application.[9] In that case, the court held that in this situation there was substantial compliance with the requirements of the 2003 Act when the application, the MHO's report and the care plan were lodged with the Tribunal and the mental health reports were lodged later, some 15 hours after the 14-day time limit had expired. No prejudice had been suffered by the patient. The mental health reports were available timeously for the hearing and the patient's solicitor had been able to question the doctors who provided the reports. Parliament would not have intended that a failure to comply with the terms of section 57(7) of the 2003 Act by 15 hours would frustrate the overriding purpose of the legislation when there was no prejudice to the patient.

Different conclusions in the mental health reports

8. In order for the CTO application to proceed the two mental health reports must reach similar conclusions about the patient's condition. In particular they must:

- agree on the category of primary mental disorder as defined in section 328(1) of the 2003 Act so that each report must specify at least one type of mental disorder that is also specified in the other; and
- specify the same compulsory measures that should be authorised by the CTO.[10]

MHO disagrees with mental health reports

9. When two medical examinations are carried out which meet the requirements of section 57(2) to (5) the MHO is required to apply for a CTO even where they do not support or agree with the application. The MHO's views on the mental health reports form part of their application, so this would be made clear in that part of the CTO application. The tribunal considering the application would be expected to weigh all the evidence, including the differing views, before reaching a decision.

Conflict of interest

10. There must be no conflict of interest in relation to the medical examinations.[11] This is dealt with in **Chapter 20**.

Timescales for a hearing

10. Where a patient is subject to a STDC or an extension certificate and the CTO application is submitted during the period of that certificate, that patient may be detained in hospital and treated under Part 16 of the 2003 Act for a further five working days.[12] This five working day extension period begins at the point when the STDC or the extension certificate expires. In terms of section 69, the Tribunal is required to determine before the expiry of that period of five working days whether or not to make an interim CTO. Where an application for a CTO is for a patient not currently detained these timescales do not apply.

[8] Sheriff Principal Lockhart, Ayr Sheriff Court, 17 April 2009, at para 25
[9] 2011 SLT (Sh Ct) 135
[10] Section 57 of the 2003 Act; These are the compulsory measures listed at section 66(1) of the 2003 Act
[11] The Mental Health (Conflict of Interest)(Scotland) Regulations 2017 (SSI 2017/174).
[12] Section 68 of the 2003 Act

Proposed change of measures

11. There are circumstances where during the proceedings a MHO proposes a change of measures to those set out in the application made under section 63 of the 2003 Act after notification of the date of the hearing has been made. This can include on the day of the hearing. Most often this will relate to a change from hospital based measures to community based measures. On occasion, the tribunal may decide that different measures from those set out in the application are appropriate, based on the evidence available. In these circumstances the provisions in section 64(7) must be followed and notice must be given to the persons mentioned in section 64(3).

12. The persons referred to in section 64(3) are:

- the patient
- the patient's named person
- any guardian of the patient
- any welfare attorney of the patient
- the MHO
- the medical practitioners who submitted the mental health reports which accompany the application
- the RMO
- the primary carer of the patient
- any curator *ad litem* appointed in respect of the patient
- any other person appearing to the tribunal to have an interest in the application.

13. Those individuals then need to be afforded an opportunity to make representations in relation to the proposal, and of leading or producing evidence. It should be noted that section 64(8) provides that, where the duty to notify the proposal to grant measures other than those specified in the application arises during the hearing of the application, notice need not be given to any person who is present at the hearing. See 'In practice' below for further information.

Granting a CTO when a person is subject to a HD or TTD

14. There are occasions when a patient is transferred from prison to hospital during their sentence under a HD or a TTD. Section 217 provides that, where a patient is released under Part I of the Prisoners and Criminal Proceedings (Scotland) Act 1993 or otherwise, the direction to which the patient is subject shall cease to have effect. So the direction cannot authorise their detention beyond the date when they are due to be released. However it may be thought that they will need continuing care and treatment after their sentence ends. In these circumstances Schedule 3 to the 2003 Act creates a process for making a CTO for a patient subject to a HD or TTD.

15. The CTO will only come into force if the direction concerned ceases to have effect within 28 days of the CTO being made.[13] In other words, it is only during a 'window period' towards the end of the sentence that the CTO can be made. If the earliest date for liberation is 28 March, that means that P is released (notionally) with effect from

[13] see paragraph 2(1)(a) of Schedule 3 to the 2003 Act

midnight at the end of 27 March, and the date on which the direction ceases to have effect is 28 March. The first day on which a CTO can be made is therefore 1 March, and the last day is 27 March. If a CTO is granted, the FFR should make clear when the CTO actually takes effect.

16. The CTO application is subject to all the usual requirements regarding evidence and criteria, though the necessity criterion is that a CTO *immediately after the … direction … ceases to have effect* is necessary.[14] The CTO will authorise the measures specified in it for six months.

17. Where the patient is subject to a HD or a TTD and an application is made for a CTO, it is not competent for the Tribunal to grant an interim CTO.[15]

Extending and varying CTOs

- **First mandatory review**

18. In terms of section 77, the RMO has a duty during the course of the CTO to carry out a first review. This involves having the patient medically examined. The RMO requires to consider whether the conditions in paragraphs (a) to (d) of section 64(5) continue to apply and whether it continues to be necessary for the patient to be compulsorily treated. The RMO requires to consult with various persons including the MHO. This review must be carried out in the two month period prior to the CTO ceasing to have effect.

- **Further mandatory reviews**

19. Section 78 deals with further mandatory reviews after the first review. The procedures are broadly the same as section 77, and again the review requires to be carried out within the two months prior to the order ceasing to have effect.

- **Further steps**

20. The duties imposed on the RMO subsequent to a review undertaken under section 77 or 78 are set out in section 79 (to revoke order), 86 (to extend order) and 90 (to extend and vary).

21. Sections 83, 84 and 85 detail the steps to be taken by the RMO, and the duties incumbent upon the RMO, where an order is to be extended.

22. Section 84 comes into play where the RMO decides that an order should be extended but not varied. In such a case, s/he must give notice to the MHO that s/he intends to make a determination extending the order under section 86.

23. Section 85 imposes duties on the MHO after receipt of notice from the RMO that the RMO intends extending but not varying the order.

- **Section 86 determination:**

24. All of this leads us to section 86, which is the actual determination by the RMO to extend but not vary an order. Section 86 provides that, once the RMO is satisfied as to the matters in section 84(2), the RMO shall make a determination extending the CTO. Section 86(2)(a) provides that the six month extension period begins on the day when the CTO "will cease". It is clear that the decision to extend must be made prior to the date when the order will cease.

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[14] Paragraph 2(2) of Schedule 3 of the 2003 Act

[15] Paragraph 3 of Schedule 3 of the 2003 Act

- **After section 86 determination**

25. Section 87 imposes duties on the RMO following upon a determination under section 86. The duty is to do certain things as soon as practicable after the determination is made and, in any event, before the day on which the CTO will cease, if it is not extended by the determination, to authorise the measures specified in it.

26. These duties include to submit the record to the Tribunal and intimate to various parties. Intimation should be made before the date when the order was due to cease. There is an argument however that the wording could be interpreted to include any date after the order was due to cease, if by reason of the determination, the actual order is itself extended. The wording is before the day on which the CTO will cease, if it is not extended by the determination.

- **Section 88**

27. This section imposes duties on the RMO where it becomes apparent that the CTO is to be extended and varied.

- **Section 90**

28. This applies where the RMO wishing to extend and vary an order has carried out a first or further mandatory review, and has complied with the terms of section 88. Where the RMO is satisfied that the order should be extended and varied, section 90 provides that they must make an application to the Tribunal under section 92 for an order extending and varying as soon as practicable after the duty to make it arises. You cannot apply to extend or vary an order which is no longer extant, and therefore the application must be made before the order ceases to have effect.

Varying CTOs

29. Separately from the duties that arise in the period leading up to the expiry of a CTO, the RMO is also obliged to keep the CTO under continuous review.[16] If such review leads to the conclusion that the measures in the CTO should be varied, the RMO is obliged to make an application to the Tribunal for variation of the CTO as soon as practicable.[17]

Reviewing CTOs

30. There are also circumstances in which the Tribunal, on being notified that a RMO has extended a CTO, is obliged to arrange a hearing to review the order. These are detailed in section 101. In summary, they are:

- If there is now a difference between the type of mental disorder the patient has and the type that was specified previously in the CTO;
- If the MHO disagrees with the determination to extend, or has failed to intimate that they agree with the proposed determination;
- That a period of two years has passed without a determination by the Tribunal of an application under section 92, 95, 99 or 100, or a review required because of the existence of one of the two circumstances described above.

31. At such a review hearing, the Tribunal may revoke the determination to extend, revoke the determination and the CTO, confirm the determination or confirm the

[16] Section 93 of the 2003 Act
[17] Sections 93(6) and 95 of the 2003 Act

determination and vary the CTO. Varying the CTO includes modifying any recorded matter which means a recorded matter can be added, removed or amended.[18]

Revoking CTOs

32. If, when carrying out a mandatory review of the CTO, the RMO is not satisfied that the conditions for the CTO continue to exist the RMO has a duty to revoke the CTO as soon as practicable.[19] The RMO must consider the views of the persons consulted under section 77(3)(c) when reaching their decision on this.

33. The RMO also requires to keep the CTO under general review and from time to time consider if the criteria for it continue to be met. If the RMO reaches the view that the criteria are not met the RMO must revoke the CTO as soon as practicable.[20]

In practice

34. In relation to proposed change of measures during the initial application for a CTO, it is rarely the case that the two medical practitioners who submitted the mental health reports which accompany the application will be present at the hearing. If one of these medical practitioners is the only person requiring notice who is not present at the hearing, then the tribunal should try and phone them and ascertain whether or not they wish to make any representations or lead or produce evidence or whether they consent to the change to the measures specified in the application.

35. It may be that the MHO or RMO has been able to intimate this to the second medical practitioner in advance. If the tribunal cannot reach the second medical practitioner but receives evidence that s/he has been given notice of the proposed change to the measures, then while the duty is on the tribunal to notify, it is unlikely that a court would find that there was any prejudice to anyone involved in the proceedings or the second medical practitioner if the tribunal accepted that as, in effect, providing notice. The purpose behind notification would have been achieved by this means.

36. If the named person (or someone else) has not been notified by the tribunal of the change in the measures, then the tribunal should adjourn to allow notice to be given to the named person (i) stating what it is proposing to do and (ii) setting out what the measures proposed are (see section 64(7)(a)); to allow the named person to make representations to the tribunal. In time sensitive cases, it might be possible to do this by telephone. In the 2003 Act 'notice' is defined as meaning notice in writing (see section 329), but it is unlikely that a court would hold that the fact notice was not given in writing would invalidate any CTO subsequently made if a named person was reached by phone, as the purpose of the statutory provision would have been achieved.

37. Where it is not possible to know the position of those persons listed at section 64(3), the provisions of section 64(7) will apply and notification will have to be made by the Tribunal Administration. Style intimation letters are available to be used for this purpose. Where a hearing has been adjourned to consider a proposed change of measures, the tribunal should make a direction clearly specifying the persons to be notified in terms of section 64(3).

[18] Sections 102 and 111 of the 2003 Act
[19] Section 79 of the 2003 Act
[20] Section 80 of the 2003 Act

CONFLICT OF INTEREST

1. Conflict of interest can arise within the process for preparing and making an application to the Tribunal. It can also arise from a connection between a tribunal member and a person or an issue in the application. Both situations are considered below.

2. Since the Tribunal began its work in 2005, the issue of when there is and is not a conflict of interest in relation to a certificate or application has been dealt with in regulations. Initially, the regulations were derived from specific provisions relating to STDCs, extension certificates and CTO applications. These provisions were made within the relevant sections of the 2003 Act. As a result of amendments made by the 2015 Act, these individual subsections have been replaced by section 291A, which provides:

> "(1) There must not be a conflict of interest in relation to a medical examination to be carried out for the purpose of section 36(1), 44(1), 47(1), 57(2), 77(2), 78(2), 139(2), 140(2) or 182(2) of this Act.
>
> (2) Regulations may—
>
> (a) specify circumstances in which, in the application of subsection (1) above—
> (i) there is to be taken to be a conflict of interest,
> (ii) there is not to be taken to be a conflict of interest,
>
> (b) specify circumstances in which subsection (1) above does not apply."

3. The regulations made under section 291A are the Mental Health (Conflict of Interest) (Scotland) Regulations 2017 (SSI 2017 no 174), ('the 2017 Regulations'). They came into force on 30 June 2017. They provide for the circumstances where there is, or is not, to be taken to be a conflict of interest in relation to certain categories of medical examination carried out under the 2003 Act and also where such a conflict of interest is permitted in relation to certain medical examinations which are required to be carried out under the 2003 Act.

Short term detention certificates

4. The provision made in relation to medical examination for the purposes of a short term detention or extension certificate is that conflict of interest exists if the medical practitioner is related to the patient in any degree specified in the schedule to the regulations (see paragraph 7 below), or is employed by or contracted to provide services in or to an independent health care service in which the patient will be detained if detention is authorised under either section 44(1) or 47(1). [1] These provisions do not apply, however if, in the opinion of the medical practitioner, a delay in carrying out the medical examination for the purpose concerned would give rise to a serious risk to the health, safety or welfare of the patient or to the safety of other persons.[2]

[1] Regulation 2 of the 2017 Regulations
[2] Regulation 3 of the 2017 Regulations

CTO applications

5. For a medical examination for the purposes of a CTO application, the same provision is made regarding conflict of interest arising where there is a family relationship between doctor and patient of the nature specified in the schedule.[3] Likewise, the medical practitioners must not be related to each other in any of these degrees. [4] There is also a conflict if it is proposed that the detention of the patient should take place in an independent health care service and both medical practitioners are employed by or contracted to provide services in or to that independent health care service.[5] Finally, if it is proposed that the CTO should authorise detention in a hospital, H, other than an independent health care service, there is a similar provision regarding the working arrangements of the medical practitioners providing the reports. If both doctors are employed by or contracted to provide services in or to the hospital H, the 2017 Regulations state that there will be a conflict of interest unless one of them is a consultant and the other does not work directly with or under the supervision of that consultant.[6] For the purposes of a hospital which is not an independent health care service, additional provision is made regarding interpretation: 'a medical practitioner shall be regarded as being employed by or contracted to provide services in or to a hospital only if they work wholly or mainly in that hospital'.[7]

Reviews of CTO or compulsion order

6. Insofar as reviews of a CTO or of a compulsion order are concerned, the same provision about family relationships between doctor and patient which generate conflict of interest is made.[8] For working arrangements, if the responsible medical officer or, as the case may be, the approved medical practitioner is employed by or contracted to provide services in or to an independent health care service in which the patient will be detained, there is a conflict of interest unless the specified exemption exists.[9] The exemption is that, in addition to the medical examination carried out for the purposes of the review, the patient has been examined during the review period by an approved medical practitioner who is not employed by or contracted to the independent health care service.

7. For the purposes of all the provisions outlined above, the list of family relationships is as follows: child; grandchild; parent; grandparent; spouse; civil partner; child, grandchild, parent, grandparent, sister or brother of a civil partner; sister; brother; daughter-in-law; son-in-law; brother-in-law; cohabitee; child, grandchild, parent, grandparent, sister or brother of a cohabitee. Relationships of the half-blood are treated as relationships of full blood and a stepchild of a person is regarded as their child.[10]

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[3] Regulation 4(1)(a) of the 2017 Regulations
[4] Regulation 4(1)(b) of the 2017 Regulations
[5] Regulation 4(1)(c) of the 2017 Regulations
[6] Regulation 4(1)(d) and 4(3) of the 2017 Regulations. It is the view of the Tribunal, based on comparison of this provision with previous formulations and study of the process leading to the current formula that the stipulation requiring the involvement of a consultant resulted from a drafting error. In an appropriate case, this may give rise to an argument regarding the effect of apparent non-compliance, along the lines set out in *Paterson v Kent* 2007 SLT (Sh Ct) 12.
[7] Regulation 4(2) of the 2017 Regulations
[8] Regulation 5(1)(a) of the 2017 Regulations
[9] Regulation 5(1)(b) of the 2017 Regulations
[10] Schedule to the 2017 Regulations

8. The provisions outlined above are in the form of rules. It may be suggested that conflict of interest could arise in circumstances not provided for in the rules. A mental health officer may have a family or work colleague relationship with a patient which makes it inappropriate for them to be involved in an application under the legislation. This is addressed in more detail in the Code of Practice on the 2003 Act.[11] In addition, a practitioner may be subject to professional requirements governing conflict of interest in particular scenarios other than those set out above. There may be connections between a doctor and patient which do not stem from either a family or working relationship. But common to the decisions addressed by the conflict of interest regulations for the Mental Health Tribunal is that an interest recognised by law – here, the right to liberty, or another right in relation to private life – is being affected by a decision taken by another person in the exercise of a duty or power. In such situations, proper process dictates that the decision maker be free from an interest of their own which could lead to their being 'a judge in their own cause'. That no one should be a judge in their own cause ('*nemo iudex in sua causa'*) is at the heart of these protective provisions. If no interest recognised by law is affected by the decision taken, the rules and practices regarding conflict will not apply.

Conflict of interest for a Tribunal member

9. For the same reasons of principle as apply to potential conflicts arising in the course of an application, members of the Tribunal need to be attentive to connections which they may have with a person or an issue arising in a case. Anyone whose case is being considered is entitled to a hearing before an independent and impartial tribunal. This right to a fair hearing exists at common law, and is protected by Article 6 of the European Convention on Human Rights, as well as by specific rights to fair process inherent in Article 5, which articulates the right to liberty and security of the person. As well as freedom from actual bias or conflict of interest, the hearing must possess the quality of being seen to be so.

10. Before considering the issue of conflict in general, it is necessary to refer to the specific rules which bar participation in a hearing when a member's connection is of a particular type. By rule 42 of the 2005 Rules, a member cannot sit on a hearing if he or she:

> "(a) is employed by or contracted to provide services in or to the hospital or independent health care service in which the patient is or may be detained;
> (b) is directly involved in providing medical treatment, community care services, relevant services or any other treatment, care or service to that patient; or
> (c) has a personal or professional connection with the patient."

11. The final paragraph of the rule is likely to give rise to some difficulty in determining what constitutes a personal or professional connection. It is worth noting that the present tense is used. That would suggest that current friendship or acquaintance would bar a member from sitting, as would being connected to the patient by a relationship of professional service (in either

[11] Code of Practice, Volume 2, Chapter 3, paragraph 16

direction, for example if the patient is the member's accountant or the member is the patient's solicitor, even for an unconnected matter).

12. The fact that a relationship has existed previously but no longer does is not, however, necessarily indicative that no issue of conflict arises. Factors which will be relevant in considering whether a past relationship should lead to recusal will be the length of time which has elapsed since the relationship was current, the closeness of the connection and whether there were any particular issues which arose between the two parties at the time. The member will need to assess whether the particular circumstances could create an appearance of bias. In this, as in any other aspect of conflict of interest, the decision is for the member, albeit after such discussion with another member or with the PO as may be considered helpful.

13. For judges and tribunal members in Scotland, the issue of conflict of interest is further explored in the Guidance to Judicial Office Holders on Judicial Ethics in Scotland, available on the website of the Judiciary of Scotland. Particular issues relating to conflict of interest are discussed at paragraphs 5.1 to 5.10. What follows is a distillation of the main points in that section of the guidance.

14. A member of a tribunal cannot adjudicate on a matter in which they or a member of their family have a monetary or personal interest. Where there exists some reason other than financial interest why a member should not handle a case, the member should recuse him or herself. A meaningful connection with a person who is a party, or a significant witness, may be such a reason for recusal (as provided for in rule 42 above for current relationships). Moreover, since the appearance of bias must also be avoided, perception of how the connection would appear must be taken into account. The test here would be whether the well-informed and fair-minded observer would consider that there was a real possibility of bias.[12] Personal friendship with, or personal animosity towards, a person involved in the hearing may be a reason for recusal. A current or recent business association with a person involved would also normally mean that a member should not sit.

15. Issues may arise in relation to a member having sat in a previous case relating to the same patient. A previous finding against a party would not usually provide, of itself, a ground for disqualification from a judicial role. The possibility that a member's comments in an earlier case might be perceived as personal animosity cannot, however, be excluded. As a matter of practice, Tribunal Administration attempts to avoid scheduling members who have sat recently on a different case involving the same patient. In the specific context of hearings under mental health legislation, and despite general principles referring to the need for objective analysis, the appearance of matters may require to be handled with particular sensitivity in order to avoid the perception of unfairness.

16. The issue of timing is also important. If a member realises before a hearing that they have an interest which they consider may disqualify them from sitting, it is better to advise Tribunal Administration as soon as possible in order that another member may be substituted. If the issue is not noticed until the

[12] *Porter v Magill* [2002] 1 AC 357

day of the hearing, or emerges during proceedings, and is not a clear instance of disqualifying interest, the best course is to advise parties and offer them the chance to consent to continued participation of that member, or not. The member should, however, avoid putting someone in a position in which it might appear that their consent is sought to cure a substantial ground for recusal. Even where the parties consent to the member sitting, if the member, on balance, considers that recusal is the proper course, the member should so act. It may be necessary for them to participate in a decision to preserve the status quo, such as the grant of an interim order, so that the case can be continued to be heard before a differently constituted tribunal. The recusal should also be notified to the Judicial Office, using the form available on the judicial members' area of the MHTS website.

17. In conclusion, the following remarks on conflict of interest from the decision of the Court of Appeal in *Locabail (U.K.) Ltd. and Another v Waldorf Investment Corporation and Others* [2000] QB 451, at paragraph 25, offer a summary of principles which may be helpful.

> *We cannot, however, conceive of circumstances in which an objection could be soundly based on the religion, ethnic or national origin, gender, age, class, means or sexual orientation of the judge. Nor, at any rate ordinarily, could an objection be soundly based on the judge's social or educational or service or employment background or history, nor that of any member of the judge's family; or previous political associations; or membership of social or sporting or charitable bodies; or Masonic associations; or previous judicial decisions; or extra-curricular utterances (whether in textbooks, lectures, speeches, articles, interviews, reports or responses to consultation papers); or previous receipt of instructions to act for or against any party, solicitor or advocate engaged in a case before him; or membership of the same Inn, circuit, local Law Society or chambers…. But if in any case there is real ground for doubt, that doubt should be resolved in favour of recusal. We repeat: every application must be decided on the facts and circumstances of the individual case. The greater the passage of time between the event relied on as showing a danger of bias and the case in which the objection is raised, the weaker (other things being equal) the objection will be.*

CONJOINING OF CASES

This chapter explores what it means to conjoin cases and the types of cases which are suitable for conjoining.

Meaning of conjoining cases

1. Rule 52(5) of the 2005 Rules provides that where there are two or more sets of proceedings pending before the Tribunal which relate to the patient, the Tribunal may, on the request of a relevant person or on its own initiative hear and determine the proceedings concurrently and give any directions necessary to enable it to do so. Conjoining cases would mean that only one hearing would take place to consider both cases. Evidence in relation to both matters would be heard concurrently. Thereafter two separate decisions would be made and written by the tribunal. There are clear benefits to cases being conjoined and being heard concurrently at one tribunal.

Types of cases for conjoining

2. All types of cases, including civil cases and restricted patient cases, can in practice be conjoined. This includes proceedings relating to an application for an order that the patient is being detained in conditions of excessive security. For example, if a patient made an application on excessive security and the CTO to which they were subject to fell to be reviewed in terms of section 101 of the 2003 Act these could be conjoined. This would result in the two cases being heard concurrently at one Tribunal hearing.

Suspending the whole or part of any proceedings

3. Rule 52(6) of the 2005 Rules provides the power for the whole of part of any proceedings to be suspended. This rule could be used to suspend proceedings to allow for a decision to be made on another related case. For example, if a two-year review had been arranged and a section 95 application was received before the renewal day of the CTO it would have to be heard on its own with the two-year review suspended until the section 95 application was decided.

Separating conjoined cases

4. There may be circumstances where it is no longer appropriate for cases to continue to be conjoined. For example, where this would result in delay in determining one of the cases which is time sensitive.

In practice

The decision to conjoin cases will usually be made by an IHC following an indication from Tribunal Administration that there is more than one ongoing application or appeal in respect of a patient.

CROSS BORDER TRANSFERS

1. Sections 289 and 290 of the 2003 Act deal with cross border transfers of patients. Detailed provision is made by the Mental Health (Cross border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005 ('the 2005 Regulations') and the Mental Health (England and Wales Cross border transfer: patients subject to requirements other than detention) (Scotland) Regulations 2008 ('the 2008 Regulations'). [1] [2] Both sets of regulations have been amended; the 2005 regulations by the Mental Health (Cross-border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Amendment Regulations 2017 and the 2008 regulations by the Mental Health (Cross-border transfer: patients subject to requirements other than detention)(Scotland) Regulations 2017. [3] [4] The Scottish provisions interact with other cross-border legislation for transfers.[5]

2. The cross border transfer provisions discussed in this chapter include:

- Patients subject to a community-based CTO or Compulsion Order CO transferring out of Scotland;
- Patients subject to a detention requirement or otherwise in hospital transferring out of Scotland; and
- Patients coming into Scotland from elsewhere in the UK, Isle of Man, Channel Islands or the EU.

Transfer out of Scotland: Patients on a Community Order (section 289 of the 2003 Act)

3. Section 289 of the 2003 Act makes provision for the transfer of a patient subject to a CTO or CO which does not authorise detention in hospital. Such transfer requires that the patient has notified their RMO of their wish to be moved from Scotland or, where they lack capacity, the named person has notified the RMO that they consider such transfer to be in the patient's best interests.[6] The 2008 Regulations govern this situation, insofar as concerns transfer to England or Wales.

4. The RMO shall consider when deciding whether to authorise the removal of a patient from Scotland under the 2008 regulations, the following factors:

- the best interests of the patient;
- that the responsible clinician and responsible hospital in England or Wales are aware of any recorded matters specified in the patient's order;
- the risk to the safety of any person; and

[1] The Mental Health (Cross border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005 SSI 2005/467
[2] The Mental Health (England and Wales Cross-border transfer: patients subject to requirements other than detention) (Scotland) Regulations 2008 SSI 2008/356
[3] The Mental Health (Cross-border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Amendment Regulations 2017 SSI 2017/229
[4] The Mental Health (Cross-border transfer: patients subject to requirements other than detention) (Scotland) Regulations 2017 SSI 2017/232
[5] Between Scotland and England or Wales in sections 80 – 80D of the Mental Health Act 1983 and from Scotland to and from Northern Ireland in the Mental Health (Care and Treatment) (Scotland) Act 2003 (Consequential Provisions) Order 2005 (SSI 2005/2078).
[6] Section 289(2)(b) of the 2003 Act

- any views expressed by the MHO,[7]

and in any event may only give authority for removal of the patient if satisfied that there are in existence in England or Wales arrangements which will secure for the patient measures, treatment, care or services corresponding or similar to those to which the patient is subject or is receiving.[8]

5. As soon as practicable after making a decision on whether or not to authorise the removal of a patient from Scotland, the RMO has to give notice of that decision to a number of people, including the patient, the named person, the primary carer, the MWC, the MHO and any welfare guardian or welfare attorney.[9] Where the RMO decides under regulation 5 of the 2008 Regulations that a patient should be removed from Scotland, and consent is provided by the relevant authorities in England and Wales, the RMO shall issue a warrant for removal and specify an effective date for removal which shall authorise the patient's removal from Scotland. The RMO shall immediately send a copy of the warrant to the patient, the named person, any guardian, any welfare attorney, the MWC, the managers of the hospital specified in the patient's order, the MHO, the responsible hospital in England or Wales and, if applicable, the responsible clinician in England or Wales.[10]

Appeal against refusal to transfer out of Scotland

6. Where the RMO decides not to allow the removal from Scotland and gives notice under regulation 6 of the 2008 Regulations that a patient is not to be removed from Scotland, the patient or the named person may, during the period of 14 days beginning with the day on which notice is received, appeal to the Tribunal under regulation 8 of the 2008 Regulations, against the decision of the RMO not to authorise the proposed removal.

7. Upon receipt of an application under regulation 8, the tribunal may make or refuse to make a direction to the RMO to issue a warrant authorising the removal.

8. In considering any appeal, the tribunal is required to have regard to the same factors as outlined in paragraph 4 above.[11]

9. The tribunal would also have to have regard, in making its decision, to the section 1 principles, any advance statement and, if relevant, the welfare of the child principle as stated in section 2 of the 2003 Act.

Transfer out of Scotland: Patients subject to detention or otherwise in hospital (section 290 of the 2003 Act)

10. Section 290 of the 2003 Act makes provision for the transfer of a patient detained or otherwise in hospital. This includes patients subject to an EDC, STDC, CTO, Interim Compulsory Treatment Order (ICTO), CO, CORO, HD, and TTD, even where detention has been suspended or where a patient has been conditionally discharged by the tribunal. The 2005 Regulations make detailed provision for such transfers.

11. Prior to the transfer of a patient out of Scotland the RMO must apply to the Scottish Ministers for a warrant.[12] The RMO has to take certain steps before seeking the warrant. If the RMO considers that it may be appropriate to apply for a warrant for cross-border

[7] Regulation 5 of the 2008 Regulations
[8] Section 289(2)(c), and regulation 5(2) of the 2008 Regulations
[9] Regulation 6 of the 2008 Regulations
[10] Regulation 7 of the 2008 Regulations
[11] Regulation 8(2) of the 2008 Regulations
[12] See process set out in Part II of the 2005 Regulations

transfer out of Scotland, they must consult with the MHO and anyone else they consider appropriate.

12. If, after having regard to any views, the RMO continues to consider that the patient should be transferred, they must give notice that an application for a warrant is to be made. The RMO is required to notify the MHO, the patient and others in writing that the RMO is proposing to apply for a warrant for removal, and that they have the right to make representations on this to the RMO and to the Scottish Ministers within 7 days. In addition to the patient and the MHO, the RMO must notify: the patient's named person (if they have one); any welfare attorney or welfare guardian; their primary carer (if there is no named person); and their nearest relative (if no named person and if known).[13]

13. Once the MHO receives notice from the RMO of the proposed application for a warrant, the MHO has to comply with certain duties within 7 days. These duties include interviewing the patient and informing the patient of their rights in relation to the application and also informing the RMO if they agree with the proposed application, stating reasons if they do not.[14]

14. If, after considering any representations received and the views of the MHO, the RMO is satisfied that the warrant for removal should be applied for, the RMO will make the application to the Scottish Ministers under regulation 7 of the 2005 Regulations.

15. Regulation 8 of the 2005 Regulations provides that, in reaching their decision on the RMO's application, the Scottish Ministers shall consider:

- the information provided by the RMO in the application;
- any wishes or preferences expressed by anyone who received notice of the application from the RMO;
- the best interests of the patient;
- the existence of arrangements in the proposed place of removal which will secure for the patient measures, treatment, care or services corresponding or similar to those which the patient currently receives; or treatment for mental disorder corresponding or similar to that which the patient is receiving in hospital;
- any wish or preference about the removal of which the patient has given notice to the Scottish Ministers; and
- any risk to the safety of any person.

16. For patients subject to detention or otherwise in hospital, where Scottish Ministers decide under regulation 8 that a patient be removed from Scotland, they shall immediately give notice of that decision to the patient, the named person, any welfare attorney or welfare guardian, the primary carer (if there is no named person), the nearest relative (if no named person and if known), the RMO, the MHO, the MWC and the country or territory to which is proposed that the patient shall be removed.[15] Notice to the patient and named person must include information as to the patient's rights of appeal under regulation 13.

17. The Scottish Ministers also have a duty to immediately send a copy of the warrant to the patient, the named person, any welfare attorney or welfare guardian, the primary

[13] Regulation 5 of the 2005 Regulations
[14] Regulation 6 of the 2005 Regulations
[15] Regulation 9 of the 2005 Regulations

carer (if there is no named person), the nearest relative (if no named person and if known), the RMO, the MHO, the MWC and the country or territory to which is proposed that the patient shall be removed.[16]

18. There is no right of appeal once a removal has taken place.[17]

Appeal against transfer out of Scotland

19. The 2005 Regulations set out the appeal provisions. Following a decision under regulation 8 of the 2005 Regulations that a patient be removed from Scotland, the patient, their named person or a person meeting the listed initiator requirements (i.e. welfare guardian, welfare attorney, primary carer or patient's nearest relative, where certain conditions are met) may appeal to the Tribunal against the proposed removal.[18] The Regulations make provision for a 'standstill period', which is a period during which transfer in implementation of the warrant may not take place. Generally speaking, for a transfer within the UK, the standstill period is (initially) seven days after the issue of the warrant.[19] This period will allow time for the patient to appeal or the MWC to make a reference to the Tribunal. If transfer is to a place outwith the UK, the period is 28 days.[20] These periods will be halted if an appeal or a reference by the MWC is made.[21] In either eventuality, the Regulations set out how the end of the standstill period will be calculated (essentially linked to the final determination of the appeal or reference).[22]

20. On appeal under regulation 13 the tribunal may make or refuse to make an order that the proposed removal shall not take place.[23]

21. In considering any appeal, the tribunal would normally have regard to the factors set out in regulation 8 of the 2005 Regulations as set out in paragraph 15 above.

22. The tribunal would also have regard, in making its decision, to the section 1 principles, any advance statement and, if relevant, the welfare of the child principle as stated in section 2 of the Act.

23. Cases involving cross-border transfers may engage rights under the ECHR.[24]

Effect of transfer on orders made in Scotland

24. Patients transferred from Scotland automatically become subject to the nearest equivalent measure in the country to which they are transferred if cross-border legislation exists that makes such provision. This is the case for transfers of patients subject to detention from Scotland to England, Wales or Northern Ireland. Where a patient is transferred from Scotland, the 2005 Regulations apply.[25] In this particular case, regulation 23 provides for the cessation of Scottish measures as follows:

> *Where a patient whose detention in hospital is authorised by virtue of the 2003 Act or the 1995 Act is removed from Scotland in pursuance of arrangements under this Part of these Regulations the measure which authorised the patient's detention in*

[16] Regulation 10(5) of the 2005 Regulations
[17] Regulation 17 of the 2005 Regulations
[18] Regulation 13 and 13A of the 2005 Regulations
[19] Regulation 10C(3) of the 2005 Regulations. The period can be shorter in an urgent case, with the agreement of the MWC.
[20] Regulation 10C(4) of the 2005 Regulations, also with provision for a shorter period in an urgent case, with the agreement of the MWC.
[21] Regulation 10C(1) of the 2005 Regulations
[22] Regulations 10D and 10E respectively
[23] Regulation 13 of the 2005 Regulations
[24] *Bensaid v UK* [2001] ECHR 82 and *R(on the application of X) v Secretary of State for Home Department* [2000] EWCA Civ 48 (7 December 2000)
[25] SSI 2005/467

hospital in Scotland shall cease to have effect when the patient becomes subject to relevant measures in the country or territory to which the patient is removed.

25. Therefore when a patient is removed from Scotland to England or Wales the patient becomes subject to the relevant measures in England or Wales. Further, the order to which the patient is deemed to be subject is treated as being made on the day the patient is admitted to hospital in England or Wales.[26]

Transfer to Scotland

26. Part 3 of the 2005 Regulations deals with the reception of patients from other parts of the UK, Isle of Man, Channel Islands or a member state of the European Union into Scotland, if they were transferred when subject to detention or otherwise in hospital.[27] Part 3 of the 2008 Regulations deals with the reception of patients from other parts of the UK, Isle of Man, Channel Islands or a member state of the European Union into Scotland, if they were transferred when subject to measures corresponding to the community-based measures set out in section 66(1) of the 2003 Act or section 57A(8) of the 1995 Act.[28]

27. Patients transferred into Scotland will be subject to the nearest equivalent Scottish measure to that which they were subject to in the country from which they were transferred once they are received in Scotland.[29] The start date of that order will be the date the measure they were subject to immediately before their transfer had effect.[30]

28. The RMO requires to assess the patient within seven days post-transfer and consider whether the grounds for ongoing detention under the relevant order are met.[31] If not, they should revoke the detention. A TX5 form should be completed. This should be sent to the Tribunal as well as other relevant stakeholders.[32]

In practice

29. In terms of Regulation 13(1) of the 2005 Regulations an appeal can only be made after the Scottish Ministers have made their decision under regulation 8.

30. The MWC has a right to make a reference to the tribunal in relation to a cross border transfer.[33]

31. The parties in an appeal against a cross border transfer are:

- patient
- named person
- The Scottish Ministers
- Any Curator *ad litem*
- Any person designated a party under rule 48

32. The following documents should be included within the papers for an appeal against a cross border transfer out of Scotland:

- The appeal

[26] section 80B(2) of the Mental Health Act 1983
[27] As provided for in section 290(8)(a) and (b) of the 2003 Act.
[28] As provided for in section 289(4) of the 2003 Act
[29] Regulation 30 of the 2005 Regulations; Regulation 19 of the 2008 Regulations
[30] Regulation 30(5) of the 2005 Regulations; Regulation 19(2) of the 2008 Regulations
[31] Regulation 36 of the 2005 Regulations; Regulation 25 of the 2008 Regulations
[32] Regulation 41 of the 2005 Regulations; Regulation 28 of the 2008 Regulations
[33] Regulation 17 of the 2005 Regulations

- The last tribunal decision(s) (FFR) and order(s)
- A copy of the notice given by the Scottish Ministers that the patient be removed from Scotland (which the patient should provide)
- A copy of the warrant for removal issued by the Scottish Ministers, if issued (which the patient should provide)
- Any response, other reports or documents submitted by a party to the appeal
- Any additional interlocutors from a tribunal in connection with the appeal
- Any advance statement of the patient

33. The provisions of section 320 of the 2003 Act apply to decisions in appeals against cross border transfers. Where an appeal in respect of a proposed removal is made to the Sheriff Principal under section 320, the effect of any warrant issued by the Scottish Ministers shall be suspended and the removal shall not take place pending the determination of the appeal.

CURATOR AD LITEM

Role of a curator *ad litem* in Tribunal proceedings

1. In Scots law, a curator *ad litem* is a legal representative who is appointed by a court to represent, during legal proceedings, the best interests of a person who lacks capacity to instruct a solicitor.

2. The difference between a curator *ad litem* and an ordinary legal representative is that the curator does not have to follow the client's instructions, but must independently act in their best interests. Curators *ad litem* in tribunal proceedings are solicitors.

Power to appoint a curator

3. Rule 55 of the 2005 Rules sets out the circumstances when a curator *ad litem* may be appointed by the Tribunal or a Convener.

4. Those circumstances are set out in rule 55(2):

- the patient does not have the capacity to instruct a solicitor to represent the patient's interests in proceedings before the Tribunal;
- (aa) an application or appeal has been initiated by virtue of a provision giving a listed initiator authority to act;
- where the Tribunal or a convener has made a decision not to disclose a document or report or part of it to the patient under rule 47, and the patient does not have a representative to represent their interests; or
- the patient has been excluded from any hearing or part of it under rule 68 or 69 and the patient does not have a representative to represent their interests.

5. Rule 55(5) states that the Tribunal shall provide all necessary information to a curator *ad litem* appointed to enable the curator *ad litem* to represent the patient's interests in proceedings before the Tribunal.

6. For a curator *ad litem* to be appointed under rule 55(2)(a) and (aa), the patient must not have capacity to instruct a solicitor.

7. For a curator *ad litem* to be appointed under rule 55(2)(b) and (c), the patient will have capacity to instruct a solicitor but will not have instructed anyone to represent their interests.

8. The appointment of a curator *ad litem,* where a patient lacks capacity to instruct a solicitor, means that the patient does not participate in proceedings as a party. However the principles set out in section 1 of the 2003 Act still apply in respect of the patient and impose duties on those discharging functions under the 2003 Act, which includes the Tribunal.[1] Where a patient lacks capacity to instruct a solicitor to represent their interests, they may still have capacity to participate in the proceedings. In those circumstances the principles apply and the patient should be involved in the proceedings in so far as they can be.[2]

9. The Tribunal has no power to appoint a curator *ad litem* in the absence of proceedings before the Tribunal. Rule 55(2)(a) specifies that a curator ad litem may be appointed where the patient does not have the capacity to instruct a solicitor to represent

[1] https://www.legislation.gov.uk/asp/2003/13/section/1
[2] Guidance to Tribunal Members No. 1/2010 – Place of patients at hearings where curator *ad litem* appointed

the patient's interests in proceedings before the Tribunal. Where rule 55(2)(aa) applies, proceedings have been commenced by a listed initiator process.

10. The Tribunal holds and maintains a list of curators *ad litem*. The criteria for appointment and process of appointment is set out in the Terms and Conditions for Curators *ad litem*.[3] The tribunal has also issued Guidance to curators *ad litem* who are conducting proceedings for a patient and curators ad litem are expected to act in accordance with this Guidance.[4]

Solicitor withdrawing from acting:

11. In any application or appeal before the tribunal a patient's solicitor may withdraw from acting for the patient. In this event the tribunal should consider whether or not the appointment of a curator *ad litem* is required to protect the patient's interests. This will involve some enquiry into whether or not the patient has capacity to instruct a solicitor. In the event that a patient does have capacity and is simply choosing to represent themselves or not to participate in the proceedings it is likely that a curator *ad litem* will not be required.

12. In the event that a solicitor withdraws from acting in proceedings that have been instigated by the patient and where that patient is no longer capable of instructing a solicitor, the tribunal can appoint a curator *ad litem* to consider and report solely on whether or not it will be in the patient's interests to continue with the application or appeal.

Duration of appointment

13. The curator *ad litem*'s appointment ends when the case is finally determined. It has been held that the curator *ad litem* does not have a right to appeal the decision of the Tribunal.[5]

Discharge of curator appointment

14. Once a curator *ad litem* has been appointed, the appointment will continue until either the conclusion of the proceedings or, in circumstances where an application/request is made for discharge, on the discharge of the curator *ad litem*. Generally a request for the discharge of an appointed curator *ad litem* is made in one of two situations: the curator *ad litem* has assessed the patient and formed the view that the patient has legal capacity and asks to be discharged, or a solicitor has been instructed to represent the patient and is satisfied that the patient has capacity to instruct them. The decision to discharge a curator *ad litem* is a judicial one and an interlocutor will be issued by the judicial decision maker.

In Practice

15. Assessment of capacity to be able to instruct a solicitor is ultimately a matter for the solicitor taking instructions. Capacity is task specific and can be viewed at different levels or degrees. There is a difference between the level of capacity that a patient needs to consent to treatment or decide to revoke the nomination of a named person and the capacity required to give instructions to oppose a CTO application, for example.

16. Where a solicitor has satisfied themselves that their client can give instructions, it is not for the Tribunal to question that assessment, unless there is good reason for doing so, for example where both a solicitor and curator *ad litem* appear at the hearing. In that

[3] TCs_curators_June 2024
[4] TCs_curators_June 2024, Appendix 1
[5] *Black v MHTS* 2012 SC 251

situation the matter would need to be resolved before determining the application. Ultimately if a solicitor, as an officer of the court, maintains that a patient has capacity to instruct them then this should be deferred to.

DAYS

1. Many provisions of the 2003 Act stipulate periods of days for which a measure lasts, or within which a step must be taken. Calculation of when these periods start and stop can be complicated. More specifically, the day on which a period begins is usually straightforward to identify but whether that day counts as the beginning of a specified period or not may need careful analysis. In other words, is the day of event E 'Day zero' or 'Day one'?

2. The following summary sets out the different ways in which periods of time are computed in the legislation.

Detention, extension, variation, suspension for a period

3. Section 44 (STDC) – detention for a period of 28 days beginning with the day on which the certificate is granted (or, if different, the day when the patient is admitted to hospital under the certificate). Thus the date of grant is day one. Expiry is at midnight at the end of day 28.

4. Section 47 (extension certificate) – adds on another three days after a STDC expires, to allow application for CTO. Only working days (see below) count.

5. Section 64(4)(a)(i) (CTO) – CTO authorises measures 'for the period of six months beginning with the day on which the order is made...'. So day of making is day one and expiry is at midnight at the end of the day before the six month date anniversary, e.g. CTO made 15/M1 expires at midnight end of 14/M7.

6. Section 68(2)(a) – CTO application lodged before expiry of STDC extends detention for another five working days (see below).

7. Sections 105, 106 (interim extension and/or variation of CTO) - extension normally from midnight at end of day CTO would otherwise expire and variation from then or from earlier date if requirement for authorisation of detention or other measure.

8. Section 114 (detention pending review or variation of CTO) - for a period of 28 days beginning with the day on which the certificate is granted. Thus the day of grant is day one.

9. Section 127 (suspension of detention) – cannot be in place for more than 200 days in a 12-month period. Period of eight hours or under does not count as a day; period >eight but <24 counts as day.

10. Sections 168, 169 (interim extension and/or variation of CO) - extension normally from midnight at end of day CO would otherwise expire and variation from then or from earlier date if requirement for authorisation of detention or other measure.

11. Sections 264, 265, 268, 269 (excessive security applications) – periods for compliance specified and begin with day on which order is made. So day of grant is day one.

12. Section 57A of 1995 Act (making of COs). If made on or after 30 September 2017, first six month period runs until midnight at the end of the date anniversary, e.g. order made on 15/M1 expires at midnight at the end of 15/M7.

Expiry thereafter will always be at midnight at the end of the date anniversary of making of the order (midnight at the end of 15/M1).

13. For COs made before 30 September 2017, expiry will be at midnight at the end of the day before making of the order, namely 14/M1 in the example above.

Appeals etc after an event

14. Section 125 (appeal against hospital transfer on CTO; not State hospital); section 126 (same for transfer to State hospital); section 178 (appeal against hospital transfer on CO); section 219 (appeal against hospital transfer on CORO; not State hospital); and section 220 (same for transfer to State hospital).

15. All these sections provide a period for appeal which is dependent on whether or not written notice of the transfer is given. In some instances, the period will begin on the day of an event, day E, so that day is day one, in others the period ends X time after the event, so day E is day zero.

Application or review before the expiry of a period or within a countdown period

16. When the duty arises on a MHO to apply for a CTO, section 57(7) requires that the application is made before the expiry of 14 days beginning with the day of the later medical examination. So that day is day one.

17. Where a duty arises to review the need for extension of an order (sections 77, 78, 139, 140), the review period ends with the day on which the order ceases to authorise measures. So an order expiring at midnight at the beginning of 15/M3 needs to be reviewed in the period 15/M1 onwards.

Working days

18. Some provisions require only 'working days' to be counted. Working days exclude Saturdays, Sundays and Bank Holidays in Scotland. Bank Holidays are those listed in the Banking and Financial Dealings Act 1971, Schedule 1 paragraph 2. As at date of publication[1] these are:

- New Year's Day, if it be not a Sunday or, if it be a Sunday, 3rd January.
- 2nd January, if it be not a Sunday or, if it be a Sunday, 3rd January.
- Good Friday.
- The first Monday in May.
- The first Monday in August.
- 30th November, if it is not a Saturday or Sunday or, if it is a Saturday or Sunday, the first Monday following that day.
- Christmas Day, if it be not a Sunday or, if it be a Sunday, 26th December.

19. Bank holidays will also be those specified in substitution for, or in addition to, the dates in Schedule 1. Such substitutions or additions are announced in The Gazette, available at https://www.thegazette.co.uk/all-notices.

[1] See website for up to date list.

DECISIONS

1. Generally the decision of a tribunal will be given orally at the end of a hearing. However the reasons for the decision are not usually explained to parties at that stage. The tribunal do however need to provide a full statement of the facts found and the reasons for their decision ('FFR'). This chapter explores the purpose of giving reasons and what constitutes adequate reasons, as well as providing guidance on practical elements pertaining to the giving of a decision and the provision of reasons.

Reserving a decision

2. There may be circumstances where the tribunal reaches a decision but considers it appropriate to reserve intimation of it. For example, where a patient has been brought from a hospital to a community venue and the tribunal is concerned that the mental state of the patient may deteriorate on hearing the tribunal's decision or where the tribunal considers that there may be a risk to a person's safety or welfare as a result of the Tribunal intimating its decision. Rule 72(1) of the 2005 Rules provides: "A decision of the Tribunal may be given at the end of the hearing or reserved." In cases where it is appropriate to reserve a decision the President's Guidance No 1/2018 on reserving intimation of a tribunal decision should be followed.

Why give reasons?

3. There are a number of reasons as to why it is essential that the tribunal give reasons. Firstly this is a statutory requirement: "A decision of the Tribunal shall be recorded in a document which contains a full statement of the facts found by the Tribunal and the reasons for the decision." [1]

4. The provision of reasons increases public confidence and may disclose error. In particular it discloses whether there are grounds for appeal.

5. However the provision of a FFR is also important as it strengthens the decision-making process:

> *The giving of reasons may among other things concentrate the decision-maker's mind on the right questions; demonstrate to the recipient that this is so; show that the issues have been conscientiously addressed and how the result has been reached; or alternatively alert the recipient to a justiciable flaw in the process.* [2]

6. Another key reason for giving a written decision is to increase public confidence. This is of particular importance in mental health tribunals, which are held in private. The public is entitled to the assurance that people are being detained and subject to compulsory treatment only on the basis of a written decision setting out the reasons why the tribunal has reached its decision on imposing restrictions on a patient's liberty.

What constitutes "adequate reasons"?

7. Adequate reasons should "deal with the substantial questions in issue in an intelligible way. The decision must… leave the informed reader and the court in no real and substantial doubt as to what the reasons for it were and what were the material considerations which were taken into account in reaching it."[3]

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[1] Paragraph 13(3) of schedule 2 to the 2003 Act. See also rule 72(7) of the 2005 Rules
[2] *R v Higher Education Funding Council, ex Parte Institute of Dental Surgery* [1994] 1 WLR 242, per Sedley J at 256.
[3] *Wordie Property Company Ltd v Secretary of State for Scotland* 1984 SLT 345 (Lord President Emslie at page 348)

8. In a case relating to an appeal of a mental health tribunal decision the Court of Session said the following on adequacy of reasons:

> *[the Tribunal is] a specialist tribunal, and regard has to be had to its expert knowledge. We accept that it is not always appropriate to indulge in an overly elaborate analysis of a decision made by such a tribunal. Nevertheless, the Tribunal must reach a decision based on the evidence. It requires to provide clear reasons for making or failing to make findings that are central to the questions in issue.*
>
> *In these circumstances, the Tribunal ought to have given clear and intelligible reasons for the rejection of that part of [the RMO's] evidence…* (underlining added). [4]

Component parts of a decision

9. It is important that a decision has some kind of structure. A number of style FFR's are available on the members' area of the website and can be found here. These should be used in order to ensure consistency of appearance in decisions. The decision will include:

- Type of application;
- Decision made and any recorded matter made;
- Preliminary and procedural matters;
- Tribunal hearing procedure adopted;
- Details of who was present at the hearing and, in particular, whether the patient and named person were present;
- The nature of the evidence before the tribunal: documentary evidence before the tribunal, who gave evidence, how was evidence given;
- Present and past wishes of the patient, views of the named person and a record of an Advance Statement;
- Findings in fact;
- Narration of the evidence; and
- Reasons for decision.

Most of these components are self-explanatory, however we say more about the findings in fact and reasons for decision below.

Finding in fact

10. Within their decision the tribunal must include findings in fact. A finding in fact is a fact which has been found by the Tribunal to be proved on the basis of the evidence before it. For example, the following is a finding in fact: The patient has a mental disorder, namely vascular dementia. A good summary of what is a finding of fact is - "*A finding in fact is a fact that has been deduced from the evidence and found by the judge to be essential to an understanding of the case or to determine the rights of the parties.*"[5]

[4] *Scottish Ministers v Mental Health Tribunal for Scotland (JK)* 2009 SC 398
[5] George, JJ., Judicial Opinion Writing Handbook, 2007, 5th ed., 2007 (William S Hein & Co., New York) at page 209

11. There is a clear distinction between a finding in fact and the evidence used to support it: evidence is used to make a finding in fact. The decision needs to explain the basis upon which the findings in fact have been found to be established. Where there is conflicting evidence, before making a particular finding in fact, the evidence around that finding needs to be analysed. Here the tribunal requires to set out:

- what each source says on the issue;
- which source the tribunal prefers; and
- why the tribunal prefers one rather than the other.

However the analysis in relation to the evidence does not take place in the findings in fact. This should follow later.

12. Only facts which are 'essential' to the case need to be included within the findings in fact and if evidence is rejected (for example where the evidence of a witness on whether or not something happened is not believed) then it should simply be ignored in the findings in fact.

Reasons for the Decision

13. Once the findings in fact are formed, the legal tests must be applied to those facts. In all cases, there will be a test(s) set down in law. This must be identified. Once the legal test(s) is identified, it must be set out clearly in the reasons for the decision.

14. Within the reasons for the decision it is essential that the tribunal narrate their analysis in relation to the evidence. There are numerous reasons why the tribunal might prefer one source of evidence over another. These might relate to one witness having greater knowledge or understanding of matters relevant to issues in dispute or the evidence of one witness being demonstrably unreliable when tested against known or verified facts. For more detail in relation to this see **Chapter 28** on Evidence.

15. The law should then be applied to the facts. A finding in law is a finding as to the applicability of a rule of law or statutory provision to particular facts. For example, with regard to the finding in fact referred to above, the finding in law would be that one of the criteria for making a CTO, i.e. section 64(5)(a) of the 2003 Act (that the patient has a mental disorder), is met.

Majority decisions

16. In the circumstances where a tribunal makes a decision by majority, the decision must state this and include within it the reasons for the minority decision.

Correction of decisions

16. This is dealt with in **Chapter 10**.

In practice

17. There are two methods by which an FFR may be completed:

- The panel may complete the FFR at the venue on conclusion of the hearing, together with the relevant Order. The Clerk will scan the FFR and Order onto CMS. A caseworker will then process the decision.
- Where the convener and panel members do not complete the FFR at the conclusion of the hearing, it may be completed at a later date. The draft FFR should be uploaded to the secure members' area of the MHTS website for the medical and general members to review. That is the only means by

which a draft or final FFR should be shared among panel members. Once the panel have agreed the contents, the convener should send the final signed FFR by uploading it for the Clerk via the secure members' area.

18. The caseworker teams are not responsible for addressing any errors in the FFR.

19. The expectations in relation to the completion of an FFR and the timescales for this are set out in Guidance to Tribunal Members No 2/2012 as revised. There is additional guidance for CORO cases Guidance to Tribunal Members No 1/2019

20. Each month the Tribunal publishes some decisions on the Tribunal's website. These can be found here. Members can use the search function of the table to find decisions under certain sections of the 2003 Act.

DIRECTIONS

1. This chapter deals with Directions under rule 49 of the 2005 Rules. This rule provides that the Tribunal may at any time, either on the request of a relevant person or on its own initiative, give such Directions as it considers necessary or desirable to further the overriding objective in the conduct of a case. This means that a tribunal may make Directions at any point during a case's proceedings, even before the first hearing has been held. The authority to issue Directions is one which allows a wide discretion and can be used extremely effectively. This chapter provides some guidance on issuing Directions effectively and what happens where a Direction is not complied with.

Guidance on Issuing Directions

2. The President's Guidance to Tribunal Members No 2/2009 deals with Directions. The guidance below is taken from that guidance. In order for a Direction to be effective, it must comply with the provisions of rule 49. Failure to comply with rule 49 will render a Direction ineffective and may result in confusion, delay and an adjournment of the patient's case. In short, the SMART acronym should be applied to all Directions. The Direction should be Specific, Measurable, Achievable, Realistic and Time related.

3. If the Direction is for someone to do something, or for someone to produce something, there must be clarity and specification as to what has to be done or what has to be produced. There should be no ambiguity as to who is under an obligation to comply with the Direction.If an organisation is responsible consideration should be given to who is responsible within that organisation; what the Direction is; and when compliance requires to be effected. The full name, address and title of the person directed is needed in a Direction so this should be obtained at the hearing and specified in the Direction. Without the person's address, the caseworker is unable to notify them of the Direction. Consideration should be given to realistic time scales, as a Direction with little prospect of compliance will simply result in delays and adjournments.

Varying or Setting aside Directions

4. Rule 50 of the 2005 Rules deals with varying or setting aside Directions. The rules provide that, *'Where a direction that affects a person is given by the Tribunal without prior intimation to that person, that person may request that the Tribunal vary it or set it aside'* but the Tribunal must not do so without first intimating the request to the relevant persons and considering any representations made by them. The requirement to intimate a request to the relevant persons does not require intimation to the person who made the request.

Failure to comply with a Direction

5. Rule 51 of the 2005 Rules deals with the failure to comply with Directions. It provides that where a Direction given to a relevant person is not complied with *'the Tribunal may, before or at the hearing, direct that [the] relevant person concerned take no further part in proceedings.'* First however the Tribunal should give the relevant person concerned an opportunity to show cause why the Tribunal should not proceed to give such a Direction.

In practice

6. A Direction must be in writing. It must be made on a separate Directions template, which will be made available by the clerk. The purpose of Directions is to have action taken. A Direction must not be contained only within the body of the determination. If stated there, it must also be stated on a separate Directions template. If a Direction is

contained only within the body of a determination, it will not be processed by the caseworker.

7. A time limit to do or produce something within a time scale from the date of intimation of the Direction is likely to be more effective than one which provides that something should be done or produced before, or within a time scale prior to, the next hearing. Hearings are often not set at the time when a Direction is given, and a Direction linked to the date of a hearing is likely to lead to uncertainty. A time scale from the date of intimation of the Direction will also allow the caseworker to monitor compliance with Directions and to take appropriate follow up action where necessary.

ESCORT NURSES

1. In terms of memoranda of understanding between the Tribunal and individual Health Boards it is the responsibility of Health Boards, when the patient is in hospital, to provide at least one nurse escort to look after the welfare of the patient during the whole Tribunal hearing.

2. A nurse escort is required to be present at a hearing when a patient is detained in hospital, unless the RMO advises this is unnecessary - for example, where a detained patient is on suspension of detention and the RMO is of the opinion that it is not necessary for a nurse escort to accompany the patient at a hearing.

3. A nurse escort is not required to be present at a hearing when a patient is based in the community, unless the RMO advises that this is necessary - for example, where the tribunal is determining an application to vary a community-based CTO to a hospital-based one. Whether a nurse escort is required at a tribunal hearing for a patient based in the community or not, appropriate support should be provided by the Health Board and/or the Local Authority for such a patient if the patient needs physical or other support relevant to their general health.

4. Nurse escorts should remain in the hearing room for the duration of the hearing and should not simply bring and collect patients. It is the nurse escort's responsibility to look after the welfare of the patient and ensure that the patient's needs are addressed, for example for toilet or meal breaks, and to ensure the patient's comfort should the patient become distressed. The nurse escort should be familiar to the patient, be able to provide support for the duration of the hearing and be trained in de-escalation techniques.

5. Tribunal Guidance on the presence of escort nurses at hearings has been issued.[1] This details tribunal practice regarding adult patients and those patients under the age of 18. It includes obtaining an indication from the nurse in advance of the hearing as to whether it would be helpful for them to sit beside the patient at the table or elsewhere nearby. It also states that for patients who are children in terms of the legislation, a request for the escort nurse to sit outside the hearing room may be acceded to, provided views on the request have been sought from those present. Opposition to such a request from the RMO or MHO should be overridden only where there are compelling reasons to do so.

6. Nurse escorts should not give evidence. If a nurse is required to give evidence, they should not also be performing the role of nurse escort.

In practice

7. A hearing of a case in respect of a hospital-based patient should not start until there is an escort nurse present in the hearing room. In the unlikely event that a patient attends a hearing without one, the tribunal should ask the RMO or attending doctor to arrange this.

[1] GUIDANCE TO TRIBUNAL MEMBERS No. 1/2024 - Guidance on the presence of escort nurses at hearings - see Appendix 9

EVIDENCE

1. There are two main types of evidence which are relevant to tribunal proceedings in MHTS. These are written or documentary evidence and oral evidence. These can be further categorised as evidence of fact and opinion evidence. There are legal rules which apply to the admissibility, presentation and the assessment of evidence. Tribunal proceedings fall within the definition of civil proceedings and so civil rules of evidence apply. This chapter considers the main types of evidence heard in tribunal proceedings and the rules of evidence. This chapter should be considered alongside **Chapter 8** on the burden and onus of proof.

Hearsay evidence

2. Hearsay evidence is evidence of what another person has said. The provisions in the Civil Evidence (Scotland) Act 1988 ('the 1988 Act') specifically apply to tribunals. The 1988 Act makes specific provision for the admissibility of hearsay evidence. Section 2 of the 1988 Act provides that a statement made by a person otherwise than in the course of the proceedings shall be admissible as evidence. However a precognition is not, the distinction being that a statement is an account in the person's own words whereas a precognition is not a word for word account of what is said.[1] Hearing evidence from the person who took a precognition of what was said is not inadmissible. However because evidence is admissible does not mean it has to be accepted and the weight which is attached to the evidence must be considered.

Exclusion of evidence

3. If evidence is inadmissible, it is not permitted to be heard or produced; it essentially has to be ignored. In addition to the civil rules of evidence, rule 49(g)(iv) of the 2005 Rules (which relates to Directions) also relates to evidence and makes provision for the exclusion of any evidence which is irrelevant, unnecessary or improperly obtained. Relevant evidence is evidence which is directly connected to the matters which are the subject of the case; evidence which is collateral to the issues before the tribunal should not be considered. Unnecessary evidence may include evidence that does not need to be heard orally because it is included within the papers. Care also needs to be taken over evidence in relation to character. There may be some types of character evidence which are relevant, for example if a patient has in the past been dishonest about compliance with treatment. However, generally, there should be no attack on the character of a witness simply to cast a shadow over them. Improperly obtained evidence is still admissible but the question of fairness arises. Where evidence is admissible it must then be assessed to determine what weight can be placed on it.

Criminal allegations

4. Schedule 2, part 3, paragraph 12(4) of the 2003 Act provides:

> *A person need not give evidence or produce any document if, were it evidence which might be given or a document that might be produced in any court in Scotland, the person having that evidence or document could not be compelled to give or produce it in such proceedings.*

This would apply where, for example, someone had disclosed that they had been involved in committing a crime but had done so without having been given a caution.

[1] There is an exception where a witness has by the time of hearing died and common law can be relied upon to seek admission of a precognition.

Whilst there is no clear caselaw on this point relating to the MHTS, given the tribunal is dealing with cases which involve deprivation of liberty it would be prudent for the tribunal to warn someone in such a situation of the right not to answer a question about an alleged confession, on the basis that it may incriminate them.

Evaluation of evidence

5. Evidence requires to be weighed up and evaluated and reasons have to be given for the rejection of evidence. Factors to be considered will include credibility, reliability and sufficiency. Credibility is about truth and lies, while reliability is about whether the witness was or was not in a position to comment. Sufficiency means sufficiency in law and gives rise to two questions. Is there sufficient evidence in law to entitle the tribunal to consider the issue to which the evidence relates? It is only if this first question is answered in the affirmative that the second question arises – whether the tribunal is satisfied with the evidence.

6. On reliability, for example, an expert might be said to be unreliable on a point due to their evidence being based on irrelevant considerations. This could mean that the evidence of the witness on that point is not reliable. Credibility is rarely an issue, since to find someone lacking in credibility (in part or wholly) requires a finding that they have been untruthful.

7. In assessing oral evidence generally, some of the factors which might influence the tribunal are as follows:

- Demeanour: how did the witness present when giving evidence?
- Internal consistency: did the witness change position, or make a statement in oral evidence which conflicted with the position stated on paper?
- External consistency: was the evidence at odds with other credible and reliable evidence from other witnesses or sources?
- Qualifications/experience to state a view: Where a witness offers skilled evidence, what are their qualifications and experience and extent of contact with the patient?

Opinion evidence

8. Any witness can talk to fact provided that the evidence they are giving is admissible. To give opinion evidence a witness must be a skilled witness. The RMO or MHO in a case will be considered a skilled witness. They will give evidence relating to the criteria for any given case. However it is for the tribunal to decide based on all the evidence presented whether the criteria are met.

9. The evidence of skilled witnesses is dealt with in **Chapter 60** .

Inferences

10. Inferences are conclusions which may be drawn from evidence, even where there is no direct evidence to support the conclusion. So, where fact A and fact B are found to exist, a tribunal may conclude that this leads to fact C, although there is no direct evidence of fact C. Sometimes an inference can be drawn from the tribunal's own expertise but caution must be exercised in such circumstances. Where possible, the tribunal should allow the parties an opportunity to comment on any such proposed inference.

Judicial and specialist knowledge

11. Please see **Chapter 55** for information on judicial and specialist knowledge and how this should be used in the assessment of evidence.

In practice:

12. A tribunal cannot find any fact to be established without evidence being available which it can rely on. It is important to note that legal submissions or arguments are not evidence.

13. There will be times when a decision can be made on written evidence alone. These occurrences are dealt with in **Chapter 52**.

EXCESSIVE SECURITY

Introduction

1. The inclusion in the 2003 Act of provisions related to excessive security was a particularly innovative part of the statute. Such provisions were recommended in the Millan report, recommendation 27.19 of which said, "*Patients should have a right of appeal to be transferred from the State Hospital, or a medium secure facility, to conditions of lower security*." The reasoning which underlay this recommendation, and some of the practical issues which it was thought might arise, are discussed in paragraphs 79 to 91 of the Report.[1]

2. In the Supreme Court appeal, *G v Mental Health Tribunal for Scotland* 2014 SC (UKSC) 84, at paragraph [71], Lady Hale said this:

> *It was … progressive and farsighted of the Millan committee to recommend that individual patients in Scotland should have the right to challenge the place of their detention on that basis and of the Scottish Parliament to pass what became secs 264-73 of the Mental Health (Care and Treatment) (Scotland) Act 2003. Despite all the recent changes to the Mental Health Act 1983 (cap 20) (which consolidated the 1959 Act with later amendments), the law in England and Wales still lags behind the law in Scotland in this respect. No doubt those with an interest in the subject south of the border will be keeping a close eye on experience with the Scottish jurisdiction.*

Provisions

3. The provisions regarding excessive security are contained in chapter three of Part 17 of the 2003 Act (sections 264-73 inclusive). They deal separately with detention in the State hospital and detention in other hospitals, but most of the provisions are to similar effect. In practice, until 2015, the right to apply extended only to those detained in the State hospital but, as a result of amendments made by the 2015 Act and related regulations, an application may now be made by or in relation to someone detained in a medium secure facility.

4. Whether detained in a State hospital or a medium secure facility, the provisions cover those whose detention is authorised by a CTO, a CO (with or without a restriction order), a HD or a TTD. There is a jurisdictional aspect to this, however, which is explained below (see paragraph 21).

Process – applying for an order

5. The general import of the excessive security chapter is that, subject to certain restrictions as to timing and expert opinion (see below), an application may be made by the patient, the named person, a welfare guardian, a welfare attorney or the MWC for an order declaring that the patient is detained in conditions of excessive security and specifying a period during which certain duties are to be performed. By section 264(2)(b) and section 268(2)(b) of the 2003 Act, the period is not to exceed three months. As is usual under the 2003 Act, there are a number of people, listed in section 264(10) and 268(10), who have to be afforded the chance to make representations and/or lead or produce evidence before an application is determined.

[1] Report on the Review of the Mental Health (Scotland) Act 1984

6. The requirements as to timing are that an application may not be made:

- If the patient is on a CTO that has not been extended;
- If the patient is on a CO, during the first six months of that order;
- If the patient is on a HD or TTD, before the expiry of six months from the making of that direction.[2]

Further, a patient may not make more than one application in a 12 month period.[3]

7. The requirement as to expert opinion is that an application must be accompanied by a report from an AMP that states that in the practitioner's opinion, the applicable test for a finding of excessive security is met and sets out their reasoning.[4]

8. In its consideration of the application, the tribunal must independently consider whether the applicable test is met. There is no onus on the RMO to demonstrate that the patient requires the conditions of security under which he is currently detained.[5]

9. The test applicable under sections 264 and 265 is 'that the patient does not require to be detained under conditions of special security that can be provided only in a state hospital' whereas the test under sections 268 and 269 is a test specified in regulations, the Mental Health (Detention in Conditions of Excessive Security) (Scotland) Regulations 2015 (SSI 2015 no. 364). It is that 'detention of the patient in the hospital in which the patient is being detained involves the patient being subject to a level of security that is excessive in the patient's case' (regulation 5). By regulation 6, further specification of the notion of excess is provided:

> *A patient's detention in a hospital is to be taken to involve the patient being subject to a level of security that is excessive in the patient's case only when the security at the hospital is greater than is necessary to safely manage the risk that the patient may pose to—*
> *(a) the patient's own safety; and*
> *(b) the safety of any other person.*

10. As explained in the Lothian Health Board case, the aspects of security which apply in the hospitals concerned can be viewed as environmental, procedural and relational.[6] Where the position is disputed, the individual tribunal hearing the case is likely to have to explore the level of security required by the patient with reference to these various aspects.

11. All four sections (264, 265, 268 and 269) confer upon the tribunal a discretion as to whether or not to make an order, even if the test is satisfied. Questions have arisen as to when, even with excessive security having been identified, the tribunal might refuse to make an order. Each case will turn on its own facts, but in the exploration of these provisions and their interpretation by the Supreme Court in the G case, it was observed that risk posed by the patient is not necessarily irrelevant at the second stage (G posed a risk to women, and there were female patients in medium secure facilities but not in the State hospital).[7] The treatments available or not available in a particular

[2] Section 264(7); s 268(7)
[3] Section 264(8); s 268(8)
[4] Section 264(7A); s 268(7A)
[5] *Lothian Health Board v M*, 2007 SCLR 478
[6] Ibid.
[7] *G v Mental Health Tribunal for Scotland* 2014 SC (UKSC) 84

hospital may also be relevant to the decision as to whether to make an order,[8] as may be the patient's physical health and capacity to adapt to different surroundings.[9]

12. In the case of *Lothian Health Board v M*, one suggested reason for refusing to make an order was the fact that no bed in an appropriate medium secure facility was available. The Sheriff Principal held that the availability of resources elsewhere was not relevant either to the first stage of the exercise (consideration of whether the security is excessive) or to the second stage (whether or not to make an order). In the G case in the Supreme Court, however, this view was disapproved, with the following comment:

> *The view expressed in Lothian Health Board v M, that the availability of accommodation in a medium secure hospital where the patient could be detained in appropriate conditions, including appropriate facilities for treatment, can never be relevant to the question whether an order should be made under section 264, and can only be raised by way of an application for the recall of the order under section 267, therefore goes too far.*

Process - after an order is made

13. Once an order has been made, the obligation to address the situation is that of the 'relevant' Health Board. The relevant health board is determined according to provisions set out in the Mental Health (Relevant Health Board for Patients Detained in Conditions of Excessive Security) (Scotland) Regulations 2006.[10] For patients who resided in Scotland before being detained, it will be the Health Board for the area where they lived. For those who did not reside in Scotland, it will be the Health Board for the hospital in which they are currently detained.

14. The intended process is that the relevant Health Board will identify a hospital to which the patient can be transferred and which the relevant Health Board and, if different, the managers of that hospital, agree is one where the patient could be detained in appropriate (less secure) conditions. The Health Board will then give notice to the managers of the hospital where the patient is currently detained. If the patient is a 'relevant patient', which by section 273 of the 2003 Act means someone on a CORO, a HD or a TTD, the Scottish Ministers must also agree that the hospital is appropriate for the patient's detention.

15. If notice of the identification of a place in a suitable alternative hospital is not provided, and no transfer has taken place, the Tribunal will arrange a further hearing, under section 265 for patients in the State hospital or under section 269 for patients in medium secure hospitals. At such a second hearing, the members hearing the case have to be satisfied that the test for excessive security is met. If they are, a further order may be granted; at this point, the time frame for compliance is shorter, with the primary reference being to a period of 28 days, although a longer period up to three months may be chosen.

16. The duty on the Health Board is only to identify a place in a lower security hospital. Thus, if such a place is identified, but the patient refuses to move to that

[8] Ibid.

[9] see Tribunal decision *RA*, 08416/22; 25/3/22.

[10] The Mental Health (Relevant Health Board for Patients Detained in Conditions of Excessive Security) (Scotland) Regulations 2006, SSI 2006 no. 172

particular facility, any loss he thus sustains is caused by his own decision, not by any failure on the part of the Board.[11]

Enforcement

17. Section 272(1) provides that an order made at a first hearing in excessive security applications is not enforceable by proceedings for specific performance of a statutory duty brought under section 45(b) of the Court of Session Act 1988. By section 272(2), however, such proceedings may be brought by the MWC, but only in relation to orders made at second hearings (those held under section 265 or 269). As an alternative mechanism for securing performance, judicial review may be available. Although resorted to on occasions, no judicial review petition has yet reached the stage of final decision. Petitions brought tend to rely on alleged interference with rights under Articles 5 and 8 of ECHR, and also to seek an order for specific performance under the Court of Session Act 1988.

Recall

18. Chapter 3 also contains provisions designed to address changes in circumstances after the making of an order declaring detention in conditions of excessive security. Whether relating to detention in the State hospital, or to detention in a medium secure unit, an order from the Tribunal that declares the detention to be in conditions of excessive security can be recalled. The relevant sections are section 267 (for the State hospital) and section 271 (for medium secure units).

19. The structure of the recall provisions is that, where the patient can (now) be demonstrated to require to be detained in conditions of special security that can only be provided in a state hospital, or where detention of the patient in the medium secure unit does not (now) involve his being subject to a level of security that is excessive in his case, the tribunal must recall the order. If grounds other than the level of security required by the patient are advanced as the basis of an application for recall, the tribunal has a discretion as to whether or not to recall the order. Recall removes the duty on the relevant health board to comply with the duties regarding identification of another facility.

20. It may happen that a patient who has succeeded in obtaining an order at a second hearing declaring that he is detained in conditions of excessive security proceeds to petition for judicial review of the failure to identify another hospital for his detention at the same time as the relevant health board seeks recall of the order. Consideration of issues which arise in such a scenario of competing applications took place in the Tribunal decision in *JM* 02204/21.[12]

Jurisdiction

21. Hearings of applications for orders in relation to excessive security follow the normal allocation of jurisdiction under the 2003 Act. Thus, any application relating to a patient detained on a CORO, a HD or a TTD must be heard by a tribunal convened by a sheriff or the President of the Tribunal.[13] All other excessive security applications require to be dealt with by a tribunal convened by a legal member.

[11] *Boyle v Greater Glasgow and Clyde Health Board*, Sheriff Reid, [2021] SC GLW 62, MHTS Case Digest, vol 2, page 70

[12] *JM* 02204/21, 13/07/21

[13] Schedule 2, paragraph 7(4) of the 2003 Act.

EXCLUSIONS OF PERSONS FROM A HEARING

1. There are two rules which relate to excluding persons from a hearing. Rule 68 and rule 69 of the 2005 Rules both provide for this. Rule 68 sets out the circumstances where the tribunal may exclude someone from all or part of a hearing where their attendance may cause serious harm to the patient or any other person. Rule 69 sets out the circumstances where the Tribunal may exclude someone from all or part of a hearing where that individual is disrupting or is likely to disrupt the hearing.

Exclusion from a hearing of persons whose attendance may cause serious harm

2. The 2005 Rules are concerned with safeguarding an individual's right to a fair process. In deciding whether to exclude a person from a hearing the tribunal can appoint a person of skill to assess whether attendance may cause serious harm and report on this.[1] In addition, prior to the making of a Direction to exclude a person, rule 68 also provides that when a convener or tribunal is considering making a direction under this rule they shall invite the relevant persons to make written representations on both the necessity of the direction and the availability of any alternative measures.[2]

3. By request, an oral hearing can hear representations.[3] If the patient is the person who may be subject to the Direction excluding them and they are not legally represented, the tribunal must invite the patient to seek an adjournment to allow them to obtain legal representation and shall grant such a request if made.[4]

4. Therefore prior to making a Direction under this rule consideration must be given to any report by a person of skill and any representations made.

5. Where a Direction is made, the person shall only be excluded to the extent strictly necessary to prevent the harm envisaged.[5] In addition, where the patient is the person being excluded and they do not have a legal representative, a curator *ad litem* may be appointed.[6]

Exclusion of persons disrupting hearing

6. Rule 69 provides for three circumstances where a person may be excluded:

- Where a person's conduct has disrupted, or is likely, in the opinion of the tribunal, to disrupt the hearing;[7]
- Where a person's presence is likely, in the opinion of the tribunal, to make it difficult for any relevant person to make representations or present evidence necessary for the proper conduct of the hearing;[8] or
- Where a person's conduct has otherwise interfered with the administration of justice or is likely to do so.[9]

7. The power to exclude extends to both a relevant person and a relevant person's representative.

[1] Rule 68(2)(b) of the 2005 Rules
[2] Rule 68(4) of the 2005 Rules
[3] Rule 68(5) of the 2005 Rules
[4] Rule 68(6) of the 2005 Rules
[5] Rule 68(7) of the 2005 Rules
[6] Rule 68(8) of the 2005 Rules
[7] Rule 69(1)(a) of the 2005 Rules
[8] Rule 69(1)(b) of the 2005 Rules
[9] Rule 69(1)(c) of the 2005 Rules

8. In deciding whether to exclude a person from a hearing the tribunal is required to have regard to the interests of the relevant person and whether that person will be adequately represented.[10] Before making a decision on whether to exclude a person from a hearing the tribunal shall:

- allow the relevant person's representative sufficient opportunity to consult the relevant person;[11]
- afford the relevant person concerned and any other relevant person as it thinks fit, an opportunity to be heard;[12] and
- consider the availability of alternative measures which may enable the relevant person concerned to continue to participate in proceedings.[13]

9. Where the relevant person concerned is the patient, and that patient does not have a representative present to represent the patient's interests, the tribunal may, before making a decision, adjourn the hearing to allow–

- the patient to obtain representation; or
- a curator ad litem to be appointed under rule 55(1).[14]

10. The issue of exclusion was explored in an Upper Tribunal case.[15] By way of background, an appellant who represented himself before the FtT Housing and Property Chamber repeatedly interrupted proceedings. He was eventually excluded from participating in the hearing, partly to allow the other party to make representations without interruption and also to allow the proceedings to continue. His appeal against this decision was successful: he should not have been excluded and should have been permitted, indeed supported, to participate or to have adequate representation. In the decision, the UT noted considerable sympathy for the chair of the FtT. Interruptions from a party litigant clearly made proceedings extremely difficult. In the circumstances, it appears to be a course of action which was taken to allow the hearing to proceed. Against that however, the appellant was described as having poor mental health, and being unable to prevent himself from interrupting the hearing. It was concluded that the exclusion of a party from their own hearing is a very significant step indeed and that, before taking such an extreme decision, other options could have been considered.

11. The 2005 Rules provide that the tribunal may make such alternative arrangements as may be necessary to enable a person excluded to continue to participate in the proceedings, including allowing the proceedings to continue through video-link or other method of communication.[16]

In practice

12. In practice it is very rare for a patient to be excluded from a Tribunal hearing. There are a number of steps which can be taken to ensure that interruptions to proceedings are minimised. Conveners can expect proceedings to be relatively free from interruptions and can make that clear to parties. Breaks can be arranged, particularly when things become heated or contentious. Patients who disrupt proceedings but who are

[10] Rule 69(2) of the 2005 Rules
[11] Rule 69(3)(a) of the 2005 Rules
[12] Rule 69(3)(b) of the 2005 Rules
[13] Rule 69(3)(c) of the 2005 Rules
[14] Rule 69(4) of the 2005 Rules
[15] *Eric Hamilton v GHA* [2020] UT37 https://www.scotcourts.gov.uk/docs/default-source/cos-general-docs/pdf-docs-for-opinions/2020ut037.pdf?sfvrsn=0
[16] Rule 69(5) of the 2005 Rules

represented can be encouraged to seek a short break to discuss the situation with their solicitor.

13. There will however be cases where it is appropriate that someone is excluded from a hearing. In some cases, particularly cases involving forensic patients, there may be a tension between the rights of a patient and the rights of a victim. In these cases it can easily be envisaged that a victim would find it difficult to make representations when the person who had offended against them was present. In these cases the safeguards within the rules are essential to ensuring fairness. Typically, where a victim wishes to make representations to be taken into account in a hearing for a restricted patient, the Tribunal will arrange a separate opportunity for them to do so, in the absence of a patient.[17]

[17] See **Chapter 58** on Victims

EXPERTS' REPORTS

1. Rule 62 of the 2005 Rules deals with the two different aspects of experts' reports. The first part relates to the Tribunal obtaining such a report and the second deals with a relevant person obtaining one.

Tribunal obtaining an expert report

2. If it would be desirable to have the assistance of an expert on any issue, rule 62(1) allows the tribunal to appoint an expert, i.e. a person with appropriate qualifications, to inquire into and report on any matter.

3. Unless the Tribunal considers that the terms of rule 47 apply (i.e. that disclosure of the report or any part of it may cause serious harm to the patient or any other person but it would nevertheless not be unfair if the report or part of it is considered by the tribunal) then it must intimate a copy of the report to the parties before the hearing.[1]

4. The Tribunal can also make a Direction that the expert shall attend the hearing and give oral evidence.[2]

Relevant person obtaining an expert report

5. Rule 63(5) of the 2005 Rules provides that if a relevant person obtains a report in relation to any particular issue before the Tribunal, they shall lodge it with the Tribunal seven days before the hearing or at such period as the Tribunal may have specified in that case (i.e. if a tribunal has made a Direction under rule 49 that a report be lodged by certain date). They may also send a request, including reasons for it, to the Tribunal that a report not be lodged.[3] As detailed in more detail below, in practice, this rule is rarely adhered to.

In practice

Tribunal obtaining an expert report

6. The rule which allows the Tribunal to obtain an expert report is used infrequently as there are rarely issues before the tribunal which the professionals attending are unable to address. The tribunal should use this power sparingly and only when necessary to determine the issue before it.

7. If the tribunal decides to appoint an expert, it should do so by making a Direction under rule 49 stating clearly the name, or at the very least the type, of expert to be instructed; the specific issues to be addressed in the report; and the time by which the report is to be lodged with the Tribunal.

Relevant person obtaining an expert report

8. In reality, rule 63(5) is not followed in practice, except in a case where a tribunal has directed that someone lodge a report by a certain time. As stated in **Chapter 44** about productions, reports are more often not lodged, or lodged when they become available, even if this is within seven days of the hearing. The Tribunal does not receive requests that a report be lodged late.

9. Frequently a patient obtains an independent medical report ('IMR') in respect of an application or review as a basis for challenging the medical evidence. Such a report may be lodged in advance of a hearing and either the report itself will be relied on by the

[1] Rule 62(2) of the Tribunal's 2005 rules
[2] Rule 62(3) of the Tribunal's 2005 rules
[3] Rule 62(6) of the Tribunal's 2005 rules

patient or the author of the report will attend the hearing to give oral evidence. At other times, the tribunal may be advised that the patient has obtained an IMR but has instructed their solicitor not to lodge it. While in the case of *Beattie v Dunbar and MHTS*[4], Sheriff Principal Lockhart commented in *obiter dicta*[5] that only in very exceptional circumstances, and on specific cause shown, should an IMR not be made available to the Tribunal, in practice, often tribunals are advised by patients' solicitors that an IMR has been obtained but will not be lodged. Paragraph 12(4) of Schedule 2 to the 2003 Act, however, provides that a person need not give evidence or produce any document if, were it evidence which might be given or a document that might be produced in any court in Scotland, the person having that evidence or document could not be compelled to give or produce it in such proceedings. Consequently, tribunals cannot insist on the production of IMRs in their proceedings.

[4] 2006 SCLR 777

[5] i.e. the comments were observations and did not form part of the reasons for the decision

HOSPITAL TRANSFERS

1. Sections 124 to 126 of the 2003 Act deal with hospital transfers within Scotland. The provisions apply to people subject to a Compulsory Treatment Order (CTO) or interim Compulsory Treatment Order (ICTO) as well as people subject to compulsion orders (CO). [1] [2] Sections 218 to 220 of the 2003 Act deal with restricted patients. This includes people subject to Compulsion Orders with Restriction Orders (CORO), hospital directions (HD) or transfer for treatment directions (TTD). These provisions largely mirror those in sections 124 to 126.

Transfers to other hospital

2. Section 124 provides for the transfer of a patient subject to a CTO, ICTO or CO, from one hospital to another provided the hospital managers in the hospital to which it is proposed the patient transfers are in agreement. [3] [4] Section 218 provides for the transfer of a patient subject to a CORO, HD or TTD, from one hospital to another as above with the additional requirement that the Scottish Ministers consent to the transfer.[5]

3. The hospital managers must provide notice in writing at least 7 days prior to the proposed transfer to:

- the patient,
- the named person; and
- the primary carer

4. The necessity for notice to be given can be waived in two circumstances:[6]

- Where the patient consents to the transfer; or
- Where there is an urgent need to transfer the patient.[7]

5. In these circumstances notice should be given as soon as possible. Notice can be given after transfer has taken place.

6. The transfer of a patient from one hospital to another is an occasion on which information complying with the stipulations in section 260(2) must be given to the patient.[8]

Appeal against Transfer to other hospital

7. Section 125 provides for an appeal where the transfer is to a hospital other than a state hospital in relation to a patient subject to a CTO, ICTO or CO. In the case of restricted patients subject to a CORO, HD or TTD section 219 applies.

8. The patient and the named person can appeal against a transfer or proposed transfer where notice is given or the proposed transfer takes place.

9. There are strict time scales to adhere to in relation to transfers. If advance notice is received by a patient they can appeal anytime from the point of receiving notice until 28 days after the transfer. If the transfer has already taken place the patient has 28 days

[1] Section 124(1)(a) and (b) of the 2003 Act
[2] Section 178 of the 2003 Act
[3] Section 218 of the 2003 Act for restricted patients
[4] In a case where a person is a 'restricted' patient, the Scottish Ministers require to consent
[5] Section 218(3)(b) of the 2003 Act
[6] Sections 124(5) and (7) and 218(5) and (7) of the 2003 Act
[7] The Code of Practice, Volume 2 describes 'urgent' as meaning there is 'a strong clinical need'
[8] See the Mental Health (Provision of Information to Patients) (Prescribed Times) (Scotland) Regulations 2005 (SSI 2005/206). See also MHTS decision AS 10491/23, 15/8/2023.

to appeal from the date he is given notice.[9] There are similar provisions for the named person.[10]

10. If the transfer has not taken place the managers shall not transfer the patient but the tribunal can order the transfer.[11]

11. In determining an appeal against a transfer to a hospital which is not a state hospital, the tribunal can either refuse the appeal or make an order, in terms of sections 125(5):

- that the transfer should not take place; or
- where the transfer has already taken place, that the patient should be returned to the hospital from which he was transferred.

12. The 2003 Act does not set out the basis upon which a tribunal decision should be made in terms of s125 and therefore the tribunal will have a wide discretion in determining an appeal under this section. The tribunal must have regard to the principles of the 2003 Act set out in section 2 and any advance statement.

13. Where the matter relates to a child, the tribunal must exercise its discretion in the manner which best secures the welfare of the child. Section 23 may also be relevant to a case involving a child.[12] Section 23 provides that the Health Board must provide any child or young person in hospital for the purposes of receiving treatment for mental disorder with such services and accommodation as are sufficient for the particular needs of that child or young person.

Transfer to other hospital unit

14. Section 124A deals with transfers to other hospital units within the same hospital for patients on ICTO or CTO. Within this section 'hospital unit' means any part of a hospital which is treated as a separate unit.

15. Section 218A deals with transfers to other hospital units within the same hospitals for patients subject to CORO, HD or TTD. The provisions in relation to rights of appeal in terms of s218 apply. Within this section 'hospital unit' means any part of a hospital which is treated as a separate unit.

Transfer to the State Hospital

16. Section 126 provides for an appeal where the transfer is to a state hospital for patients subject to a CTO, ICTO or CO. Section 220 provides for an appeal where the transfer is to a state hospital for restricted patients subject to a CORO, HD and TTD.

17. Where a patient is to be transferred to the State Hospital the period within which the patient or the patient's named person can appeal against the transfer is either from the date notice was given and ending 12 weeks after the transfer or, where no notice is given or the notice is given on the date of the transfer, 12 weeks after the transfer beginning on the day they were transferred.[13]

18. If the transfer has not taken place the managers shall not transfer the patient but the tribunal can order the transfer.

[9] Sections 125(3)(a) and 219(3)(a) of the 2003 Act
[10] Sections 125(3)(b) and 219(3)(b) of the 2003 Act
[11] Sections 125(4)(b) and 219(4)(b) of the 2003 Act
[12] A child is a patient who is under 18 years of age.
[13] Sections 126(3) and 220(3) of the 2003 Act

19. The test for an appeal against transfer to the State Hospital is set out in section 126. The test is whether the patient requires to be detained in hospital under conditions of special security and that those conditions of special security can be provided only in a state hospital.[14]

20. Where an appeal is made against a transfer to a state hospital, the tribunal can either refuse the appeal or in terms of section 126(5) make an order:

- that the transfer should not take place; or
- where the transfer has already taken place, that the patient should be returned to the hospital from which he was transferred.

17. The tribunal can only make such an order where it is not satisfied that the following conditions are met:

- the patient requires to be detained in hospital under conditions of special security; and
- those conditions of special security can only be provided in a state hospital.

21. However the terms of the section are discretionary and even if either or both of these tests are not met the tribunal is not required to make an order that the transfer should not take place, or where the transfer has taken place, requiring the patient to be returned to the hospital he was transferred from.

In practice:

22. There is no provision dealing with the transfer of patients from one hospital to another when subject to an EDC, a STDC or an extension certificate.[15] However the Code of Practice[16] should be followed and consent obtained where possible. Similarly there are no provisions for Assessment Orders, Treatment Orders, Temporary Compulsion Orders or Interim Compulsion Orders.

23. In the case of *G v MHTS*, which related to a decision of MHTS not to make an order in an appeal against being detained in conditions of excessive security in terms of s264(2) of the Act, Lord Bonomy at paragraph 12 stated that:

> *…the exercise of that discretion is subject to the general rules that apply to the exercise of any discretion in particular that all relevant material should be taken into account and that material irrelevant to the exercise of discretion should be left out of account.*[17]

24. It is the tribunal's role to determine what is and what is not relevant in considering the legal tests to be applied. The section 1 principles will be relevant factors.

25. The tribunal has no power to decide that the hospital managers acted 'unlawfully' in respect of the transfer procedure.

26. The only remedy in an appeal in terms of sections 125 and section 126 is for the patient to be returned to the hospital from which he was transferred. Therefore if the tribunal consider that the test for transfer to the State Hospital is not met but that the

[14] Section 126(6) of the 2003 Act
[15] An EDC or STDC authorise detention in the named hospital or another hospital in terms sections 36(8) and 45(5) of the 2003 Act
[16] Volume 2, para 9.19
[17] [2011] CSIH 55. The Inner House decision was upheld by the Supreme Court: 2014 SC (UKSC) 84.

patient requires a level of security above that provided for in the hospital they were transferred from they cannot require the patient to be transferred to a medium secure bed, for example.

27. Section 257A listed initiator provisions apply where there is no named person and the patient lacks capacity in relation to a decision to initiate an appeal in relation to section 125 or section 126.

28. The decision by a tribunal in an appeal against transfer in terms of section 125 and section 126 is subject to the provisions in section 320 and can be appealed to the Sheriff Principal.

INTERIM COMPULSORY TREATMENT ORDERS

1. An ICTO (ICTO) is a short-term order which can be put in place by a tribunal if a substantive decision on a CTO application cannot be reached. This may be due to a number of factors, for example a party from whom evidence requires to be taken failing to attend, the need for more information which cannot be provided at that time, or the patient's wish to obtain an IMR. On the making of the interim order, any STDC in place is automatically revoked.[1] This chapter outlines key points that members should be aware of when dealing with ICTOs.

Maximum length of an ICTO

2. An interim order can be put in place for a maximum of 28 days per interim order and for no more than 56 consecutive days on two or more interim orders. When a tribunal makes an interim order, the date of the hearing where the interim order is made is considered the start date (day one) of the interim order and the start of the continuous 56 day period. Where an interim order is made, a further hearing must be held before the expiry of the interim order otherwise it will fall and the patient becomes informal. Therefore a final decision MUST be reached by the 56th day.

Measures in an ICTO

3. The compulsory measures put in place by an interim order are specified on the order form completed by the tribunal and can be either the same as sought in the original application or different, if this has been discussed and agreed at the hearing by the parties. Where an interim CTO is in place, the RMO must keep under review the need for the order and the question of whether the patient still meets the statutory conditions in section 64(5)(a) to (d) of the 2003 Act. If not satisfied of either of these conditions, the RMO must revoke the ICTO.[2]

Effect of unauthorised absence on an ICTO

4. Where a patient is subject to an ICTO authorising detention and that patient absconds from the place he is due to be detained, section 302 of the 2003 Act applies. Such a patient is liable to be taken into custody and dealt with in accordance with section 303. Section 303 provides various specified persons with powers to take the patient into custody or to return him to the hospital where he was previously detained, etc. The powers are exercisable by an MHO, a police constable, a member of staff of any hospital or any other person authorised for the purposes of section 303(1) by the patient's RMO.

5. It should be noted that the period of unauthorised absence does not affect the ICTO. The ICTO continues in effect and authorises the measures specified in it until the ICTO ceases to have effect. The patient can only be detained under section 303 for the period ending with the expiry of the ICTO which authorised the patient's detention. Where a patient subject to an ICTO has absconded but a further hearing date has been set the next hearing should take place even if the patient who has absconded has not been detained by the date of the next hearing.

[1] Section 70 of the 2003 Act
[2] Section 72 of the 2003 Act

Interim Extension or Variation of a CTO

6. A CTO can also be extended or varied on an interim basis, if appropriate, where an application under section 92 is made and the tribunal would be unable to determine an application before the CTO expires.[3]

7. Where an application is made under section 95, section 99 or section 100, there is a reference under section 96 or section 98, or the tribunal is reviewing a determination under section 101, the tribunal may make an interim order varying the measures in a CTO, including any recorded matter, where it is appropriate to do so.[4]

8. The same limitation applies in both these cases – it is *ultra vires* for the tribunal to make an interim order which would take the continuous period of the interim orders being in force to more than 56 days.[5]

9. Similar provisions apply to COs under section 168 and section 169.

Effect of Interim Orders on calculation of time periods

10. When calculating the day upon which a CTO is due to cease, any period of interim extension (including interim extension and variation) will be disregarded. Therefore if a CTO is due to expire on 20 September 2024 but an interim extension is granted to 30 September 2024 and a substantive decision is then made to extend the CTO, the start date of the new order will be 21 September 2024 and the end date will keep the same anniversary and fall on 20 September 2025.

Effect on Interim Order when application withdrawn

11. Rule 20 of the 2005 Rules makes provision for the withdrawal of certain types of applications including those under sections 50, 63, 99, 100, 120, 163, 164, 192 or 214 of the 2003 Act (excluding those which relate to applications for extension or variation of COs or to applications under section 191 of the 2003 Act, which are applications in respect to COROs) at any time, including on the day of the hearing. Where an application is withdrawn an interim order will continue until its expiry unless it is revoked. For example, if a tribunal at a first calling grants an interim CTO for 28 days and on day 21 the MHO withdraws the application for a CTO the interim CTO will continue to authorise the measures within it until day 28 unless it is revoked. There is no provision within the rules for the withdrawal of references or reviews.

In practice:

12. An IHC can put an interim order in place if an application has been received for an order which is due to expire before a hearing can be arranged (for example, an application to extend and vary received a day before the current order expires.) The IHC can make a decision based on the written application and evidence provided and issue an interim order until a date when a hearing can be fixed.

13. Directions under rule 49 of the 2005 Rules can be issued with an interim order (this is discussed in **Chapter 26**.

[3] Section105 of the 2003 Act
[4] Section 106 of the 2003 Act
[5] Section107 of the 2003 Act

LISTED INITIATORS

1. The listed initiator provisions were introduced by the Mental Health (Scotland) Act 2015. The 2015 Act removed provisions for the appointment of named persons by default so that adult patients only have a named person if they choose to have one (this does not apply to patients under the age of 16). At the same time it introduced a limited right for listed persons to appeal or make an application to the tribunal.[1] These provisions are referred to as the listed initiator provisions. The 2005 Rules were amended to make provision for applications brought by a listed initiator. This chapter explores the rules and practice around use of the listed initiator provisions.

Categories of person who fall within the Listed Initiator Provisions

2. A patient's guardian, welfare attorney, primary carer (if any) and nearest relative may apply to initiate one of the applications or appeals listed in section 257A(3) of the 2003 Act. 'Nearest relative' is defined in section 254.

Listed Initiator Requirement

3. The relevant rules relating to applications require that the listed initiator comply with the listed initiator requirement. This can be found in rule 2(1A) of the 2005 Rules. As well as the individual providing information as to the type of appeal or application they wish to lodge, the appeal must be accompanied by–

> (a) a written statement by an AMP confirming that in the opinion of that practitioner the patient is incapable in relation to a decision as to whether to initiate an application or appeal; [2] and
>
> (b) a written statement from the person making the application or appeal stating –
>
> (i) that the patient has attained the age of 16 years and has no named person;
>
> (ii) within which category of person who may initiate an appeal or application (i.e. guardian, welfare attorney, primary carer or nearest relative) the person falls;
>
> (iii) that the patient has not made a written declaration which precludes him/her from initiating the appeal or application.

Party Status

4. Listed initiators and their legal representatives are not parties to proceedings, therefore should the application or appeal be deemed valid, the listed initiator will not receive any paperwork relating to the hearing. Should they wish to seek papers, they can apply to the Tribunal under rule 46. Should they wish to be considered as a party to proceedings, they require to send a written request for leave to enter the proceedings under rule 48.[3]

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[1] Section 257A

[2] 'Incapable' is defined in the Act as meaning incapable by means of a mental disorder or of an inability to communicate because of a physical disability; but a person shall not fall within this definition by reason only of a lack or deficiency in a faculty of communication if that lack or deficiency can be made good by human or mechanical aid (whether of an interpretative nature or otherwise).

[3] See **Chapter 51**

In practice

5. An IHC will ensure that the listed initiator requirements are met before the caseworker processes such a case. So the tribunal considering the listed initiator's application or appeal need not revisit this.

6. In terms of rule 55(2)(aa), a curator *ad litem* may be appointed when an application or appeal is made by a listed initiator. An IHC will consider whether it is appropriate to appoint a curator *ad litem* in the usual way.

7. Once a final decision has been made and the case is closed down, that listed initiator status ceases. If the person who has acted as listed initiator wants to lodge any further applications, they must apply again in the same way.

MEMBER REVIEW SCHEME

1. Under their terms and conditions of appointment by the Scottish Government, members of MHTS are subject to review once in every term of appointment. This has applied since the inception of MHTS in 2005. For ordinary and legal members of the Scottish Tribunals, the Lord President is responsible for making and maintaining arrangements for training and guidance. The statutory framework is found in section 34 of the Tribunals (Scotland) Act 2014 ('the 2014 Act').

2. For the Scottish Tribunals, the Judicial Office for Scotland's Review Guidance for Members and Reviewers was issued by the Lord President under section 34(2) of the 2014 Act. In anticipation of moving into the First-tier Tribunal for Scotland, in July 2016 the Review Scheme was applied to MHTS members. The review of members is a crucial part of continuous professional development. It is an important tool which is used to ensure that judicial standards are maintained and public confidence in decisions of Tribunals in Scotland remains high.

3. Members will normally be reviewed 12 months after their initial appointment and thereafter once every three years, or at least once during their five year period of appointment. The process is designed to encourage self-analysis, reflection on each member's judicial function and to feed into training development aimed at improving the standards and consistency of services delivered by tribunal members. The review guidance sets out the principles of the review scheme which include openness, fairness and being evidence-based.

4. A reviewer is either the President or a member who has been appointed by the President and received appropriate training ('the reviewer'). The role of the reviewer is to carry out formal reviews in accordance with the Review Scheme and to provide feedback to the member. The review process may include observation of a hearing.

5. The review process is set out in the Review Guidance for Members and Reviewers.[1] In summary the process is as follows:

- The member will be notified of the upcoming review by the PO and then subsequently contacted by the reviewer. The reviewer and member will liaise about where and when the review should be completed. It may take place at an in-person hearing or the member and reviewer may arrange to speak by video conference or telephone;
- The member requires to complete a self-assessment form and two case analysis forms.[2] Legal members should also provide a copy of a redacted tribunal decision (the FFR) which they drafted. The self-assessment form requires the member to assess themselves against the review competencies which are: critical analysis and decision making; working with others; written and oral communication; knowledge and skills; and (for legal members only) convenership. Details of what is covered in each competency is provided in the Review Competencies document.[3] Once completed, the paperwork should be submitted to the reviewer two weeks before the review is due to take place. In practice there can be flexibility about this timing, as agreed between the member and the reviewer.

[1] Review Guidance for Members and Reviewers
[2] Members Self-Assessment Form; Case Analysis Form
[3] https://www.mhtscotland.gov.uk/mhts/files/ReviewCompetencies_MemberandReviewer.xlsx

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- The member and reviewer meet/speak and an in-person hearing may be observed. Discussions between the member and the reviewer may include the hearing observed, the documents submitted, the review competencies or any other matter raised by the member or reviewer.
- After the review meeting, the reviewer will complete the Review Discussion Report which will include an assessment of the member's competencies, identify their strengths and any areas which could benefit from development.[4] This report is designed to provide constructive feedback to members to assist their professional development and to improve the service provided by the Tribunal. Within 21 days of the meeting or discussion, the reviewer will then send the draft report to the member for comment. Once the terms of the report have been agreed between the reviewer and member, it will be signed by both. The member will have the opportunity to record any comments on the report. The reviewer will submit the signed report and the other documents to the President. If specific training needs are identified following the review, a personal development plan with approved timescales will be agreed.

6. The scheme allows for a re-review in two situations:

- where the member requests a second review. It will be for the President to approve such a request where there is just cause and/or there is sufficient disagreement which cannot be resolved through discussion between the reviewer and member; or
- where significant concerns following the review are raised by the reviewer and the President.

[4] Review Discussion Report

MODE OF HEARING

1. This chapter deals with the various modes of hearing. There are three main modes of hearing: in-person, video-conference and teleconference. In-person hearings take place at a physical venue. There are venues throughout Scotland located within hospital and community settings. They are ordinarily attended by all three tribunal members and the clerk as well as other relevant persons. Video-conference hearings usually take place at Hamilton House where the tribunal members and the Clerk will be co-located with other people joining via a video link. A teleconference hearing may take place with all tribunal members and the clerk in a physical venue or with the tribunal members and the clerk joining from different locations. There is guidance available as to how to conduct a hearing by teleconference.[1]

Importance of fairness

2. Wherever possible patient preference will be adhered to. There is a leaflet for patients explaining the different types of hearing.[2] However the tribunal must be satisfied that the mode of hearing is fair to all parties.[3] There will be cases where, for example, it is not appropriate to proceed to make a substantive decision at a teleconference and a hearing may need to be adjourned with a direction for a hearing to take place in-person. Reasons may include a patient or named person being unable to participate in the hearing due to a hearing impairment or communication difficulties.

Attendance by other means

3. The tribunal has significant discretion as to how it takes evidence provided that the way in which it does so is fair (rule 71 of the 2005 Rules). There may be occasions when an in-person hearing is arranged but a relevant person is unable to attend the hearing either through 'illness, age, capacity or other sufficient cause.'[4] In those circumstances it may be appropriate to take evidence from that person by telephone or via video link. However the tribunal must ensure that the evidence can be heard by all relevant persons in the room and that there is the same opportunity to cross-examine the witness as there would be had they attended in person. Before determining that evidence should be taken by telephone or video link, parties should be provided with an opportunity to make representations on this.

Relocating hearings

4. On occasion a tribunal may be asked to relocate. For example in one case a tribunal was asked to convene in a meeting room in a ward rather than in the hospital's tribunal suite due to concerns regarding the safety of escorting the patient to another area of the hospital. Any proposal must be considered carefully and canvassed fully with parties.

Deciding a case without an oral hearing - Rule 58

5. Rule 58 of the 2005 Rules gives the Tribunal the power to decide a case without an oral hearing where certain conditions are met. This is discussed in **Chapter 52**.

In practice

6. Hearings where an interpreter is required will ordinarily be arranged as an in-person hearing wherever possible.

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[1] Teleconference_Guidance_Legal_and_Sheriffs.pdf (mhtscotland.gov.uk); Teleconference_Guidance_Medical_and_General_Members.pdf (mhtscotland.gov.uk)
[2] MHTS_hearings_type_leafletV2.pdf
[3] Rule 4 of the 2005 Rules
[4] Rule 71 of the 2005 Rules

NAMED PERSON

1. This chapter deals with the role of Named Person and the rights which a Named Person has in relation to tribunal proceedings. It should be read together with **Chapter 42** on Parties and Relevant Persons. The main provisions relating to named persons can be found in Chapter 1 of Part 17 of the 2003 Act.

The role of named person

2. The Act defines 'named person' as the person (if any) who is, in relation to another person, that person's named person by virtue of the provisions within the 2003 Act[1]. The role is not dependent on a tribunal taking place.

3. The role is not defined in the 2003 Act but a named person should be involved in discussions about a patient's care. They also are a party to legal proceedings concerning the use of compulsory measures and are able to initiate appeals. When discharging functions under the 2003 Act, a person or the tribunal must consider the views of the named person before making a decision on a person's care and treatment.

Appointment of a named person

4. As of the 30th June 2018 all named persons should now be appointed by nomination, with patients no longer having a default named person unless they are under 16. Provided an individual has capacity to do so, they can appoint a person over the age of 16 to be their named person. A valid nomination requires the nominator to sign a nomination declaring they wish the proposed named person to act as their named person. This needs to be witnessed and signed by a prescribed person who certifies that the person nominating a named person understands the effects of nominating that person and has not been subject to any undue influence in making the nomination. [2] This nomination must be accompanied by a docket declaring that the person nominated consents to this and must then be signed by that individual. Unlike the nominator's signature, the nominee's signature does not need to be witnessed.[3]

Revocation of a named person

5. A person who has appointed a named person can revoke the appointment in the same way by signing a revocation document and having this witnessed and signed by a prescribed person who certifies that, in their opinion, the nominator understands the effects of revoking their named person and has not been subject to undue influence.[4]

6. If a named person decides they no longer wish to continue in that role they can stop by giving notice to that effect to the nominator; and the local authority for the area in which the nominator resides.[5]

Named person for people under the age of 16

7. A person under the age of 16 cannot appoint their own named person. Their named person will be a default named person. They will normally be a parent, however there may be cases where a local authority holds parental rights and responsibilities.[6] Where there is a dispute between two or more people who hold parental rights and responsibilities over who should be named person the named person shall be the person

[1] Section 329(1), referring to ss 250 to 254 and 257 of the 2003 Act
[2] See regulation 3 of The Mental Health (Patient Representation) (Prescribed Persons) (Scotland) Regulations 2017 (SSI 2017/175) (legislation.gov.uk)
[3] Section 250(2A)(c) of the 2003 Act having been repealed by the Coronavirus (Recovery and Reform) (Scotland) Act 2022, Pt 3 s.37(2)(b) (October 1, 2022)
[4] Section 250(4) of the 2003 Act
[5] Section 250(6) of the 2003 Act
[6] Section 252(1) of the 2003 Act

they agree upon, if they are able to. If they are not able to agree, then the person who provides on a regular basis all or most of the care and support to the child, or who did so before the child was admitted to hospital, shall be the named person.[7]

8. Although someone under the age of 16 cannot appoint a named person they can ask the tribunal to remove someone who is unsuitable. This process is dealt with in further detail below.

Named person living abroad

9. There is no such prohibition where the patient nominates a named person. A patient may nominate someone to be a named person even if that person is ordinarily resident abroad.

Mental Health Officer duties in relation to named persons

10. The provisions dealing with applications relating to the appointment of named persons are contained within sections 255 to 258 of the 2003 Act, and rule 17 of the 2005 Rules.

11. The MHO has a number of functions set out in the 2003 Act. In discharging some of those functions, the MHO requires to establish if someone has a named person, and if so ascertain who that named person is.[8] Where an MHO, having made enquiries to find out who a patient's named person is, establishes that there is a named person, and finds out who that person is, but considers that it is inappropriate for that person to be the patient's named person, the MHO must make an application for an order from the Tribunal under section 257(2)(b).[9]

Application for removal of named person

12. Other parties, including the patient and the RMO, have the power to make similar applications under section 256. The list of persons who can make such an application is detailed at section 256(2).

13. On receipt of an application for the removal of a named person, the Tribunal requires in terms of rule 17(2) to intimate that application to the other parties, and to any person whom it is proposed shall be the new named person. Those parties are then entitled to respond to the application, and those responses would be considered by the Tribunal. Parties are entitled to make representations either orally or in writing, or to lead or produce evidence. Copies of any notices of response must be sent to all other parties.

14. The tribunal's powers are contained within section 257. The tribunal may, if satisfied that it is inappropriate for the acting named person to be the patient's named person, make an order declaring that the acting named person is not the named person. Where the application relates to a person under the age of 16, the tribunal can also then appoint someone whom they detail in their decision to be the patient's named person in place of the acting named person. That person must consent to the appointment by signing a document to that effect, and that document would also need to be witnessed. Such a person can still give notice that they no longer wish to have the role and in this case would give notice to the patient, the local authority for the area in which the patient resides and the Tribunal.

[7] Section 252(2) of the 2003 Act
[8] Section 255(2) of the 2003Act
[9] The duty arises under section 255(6) of the 2003 Act

In practice

15. If a person has had their named person status revoked by a patient or by the tribunal, that person is no longer entitled to receive intimation of case papers or intimation of a hearing date. The only circumstances where it would be appropriate to intimate these details and send papers would be where either:

- the former named person had sought and was granted leave by the Tribunal to enter the Tribunal proceedings under rule 48, as a party or as a relevant person; or
- the Tribunal has decided that the person appears to have an interest. That will be a matter for either the tribunal or for an IHC to decide.

16. There is no provision in the 2003 Act which deals with a scenario where someone nominates a person to act as their named person where an order has previously been made by a tribunal under section 257(2)(b) declaring that they should not be the named person. It is likely that the declaration under section 257 would hold unless there had been some significant change of circumstances or new information has come to light.

17. Further information and guidance can be found here: Mental health law in Scotland: guide to named persons

NON-COMPLIANCE WITH STATUTORY PROVISIONS

Introduction

1. From time to time, an application submitted to MHTS under the 2003 Act will reveal a failure in compliance with a statutory provision. The question then arises of whether the application is rendered invalid. Depending on the content of the statutory provision and the nature of the non-compliance, different outcomes are possible.

Caselaw

2. Shortly after the Tribunal began sitting, in October 2005, a number of examples of this problem arose. Helpful guidance was provided in *Paterson v Kent.*[1] There, a tribunal had proceeded to consider an application under section 63 for a CTO, and granted an interim CTO, despite non-compliance with section 69.

3. In *Paterson*, because the patient had been detained in hospital on a STDC, and the application had been lodged before the expiry of that certificate, the additional five days' detention permitted by section 68 had been effected. Section 69 meant that a hearing should have taken place in that five-day period, which ended on 25 January 2006. Instead, the first hearing had been held on 31 January.

4. The Sheriff Principal held that this did not render the hearing and the interim CTO invalid. The overriding purpose of the legislation was to secure that appropriate care and treatment was provided to a person having a mental disorder. It was unlikely that Parliament intended that a failure to comply with the time limit in section 69 would result in the Tribunal being unable to determine an application properly made to it. In so finding, the Sheriff Principal relied on the decision of the House of Lords in *R v Soneji*[2], which adopted the approach of asking whether it was a purpose of the legislation being examined that an act done in breach of a specific provision concerned should be invalid.

5. In MHTS caselaw, this approach was then adopted in relation to other instances of non-compliance with the 2003 Act:

- Mistaken sequencing of section 57(1) and section 60(1) steps preceding application (giving notice of intention to apply for CTO before having both medical reports): *JG v MHTS*, 14 October 2010;
- Not lodging documents required by section 63 (omitting to include medical reports with CTO application): *N v MHO North Ayrshire* 2011 SLT (Sh Ct) 135;
- Extending CTO under section 86 without complying with section 84 and section 85 (not providing notice to MHO, to permit notification of patient): *D v MHTS* 2014 SLT (Sh Ct) 39; and
- Applying to extend CO under section 149 without compliance with section 147 (lacking MHO interview of, and provision of information to, patient): *SL v MHTS*, 8 September 2021.

6. These cases are summarised in Volumes One and Two of the MHTS Case Digest. They illustrate the courts examining the extent of non-compliance with the

[1] 2007 SLT (Sh Ct) 8

[2] [2006] 1 AC 340

statute, and also whether there has been prejudice to the patient from that non-compliance.

Prescribed outcomes

7. It may be, however, that the legislation expressly deals with the situation under examination. This can be in different ways. For instance, the legislation may specifically forbid a certain course of action, such as the granting of 'back-to-back' STDCs[3]). Or the consequences of non-compliance may be set out, such as with failure to reside at the address specified in a CTO, and persistence of that for more than three months.[4] These are not situations in which a tribunal requires to assess the presumed intention of Parliament; the express words must be given effect. As Lord Reed observed in *Shahid v Scottish Ministers*[5]: *no amount of purposive interpretation can entitle the court to disregard the plain and unambiguous terms of the legislation*.

Inferring Parliamentary intention

8. If the 2003 Act does not set out consequences of failure to comply with a particular provision, however, the approach set out above in paragraphs 4 to 6 should be adopted. It may be helpful to follow these steps:

- Define the flaw;
- Decide if the 2003 Act sets out its consequences;
- If not, confirm whether the non-compliance has been the subject of an appeal to a Sheriff Principal already;
- If not, analyse the role of the requirement in the overall scheme. How do the considerations of substantial compliance and prejudice apply to the facts?

[3] see section 44(2) of the 2003 Act

[4] see sections 301(3) and 304 of the 2003 Act

[5] 2016 SC (UKSC) 1

NON-DISCLOSURE OF DOCUMENTS

1. The Tribunal has power under rules 46A and 47 of the 2005 Rules to withhold all or part of a document from a party or parties. As withholding documents from a party goes against the rules of natural justice and the principle of fairness, this is a power which should be used sparingly and only where there is good reason.

2. Rule 46A applies where a request is made by the person sending the document to the Tribunal, for example by a MHO when they submit a CTO application or by a RMO submitting a determination to extend a CTO. Rule 47 applies where the Tribunal has a document and considers not disclosing it on its own initiative.

3. It is important to identify a specific request made under rule 46A and distinguish it from the separate issues of a patient not being given notice of a CTO application by an MHO before the application is made under section 60(1)(a) of the Act or the RMO withholding documentation about the extension of a CTO or CO under sections 87(3) and 153(3) of the 2003 Act (see paragraphs 11 and 12 below).

Rule 46A of the 2005 Rules

4. Under rule 46A, a request for non-disclosure of any document, or part of a document, should be made in writing when the document is sent to the Tribunal. For a request for non-disclosure to be considered, the person making the request must state the words or passages which they do not wish to be disclosed and give reasons for the request.

5. It is important that the person making the non-disclosure request specifies clearly whether it is the whole document or part of the document which they wish not to be disclosed. If it is part of a document, they require to specify exactly what part/s should not be disclosed and to provide reasons for the request. If so directed by the Convener or the Tribunal, the person making the request must, where practicable, supply a disclosable version of the relevant document. This means they must supply a copy of the document with redaction of the part(s) which they wish not to be disclosed.

6. Upon receipt of a request for non-disclosure, the Tribunal will determine whether the request requires to be intimated to any person. If it is decided to intimate the request, a letter or email should be sent inviting those persons to make representations within such period as may be specified, or to make representations at a hearing on a date specified in the intimation. Thereafter, the Tribunal will reach a decision on the request.

7. Rule 46A does not specify a test to be applied in considering requests under this Rule. Please note that the “serious harm” test in rule 47 does not apply to requests under rule 46A. Each request under rule 46A will be considered on its own facts and circumstances. Given the impact of such an order, as referred to above, usually it is an insufficient reason that a person may become distressed on receiving papers and some stronger reason will be required.

8. The Tribunal’s decision on the request must be intimated to the person who made the request and to any person who made representations.

Rule 47 of the 2005 Rules

9. Exceptionally, the Tribunal may decide on its own initiative that a document or report should not be disclosed to a person. Such a decision will be taken under rule 47 on the basis that disclosure may cause serious harm to the patient or any other

person such that it would be wrong to disclose it to the patient or another person, but in all the circumstances it would nevertheless not be unfair if the document or report were to be considered by the tribunal.

Possible Rule 47 interlocutors

10. Where a document or application received by the Tribunal reveals that the patient has not been given information, this may indicate circumstances in which an interlocutor under Rule 47 may be appropriate. If the following circumstances apply, the caseworker will send the papers to an IHC as a "possible Rule 47 interlocutor".

11. Where a CTO application is received by the Tribunal and an AMP has shaded the box at the top of page 6 of the mental health report form (CTO2) indicating that notice of the CTO application should NOT be given to the patient by the MHO under section 60(1)(a) of the 2003 Act, but there is no application under Rule 46A, an in-house convener should be asked if the application form (CTO1) and mental health reports (CTO2) should be withheld under rule 47 from the patient or another person. Before reaching a decision, the IHC may – but need not – appoint a person of skill to assess and report on the potential for serious harm. With or without such a report, the IHC will reach a decision on the question of disclosure. If a document is to be wholly or partly withheld, a curator may be appointed (if there is not already a curator in place). The Tribunal is obliged to notify the representative of the patient or other person to whom the document is not to be disclosed that such a decision has been made, and the reasons for it.

12. Separately when a RMO makes a determination to extend a CTO or CO then in terms of section 87(3) (CTOs) and section 153(3) of the 2003 Act (COs), the RMO has a power to withhold documentation about the RMO's extension of the order from the patient. They can do this if they consider there would be a risk of significant harm to the patient or to others from disclosure. The fact that the RMO has withheld information in this way does not change the Tribunal's duty to send the documents for the hearing to the patient but it can withhold documents if a request is granted under rule 46A or if the Tribunal decides under rule 47 that they should be withheld, as above. So if a CTO3a reveals at the foot of page 9 that a copy of the extension has not been provided to the patient, the same process will operate as in relation to CTO applications under section 63 of the 2003 Act – the case should be referred to the PO as a possible rule 47.

13. In exceptional circumstances in both the above examples the IHC may ask the caseworker to revert to the person who submitted a document, i.e. the MHO or RMO, to ask if they wish to make a specific request under rule 46A.

The decision of the tribunal

14. Non-disclosure cannot be granted under either rule 46A or 47 in relation to the decision of the tribunal i.e. the FFR and order. This is because there is a statutory requirement under paragraph 13(3) of Schedule 2 to the 2003 Act and rule 72(3) for all parties to receive notice of the decision. Additionally rules 46A and 47 relate to documents sent to the Tribunal (which the decision is not). For cases where there has previously been a non-disclosure decision made, the tribunal should very carefully consider the terms of the final decision having regard to the terms of any previous non-disclosure interlocutors.

NOTICE OF HEARINGS

1. Notice of a hearing should be given to all parties to that hearing and to other persons specified in the relevant rule in adequate time, setting out the date, time, place or method and the nature of the hearing. Rule 5 through to rule 21 of the 2005 Rules list the notification requirements for each type of application or appeal that can be determined by the Tribunal. For example, rule 6(3) lists those who should receive notice of a CTO application and includes guardians, welfare attorneys and primary carers.

2. The specific details of the notice of hearing that the Tribunal requires to issue depends on the nature of the application or appeal lodged with the Tribunal, however the notice generally requires to include the case number details, that the recipient is being afforded the opportunity to make representations (orally or in writing) and of leading or producing evidence, details of the date, time and place of the hearing and that the recipient must respond to the notice within a specified period of time.

3. In addition to the requirement to provide notice to parties, the Tribunal requires to provide notice of proceedings to any other person appearing to the Tribunal to have an interest in the application (see **Chapter 42** on relevant persons). Unlike parties, relevant persons will only receive notice of the hearing with the relevant notice requirements listed in paragraph two above; relevant persons will not receive a full copy of the hearing papers along with the notice unless an order is issued for disclosure of the papers under rule 46 or the relevant person is granted party status under rule 48.

4. Rule 2(1)(a) to (g) defines 'party' i.e. those who should be given such notice of a hearing.

5. Under Rule 2(1) 'hearing' means a sitting of the Tribunal for the purpose of enabling the Tribunal to take a decision on any matter relating to the case before it and 'notice' means notice in writing.

6. Those entitled to receive notice must be given reasonable notice of the time and place of any hearing, and of any changes to the time or place of any hearing. The period of notice will be determined by the 2003 Act and relevant rule under which the application for a hearing was made. In general, where not otherwise specified, the period of notice should be at least 14 days unless:

- the legislation or rules specify a different period in respect of the type of application being made;
- Parties specifically consent to or request a shorter period of notice for any reason including availability of parties and tribunal resources; or
- there are urgent or exceptional circumstances. (This includes urgent and time-critical applications; see 'in practice' below, for further information).

7. Where the 2003 Act or relevant rule provides a specific notice period, this is calculated in working days. (**See Chapter 24**)

8. Rule 2(3) provides that where the time specified by the rules for any act ends on a non-working day, the act is done in time if is done on the next working day.

In Practice

9. Intimation of notice of a hearing by electronic means is valid, but this is limited to email to a secure email address provided for that purpose. Notice of hearings which cannot be given by secure email should be sent in writing to the relevant party. In practice, generally only those who work in local authorities, the NHS and some solicitors' firms will have secure email. This means that patients, named persons and other parties or relevant persons who don't have a secure email address will only receive documents when delivered by post.

10. Whilst 14 days' notice is specified in the 2005 Rules, the nature of the cases and associated arrangements means that hearings set down will often be time-critical, and there will not be sufficient time to give 14 days' notice. When a matter is time critical, as long a period of notice as is possible should be given, but it is generally understood that this may be considerably shorter than 14 days in many cases.

11. The Tribunal and parties may assume that the address provided by a party or his representative is and remains the address to which documents should be sent until receiving written notice to the contrary. If a party has not attended and has not intimated any intention to do so, the Clerk may be asked to check with the Tribunal administration as to the address where notice was sent.

12. Where a party can show that improper or insufficient notice was given, they may make representations on this as a preliminary matter. It will be for the tribunal to determine, subject to the overriding objective set out in rule 4, and to the principles set out at section 1 of the 2003 Act, whether it is fair in all the circumstances to proceed with the hearing.

OBSERVERS

1. Rule 66 of the 2005 Rules provides that hearings of the mental health tribunal are held in private. There is provision within the rule for a patient to request that the hearing takes place in public. The request may be refused if one of the reasons for refusal (welfare, fairness or prejudice to the interests of justice) is present. Rule 66 also sets out who is entitled to attend a hearing in private.[1] The remainder of this section assumes that the hearing is taking place in private.

2. Individuals in training who will be involved in the mental health tribunal hearing process are permitted to attend and observe a tribunal hearing for training purposes. This includes trainee solicitors, MHOs, doctors, advocacy workers, etc. It may also, at times, be individuals who are trained but require to familiarise themselves with the tribunal hearing process.

3. There is guidance on the Tribunals' website providing information as to who can observe a tribunal hearing as well as details on information required to be submitted when making the request. Observation requests require to be emailed to the PO.

4. This guidance plus details on the information to be submitted when requesting an observation can be found on the Tribunals' website.[2]

5. The information required is;

- date and time of the hearing
- casework reference number
- observers name and job title
- reason for the request
- who the observer is observing or working with (if applicable)

6. Only when all the required information is submitted will the request be processed, therefore the onus is on the individual making the observation request to ensure all the relevant information is submitted.

7. Where a person in training has been providing a service to a patient, and that person is being supported by a more senior colleague, neither of these individuals require to seek prior approval from the President but do need to advise the relevant caseworker that their names should be added to the list of attendees.

8. The same process requires to be followed for any colleague within SCTS undergoing training within MHTS with the exception of the Clerks. Rather than contacting the PO to request the President's permission to observe every hearing on which a new Clerk will be shadowing an existing Clerk for training purposes, the President is content for the Clerk to notify the convener at the pre-hearing discussion on the day.

9. Training observations are also required to be undertaken by new tribunal members, sheriffs who have undergone training to sit on CORO hearings and new curators *ad litem*. The organising of these observations is managed by colleagues within the PO.

10. It should be noted that for any observation, consent must be sought from the convener and the patient at the time of the hearing. If the convener or patient do not give

[1] See **Chapter 42** on Parties and Relevant Persons [2] MHTS: Observation Requests

permission for the observer to attend the hearing, then unfortunately they will not be permitted to do so.

11. Only one observer is allowed per tribunal hearing. Trainees are permitted to observe no more than four tribunal hearings. Those who are familiarising themselves with the tribunal hearing process are allowed to undertake no more than two observations.

12. A minimum of two working days' notice requires to be given for any observation request.

13. The President will not grant permission to any person under 18 years of age or for the observation of Child/Adolescent hearings.

PARTIES AND RELEVANT PERSONS

1. There can be confusion at a tribunal as to who the parties, relevant persons, witnesses and attendees are. This chapter provides clarification on who is a party and who is a person entitled to be present and to be heard (a 'relevant person'). It is important to realise that a party is a relevant person, but the category of 'relevant person' also includes others who are entitled to present evidence and make submissions.[1]

Parties

2. A party is defined in the Rules as: [2]

- The person who initiated proceedings before the Tribunal (except Listed Initiators);[3]
- The patient to whom the proceedings relate;
- The Named Person for that patient;
- Any person whose decision (Direction, Order, Determination or Certificate, but not a decision by a court), is the subject of the proceedings before the Tribunal;
- Any person added as a party under Rule 48 of the 2005 Rules;
- The Scottish Ministers in any proceedings which relate to a relevant patient;
- The relevant Health Board in any proceedings under sections 264 to 271 of the 2003 Act; and
- The patient's RMO in any proceedings in relation to an application under section 164A of the 2003 Act.

3. Parties are entitled to be present throughout the hearing and will have the right to make representations, whether orally or in writing, and to lead or produce evidence. Parties will also have the right to cross-examine witnesses and to make submissions.

The Patient

4. The Act defines 'patient' as a person who has or appears to have a mental disorder. The patient in any particular case will be the person to whom the application or appeal relates.

5. The patient, as with all parties, has a right to legal representation. Where a patient is unable to instruct a solicitor in relation to tribunal proceedings a Curator *ad litem* may be appointed to represent the patient's interests. This is explored further in Chapter 23.

The named person

6. The Act defines 'named person' as the person (if any) who is, in relation to another person, that person's named person by virtue of the provisions within the 2003 Act.[4] The role of named person is explored in more detail in Chapter 37.

The MHO

[1] Rule 46 is dealt with in Chapter 50 and Rule 48 is covered in Chapter 51
[2] Rule 2(1) of the 2005 Rules
[3] Each application is made to the Tribunal under a specific section of the 2003 Act. Applications can be made by the Patient, the Named Person, Listed Initiators, mental health professionals e.g. Mental Health Officer (MHO) and Responsible Medical Officer (RMO) and the Mental Welfare Commission. Parties can therefore be different for each application.
[4] Sections 250 to 254 and s257 of the 2003 Act

7. The Act defines 'mental health officer' as meaning a person appointed (or deemed to be appointed) under section 32(1) of the 2003 Act, which imposes a duty on local authorities to appoint enough mental health officers in any particular local authority area. MHOs are qualified social workers who undergo further training to allow them to fulfil the role; the requirements for appointment are contained within directions given by Scottish Ministers.[5] The relevant local authority must designate a MHO for a patient after a relevant event.[6] They have a safeguarding role in ensuring the rights of patients are upheld and act independently of the local authority or medical practitioners.

8. The MHO has a right to be heard in all applications which come before the Tribunal and in many cases will be a party. For example, in an application for a CTO, the MHO is the person who initiates the proceedings, as they have a duty to apply for a CTO in certain circumstances.[7] The MHO will therefore be a party in an application for a CTO. In other cases the MHO will have provided consent to detention, for example in a STDC or will have a duty to prepare certain statutory reports.[8]

The RMO

9. The RMO, like the MHO, is almost always either a party or a relevant person with a right to be heard in Tribunal proceedings. The RMO is appointed by hospital managers in relation to a patient.[9] The RMO has various duties which include keeping compulsory orders under review and, where appropriate, making an application to vary these. The RMO must be an AMP which means they must satisfy the statutory requirements as to training and experience and be approved by a Health Board. [10]

The hospital managers

10. For NHS hospitals vested in Scottish Ministers, hospital managers are defined within the Act as the Health Board or Special Health Board responsible for the administration of the hospital. The provisions of section 329 of the 2003 Act specify how the managers of other hospitals are identified. In appeals against transfer between hospitals or hospital units the hospital managers are a party to proceedings.

The Scottish Ministers

11. The Scottish Ministers are a party in cases where a patient is subject to a CORO, TTD or HD, and cross border transfer cases.

Listed Initiators

12. Listed Initiators are not treated as a party to a case even where they make an application.

Persons entitled to be heard

13. The 2005 Rules provide individuals who are not a party with a right to be heard. The rules provide details of who should be sent notice of an application. This varies depending on the type of application but will include parties as well as any Curator *ad litem*, primary carer, guardian of the patient, welfare attorney and any other person appearing to the Tribunal to have an interest. Each person is notified that they are being afforded the opportunity of making representations and of leading, or producing,

[5] Mental Health (Care and Treatment) (Scotland) Act 2003 (Requirements for appointment as mental health officers) Direction 2009 and Mental Health (Care and Treatment) (Scotland) Act 2003 (Requirements for appointment as mental health officers) Direction 2006

[6] Section 229. A 'relevant event' is defined in section 232 of the 2003 Act

[7] Section 57 of the 2003 Act

[8] Sections 44(3)(d) and 45 of the 2003 Act

[9] Section 230 of the 2003 Act

[10] Section 230(1); for 'approved medical practitioner' see section 22 of the 2003 Act and **Chapter 7.**

evidence. The 2005 Rules provide that if a party or any other person is notified of an application and they wish to make representations or to lead or produce evidence they should send a notice of response to the Tribunal. By doing so they will become a relevant person for the purposes of the 2005 Rules.[11] In practice, the Tribunal does not insist on receipt of a notice of response as a precondition for relevant person status.

Primary Carer

14. A primary carer is defined within s329(1) of the 2003 Act. The primary carer is someone who provides all or most of the care and support to an individual. It does not include a person who provides such services under a contract, of employment or otherwise, or volunteers for a voluntary organisation.

Guardians and Welfare Attorneys

15. A welfare attorney is an individual authorised to act by a welfare power of attorney granted by the patient under section 16 of the Adults with Incapacity (Scotland) Act 2000 ('the 2000 Act') and registered to act as this.

16. A guardian is a person appointed as a guardian under the 2000 Act who has powers in relation to the personal welfare of another individual.

Advocacy workers

17. Every person with a mental disorder has a right to independent advocacy. Advocacy workers may attend the hearing with the patient where the patient wishes this support. At the hearing they may convey the views of the patient with the patient's agreement. An advocacy worker is not a replacement for legal representation. Please see **Chapter 4**.

Medical Practitioners who have submitted mental health reports

18. In an application for a CTO the medical practitioner who has completed a report which is submitted alongside the application is entitled to be notified of a hearing and if they attend the hearing, will be a relevant person entitled to make representations, lead and produce evidence. [12]

Other persons appearing to the Tribunal to have an interest

19. The rules provide that any other person appearing to have an interest should be notified of a hearing. This can include a wide range of individuals but commonly includes a patient's community psychiatric nurse, a key worker, or a relative who is not already included by way of being a primary carer or named person.

Persons Entitled to be present

20. A party is entitled to be present throughout the hearing. A relevant person who is not a party will ordinarily be afforded the opportunity to be present. However there will be certain circumstances where there is objection to this, for example where a patient objects to their primary carer being present throughout the hearing for reasons of privacy and confidentiality. Such cases should be dealt with sensitively. In extreme cases the provisions regarding exclusion of parties can be considered. These are dealt with in **Chapter 30.**

21. In the circumstances where a relevant person does not attend a hearing this may require to be dealt with as a preliminary matter and consideration given to whether it is appropriate to proceed in their absence.

[11] Rule 2 of the 2005 Rules
[12] Rule 6(3)(f) of the 2005 Rules and section 64(2) and 3(f) of the 2003 Act

22. The 2005 Rules provide for two situations where a person doesn't attend. The first of these is a failure to attend and the second an inability to attend.[13]

Failure of a Relevant Person to Attend

23. Where a relevant person fails to attend a hearing and the tribunal is satisfied:

- the relevant person was notified of the hearing; and
- there is no good reason for the relevant person's absence;

the tribunal may proceed to hear the case in the relevant person's absence. Any representations provided in writing by the relevant person must still be considered and where the relevant person is a party they should be given an opportunity to be heard to explain their absence and advise if they wish to proceed. In the latter case, the requirement to give an opportunity to be heard can be interpreted as meaning on the day of the hearing.[14]

Inability to attend

24. Where the convener is satisfied that any relevant person is unable to attend a hearing through illness, age, incapacity or other sufficient cause the convener may make such arrangements as they consider appropriate to hear the case fairly, including:

- for the relevant person to provide their evidence in a form the tribunal considers appropriate such as by signed statement, via telephone or videolink;
- for taking the evidence of an expert or other witness on behalf of the relevant person;
- for enabling the relevant person to make representations on the evidence; and
- for the case to be decided in the absence of the relevant person. [15]

25. It should be noted this list of steps which can be taken is not exhaustive, and before any such step is taken representations should be sought to ensure fairness.

26. There may be occasions where it is appropriate to proceed to decide a case in the absence of the relevant person and in the absence of alternative arrangements such as those set out in the first three points detailed in paragraph 24, however care must be taken. In an Employment Tribunal decision it has been held that where a party cannot attend through no fault of their own this should usually lead to an adjournment.[16]

In practice

27. The 2005 Rules provide that a party or any other person who is notified of an application and who wishes to make representations or to lead or produce evidence should send a notice of the response to the Tribunal. In practice, it is rarely the case that a person will send a notice of response. However, the Tribunal Administration has a form which is circulated to those persons who require to be notified in terms of the Tribunal Rules in relation to each application, review, appeal, reference, etc.

[13] Rules 70 and 71 of the 2005 rules
[14] Auchie D and Carmichael A, The Scottish Mental Health Tribunal: Practice and Procedure, Dundee University Press, 2010, page 70 -71
[15] It is for the convener to determine whether there is 'sufficient cause' but this may include factors such as the need to travel a far distance, or having other commitments which cannot be changed
[16] *Teinaz v London Borough of Wandsworth* [2002] EWCA Civ 1040

28. The letter the Tribunal sends to those invited to a hearing who are not parties highlights the right to request a copy of the papers in the case under Rule 46 and also the right to apply to be a party under rule 48. A factsheet explaining this has been placed on the Tribunal's website.[17]

29. When the Tribunal receives a request under rule 48[18] of the 2005 Rules for a person to be granted party status, such a request it is sent over to an IHC. If the IHC is satisfied that the request meets the requirements of rule 48(1), the IHC will ask the caseworker to intimate the request to the parties (the parties will include a Curator *ad litem* if one has been appointed to represent the patient's interests in the proceedings). A decision will then be taken on the request and any opposition to it.

30. It is not unusual to have several attendees arrive at hearings, particularly for hearings for children and young people. Too many people being present can be a source of distress and young people have spoken about how it can feel crowded and uncomfortable. There is also the issue of privacy and confidentiality. It is important to identify at the pre-hearing stage exactly who the parties, relevant persons, witnesses and attendees are. Witnesses who are not a party can be asked to leave after giving evidence.

31. In practice, if a relevant person does not attend a hearing, enquiries should be made of the Clerk in relation to this to ascertain that they were properly notified and whether there are any casenotes on CMS about this. Further to this, ordinarily members will enquire with the attendees as to whether they are aware of the relevant person's position about attending. Where there is no information, it is incomplete or there is any dubiety attempts should be made by the Clerk to contact the individual by telephone.

32. As rule 70 of the 2005 Rules refers to a 'Convener' rather than a tribunal this could be dealt with as part of case management by an IHC.

[17] www.mhtscotland.gov.uk/mhts/Applications_and_Appeals_to_the_Tribunal/Guidance

[18] See **Chapter 51**

PRESIDENT; PRESIDENT'S DIRECTIONS AND GUIDANCE

Appointment of the President; delegation of functions

1. Schedule 2 of the Mental Health (Care and Treatment) (Scotland) Act 2003 makes provision in relation to the Mental Health Tribunal for Scotland and its proceedings. Paragraph 3 of Schedule 2 provides that Scottish Ministers shall appoint a President of the Tribunal. Regulations the set out the qualifications and experience required of the person appointed.[1] That person shall preside over the discharge of the Tribunal's functions and may serve as a convener of the Tribunal. If the President is absent or otherwise unable to act, their functions may be discharged by another legal member of the Tribunal. It is also possible for the President's functions to be delegated to any of the members of the Tribunal or its staff. Regulations make detailed provision in relation to such delegation.[2]

Powers and Duties of the President

2. Paragraph 7 of Schedule 2 confers on the President the power to determine the times and places of tribunal hearings. He or she will select the members of individual tribunals. The President is also required to secure that the functions of the Tribunal are discharged efficiently and effectively. So far as administration of the Tribunal is concerned, under paragraph 7(6), the President may issue such directions and guidance as he or she considers necessary or expedient to secure the efficient and effective discharge by the Tribunal of its functions.

Practice Directions to Members

3. Paragraph 11 empowers the President to give directions as to practice and procedure to be followed by the Tribunal in relation to any matter, subject to any rules also applying to that matter. From time to time since 2005, the President has issued guidance to the members of the Tribunal. The guidance to members currently operating is set out in the **Appendix** to the Benchbook.

Annual Report and other information

4. Paragraph 14 of Schedule 2 imposes on the President a responsibility to prepare an Annual Report on the work of the Tribunal, to be submitted to Scottish Ministers who will, in turn, lay a copy before the Scottish Parliament.[3] Under paragraph 15, the President is also required to provide Scottish Ministers, or any person specified by them, with such information relating to the discharge of the Tribunal's functions as Ministers may direct.

[1] Mental Health Tribunal for Scotland (Appointment of President) regulations, SSI 2004/155)
[2] Mental Health Tribunal for Scotland (Delegation of the President's functions) regulations, SSI 2004/373
[3] These reports are available on the Tribunal's website: MHTS - President's Guidance and Directions

PRODUCTION OF DOCUMENTS

1. Documents which a party or witness intends to rely on should be lodged with the Tribunal before the hearing. In practice, such documents can include advocacy statements, independent medical reports and updated reports from a MHO and/or a RMO.

2. Rule 45(1) of the 2005 rules provides that a relevant person shall send to the Tribunal, at least seven days before a hearing, a list of documents and the documents which they wish to lead as evidence. The Tribunal may allow documents to be lodged late where it is fair and reasonable to do so in all the circumstances.

3. The Tribunal has to send all documents lodged to the parties as soon as reasonably practicable.[1] The Tribunal only sends documents by email to secure email addresses. This means that documents are usually sent by post to patients and named persons and will take longer to arrive.

4. In practice, the procedure set out in rule 45(1) is rarely followed. Reports and letters are often received from parties and attendees a day or so before the hearing and sometimes on the day of the hearing itself. This can cause difficulty in intimating these productions to those without a secure email address.

5. It is a principle of fairness that all parties are entitled to have time to consider documents lodged if they are to be relied on as evidence. Sometimes a brief adjournment at the time of the hearing may be sufficient to allow parties time to consider late documents. Alternatively it could be considered if the evidence contained in the late production (for example, an advocacy statement) could be given orally at the hearing instead. If neither of these options is appropriate then the hearing will need to be adjourned to a later date.

6. Rule 49 gives the Tribunal power to require a person to lodge a document, including written representations, by a certain date.[2]

7. Rule 59 gives the Tribunal power, on the request of a relevant person or on its own initiative, to send a citation to any person requiring that person to attend and produce any document which is in their custody or under their control.[3]

8. Please see **Chapter 31** for more information on production of independent medical reports obtained on behalf of a patient.

[1] Rule 46(1) of the 2005 Rules [2]
See **Chapter 26** (re Directions)
[3] See **Chapter 9** (re citations)

PROVISION OF DOCUMENTS GUIDANCE

1. This Guidance is a document which has been produced by the President's Office for use by caseworkers when processing cases.

2. It was first produced in 2010 and has been updated at various times since then.

3. It is available on the MHTS website.

4. The purpose of the guidance is to clarify which documents shall be provided by the Tribunal Administration to parties and tribunal members in each Tribunal application. Appendices to the Guidance list the documents required in respect of each application, appeal, reference and review. The appendices follow the numerical order of the sections of the 2003 Act to which this guidance applies.

5. The guidance applies to applications, etc. in respect of CTOs and COs.

6. The guidance does not cover applications, etc. in respect of CORO cases. A separate guidance note No. 2/2014 has been produced to clarify to whom notice and documents shall be given by the Tribunal in proceedings before it concerning restricted patients. That guidance applies to applications, references and appeals in respect of COROs, HDs and TTDs.

In practice

7. The Tribunal Administration use this guidance as a checklist for documents required in respect of the case they are processing.

8. If a tribunal member or a party requests a document not specified in the Guidance, this request should be sent over to an IHC for advice.

PRINCIPLES OF MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003; OVERRIDING OBJECTIVE

Principles of the legislation

1. In section 1 of the 2003 Act, a number of principles are set out. The principal source of these principles was the Millan report, the report of the review of the Mental Health (Scotland) Act 1984. The review was chaired by the Right Honourable Bruce Millan, former Secretary of State for Scotland, and carried out its work between March 1999 and January 2001, when the Report was laid before the Scottish Parliament. In Chapter 3 of that report, the review recommended that there should be a Statement of Principles, these being 'the principles by which the legislation should be operated'.[1] The specific principles recommended by the review reflected what are described as 'four key underlying principles'. Those are justice, autonomy, beneficence and non-maleficence ('do no harm'). In its work, the Millan Committee endeavoured to apply those principles when developing recommendations. So far as concerns operating the legislation once passed, the expectation was that the principles would be applied reflectively. They are to apply whenever a function is being discharged under the Act.

2. The content of the principles set out in section 1 is based on the Millan Report, but does not reproduce the specific wording in the Report. There are fourteen specific principles, which can be summarised as:

3. A requirement to have regard to:

- the wishes and feelings, past and present, of the patient so far as relevant;[2]
- the views of the named person, and of any carer, guardian or welfare attorney so far as relevant;
- the importance of patient participation in the discharge of the function;
- the importance of providing information and support to the patient as necessary to enable their participation;
- the range of options available;
- the importance of providing maximum benefit to the patient;
- the need to ensure no less favourable treatment of the patient as compared to someone who is not a patient;
- the patient's abilities, background and characteristics, including age, sex, sexual orientation, religious persuasion, racial origin, cultural and linguistic background and membership of any ethnic group.

4. A requirement, after having regard to the matters above, to discharge the function so as to impose only the minimum necessary restriction on the freedom of the patient.[3]

5. A requirement to have regard to:

- the needs and circumstances of any carer;

[1] Paragraph 1 of Chapter 3 of the Report.
[2] For a discussion of the need to take the patient's wishes and feelings into account in connection with a potential move from medium to low security see paragraphs 108 to 110 of *Boyle v Greater Glasgow and Clyde Health Board*, Sheriff S Reid, Glasgow Sheriff Court 4 June 2021.
[3] This principle has been held by the Supreme Court to apply to general policies for the running of a hospital, such as a ban on smoking (*McCann v State Hospitals Board for Scotland*, 2017 SC (UKSC) 121).

- the importance of providing information to assist the carer to care for the patient.

6. A requirement to have regard to:

- the importance of the provision of appropriate services to someone who is or has been detained.

7. A requirement to discharge the function in the manner that will best secure the welfare of the patient, if they are under the age of 18.

8. A requirement to discharge the function in a manner that encourages equal opportunities and the observance of equal opportunity requirements, those being defined by reference to the provisions of equal opportunities law encapsulated in Section L2 of Part II of Schedule 5 to the Scotland Act 1998.

9. It will be noted that some principles are connected more to process and some more to substance. For example, a requirement to have regard to the views of various individuals connected to the patient, such as a named person, means that, as part of its process, a hearing will need to hear from the named person, or to ask about their views if they are not present. The importance of providing services to someone who is or has been detained will invoke the principle of reciprocity, and will be relevant to the substance of the tribunal's decision.

10. The role of the principles in governing the process of the tribunal will sit alongside specific provisions of the legislation regarding the right to make representations, and to lead or produce evidence. Such provisions are generally found in all sections of the 2003 Act which reflect the right to be heard on a particular application (see, for example, section 50(2), section 64(2) and section 103(5)). So far as the substance of a tribunal's decision is concerned, the principles cannot generate a decision in contravention of the statutory criteria for a particular order. Thus, a tribunal could not refuse to revoke a STDC on the basis of a view that maximum benefit would accrue to the patient from continuing to be detained, even though the patient's decision-making about treatment is not significantly impaired. If, however, the criteria for a CTO under section 64(5) are all met, the Tribunal is empowered to make the order, but is not under a duty to do so. In practice, it is virtually unheard of for an individual tribunal to find that all the criteria for granting an application are met, yet refuse to make the order concerned, but such an outcome is theoretically possible.

Overriding objective

11. The procedural rules of the Tribunal are the 2005 Rules. Rule 4 of these sets out the overriding objective of the rules, which is to secure that proceedings before the Tribunal are handled as fairly, expeditiously and efficiently as possible.

12. Fairness, expedition and efficiency are subjective concepts and, individually, may point in opposite directions. A decision could be highly efficient, but unfair. Or a course of action which is mandated by considerations of fairness may take time and, therefore, be less expeditious. Ultimately, it is likely that, in any one case, the individual limbs of the objective will need to be balanced against each other. What constitutes an acceptable balance in a specific situation may be an assessment on which reasonable people differ. Prescription of such an overriding objective does, however, serve to promote these particular aims beyond others, and implies that a degree of case management by the Tribunal is permissible if directed to this goal. The objective covers three elements generally material to decision-making in disputes:

time, use of resources and quality. In desiderating that a just result be reached, with reasonable speed and avoiding unnecessary process, it appears uncontroversial.

13 The centrality of the overriding objective in the proceedings of the Tribunal is reinforced by its specific reference in particular rules: rule 49 regarding the making of Directions by the Tribunal and rule 63 regarding the procedure to be adopted by a tribunal in hearing an individual case. Its reach extends to both preliminary or procedural decisions, and to decisions which deal with the substance of an application.

RECALL TO HOSPITAL/BREACH OF ORDERS

1. This chapter deals with breach of compulsory measures of community-based CTOs and interim CTOs.

Attendance Requirement

2. Community based CTOs and interim CTOs may contain compulsory measures requiring the patient to attend at specified or directed places on specified or directed dates to receive medical treatment.[1]

3. Section 112 of the 2003 Act authorises the RMO to have the patient taken into custody and detained for a period of up to six hours if there is a failure to comply with the attendance requirement. The RMO can only exercise this power if they consult an MHO and the MHO consents.[2]

Breach of any measure

4. Section 113 applies where a patient is subject to either a community based CTO or interim community based CTO and fails to comply with any measure specified in the order. The RMO can have that patient taken into custody, taken to hospital and detained for a period of up to 72 hours.[3] Before exercising this power, the RMO must be satisfied that:

(a) Reasonable steps have been taken to contact the patient
(b) Where contact has been made, the patient has had a reasonable opportunity to comply with the measures
(c) Continued failure to comply is reasonably likely to cause a significant deterioration in the patient's mental health.[4]

5. One notable difference between sections 112 and 113, is that under section 113 the consent of a MHO is not required.

6. The power can be exercised whether or not the patient has a reasonable excuse for not complying with an attendance requirement; however, if the RMO and MHO are aware of the reasonable excuse, it would be expected that the power would not be exercised (under section 113) or the MHO (under section 112) would refuse to consent. The exercise of the power by the RMO is discretionary and not mandatory.

7. Once conveyed to hospital, the RMO must, as soon as reasonably practical, examine the patient or arrange for an AMP to do so. The purpose of the examination is to assess the patient's mental state and consider if further steps should be taken under sections 114 or 115.

Detention

8. Under section 114, the RMO can grant a certificate authorising continued detention for up to 28 days to allow for an application to be made under s.95 to vary the CTO. The MHO must be consulted and consent given before the power is exercised. The RMO is also expected to consult with the NP where practicable. The certificate must contain the reasons why the RMO believes detention is necessary to prevent a significant deterioration in the patient's mental health. The same process applies under section 115 for patients subject to interim community CTOs.

Revocation

9. A section 114 or 115 certificate can be revoked by the RMO under sections 117 and 118.

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[1] Section 66(1)(c) of the 2003 Act
[2] Section 112(2) of the 2003 Act
[3] See section 121 of the 2003 Act for effect on the original order.
[4] Section 113(2) of the 2003 Act

10. The patient or their NP can apply to the Tribunal for revocation of a certificate which has been granted under sections 114(2) or 115(2) of the Act. The test to be applied by the tribunal is stated in section 120(2) of the Act. The certificate should be revoked where either the RMO or tribunal are not satisfied that it is reasonably likely that there will be a significant deterioration in the patient's mental health if the patient does not continue to be detained.

11. Although the section does not state so expressly, it would appear that the effect of revocation is that the original CTO or interim CTO will continue to remain in effect up until the date on which it is due to expire.

RECORDED MATTERS

1. Currently, the tribunal only has the power to make a recorded matter in CTO cases. RMOs and patients may lodge an application under sections 95 and 100 of the 2003 Act respectively for variation of an order solely by the addition or removal of a recorded matter. In terms of section64(4)(a)(ii), the tribunal may, if satisfied that all of the conditions for granting are met, make a CTO containing measures in section 66 and:

- specifying such medical treatment, community care services, relevant services, other treatment, care or service as the Tribunal considers appropriate (any such medical treatment, community care services, relevant services, other treatment, care or services so specified being referred to in this Act as a "recorded matter").

2. Under section 329, 'medical treatment' means treatment for mental disorder; and for this purpose "treatment" includes nursing, care, psychological intervention, habilitation/rehabilitation (including education, and training in work, social and independent living skills). 'Community care services' includes residential accommodation, personal care and personal support designed to give the opportunity to live as normal a life as possible, social, cultural and recreational activities, and training and assistance in obtaining and undertaking employment. 'Relevant services' has the meaning given by section 20(2) of the Children (Scotland) Act 1995. 'Other treatment care or service' covers everything else that doesn't fall neatly within one of the other definitions, for example:

> *The Mental Health Officer (MHO) should liaise with the patient's named person and grandfather to arrange such assistance as is possible to facilitate the continued visits by family to see the patient in hospital. The MHO agreed to do this at the hearing.*

3. Recorded Matters are a means of extending the Tribunal's input into the care and treatment of a patient, particularly when there is clearly something missing. They are an important tool in addressing the principle of reciprocity and may assist in ensuring the patient receives that missing service or enable them to progress from a situation that doesn't address their care needs, for example one characterised as "a delayed discharge".

4. A recorded matter can be made at any hearing in relation to a CTO, provided the tribunal has sufficient information about the appropriateness or availability of the treatment/service in contemplation. Adjournments or interim decisions (if the criteria are met) can be considered if it is necessary to make a direction to obtain more information from specific individuals before being able to make a recorded matter.

5. If the recorded matter is directed towards a particular post holder who is not present or represented at the hearing, consideration must be given as to how the recorded matter is to be communicated to that post holder. This could take place by, for example, securing an undertaking from another party to communicate the recorded matter or by the issuing of a Direction to Tribunal Administration to communicate the making of a recorded matter.

6. If a Direction is to be issued, attempts should be made to obtain accurate contact information for the relevant post holder to allow the recorded matter to be communicated to them without delay.

7. RMOs and Patients may lodge an application under sections 95 and 100 for variation of an order solely by the addition or removal of a recorded matter, or a recorded matter may be suggested by a party or the tribunal themselves in the course of a hearing.

Framing

8. When framing a recorded matter members may want to consider the following:

- What treatment, care or service does the Tribunal consider it appropriate that the patient receives? What is missing?
- Does the tribunal have the power to specify this?
- Is it realistic and achievable that this treatment, care or service be provided to the patient?
- Who is responsible for providing this? Which organisation as opposed to individual post holder?
- By what date is it reasonable to expect the patient to be receiving the specified treatment, care or services?

Examples

- *Within two months of the date of the tribunal hearing, the MHO, or some other suitably qualified member of social work staff will carry out a Comprehensive Community Care Needs Assessment in respect of [the patient].*

- *Dr XY, Anytown Hospital, [address], the responsible medical officer for [the patient], shall make a referral to Learning Disability Services for a Speech and Language Communication Assessment for [the patient]. The referral shall be made no later than 23 December 20xx. The referral shall be made to Dr AB, Clinical Director of the Specialist Learning Disability Services, Headquarters House, Chestnut Road, Anytown. The Learning Disability Service shall prepare and produce the Speech and Language Communication Assessment no later than 23 September 20yy. If the Assessment is not available by that date, Dr XY shall refer the matter back to the Tribunal.*

- *Not later than 31st August 20xx, Countrywide Health Board shall produce, and the patient's multi-disciplinary team (under the direction of the patient's RMO) shall procure, a forensic learning disability assessment of the patient's current clinical condition. It shall include assessment of the patient's suitability for transition to a community care service."*

REPRESENTATION

1. This chapter explores who can represent a relevant person, the rights of representatives and the rules around exclusion of representatives.

Relevant persons and representation

2. A "relevant person" who initiates proceedings before the Tribunal or who wishes to take part in such proceedings has a right, if they wish, to representation at the tribunal hearing. Rule 54(3) of 2005 Rules provides: *"(3) At any hearing a relevant person may conduct the relevant person's own case (with assistance from any person if the relevant person wishes) or may be represented by any person whether or not legally qualified."* See **Chapter 42** for more on relevant persons.

Who can represent a relevant person?

3. Rule 54(3) provides that the relevant person's representative does not require to be legally qualified. Accordingly it is competent for a trainee solicitor to appear for a relevant person as a representative. It is also competent for a non-legally qualified person to act as representative. Anyone representing a party or relevant person however should not be someone who will be a witness before that particular tribunal. Representatives should not give evidence to the tribunal; they are only in attendance to represent a party or relevant person's interests.

Rights of representatives

4. Subject to the rules of exclusion (below), representatives are entitled to conduct proceedings on the relevant person's behalf including leading or producing evidence, making submissions and representations and receiving all paperwork, including a copy of any decision or order of the tribunal.

Exclusion of a relevant person's representative

5. Rule 68 allows a party's representative to be excluded if their conduct has disrupted or is likely to disrupt the tribunal or if that person's presence is likely to make it difficult for any relevant person to give evidence or make representations. In the event of a *patient's* representative being excluded the tribunal will require to consider whether or not a curator ad litem should be appointed on the patient's behalf.

In practice

6. For patients who elect to instruct a solicitor; it is a matter for each solicitor, as an officer of the Court, to satisfy themselves as to the patient's capacity to be able to provide instructions to that solicitor. It is not for the tribunal to look behind any conclusion that a solicitor has reached in this regard. In the event that a view is expressed by anybody about a patient not being capable of providing instructions, this may be brought to the patient's solicitor's attention however if the solicitor is satisfied that the patient is capable of instructing them in connection with the matter being determined by the tribunal then the hearing should proceed on this basis.

7. Tribunals should ensure they are clear regarding the status and designation of the relevant person's representative; and should record in the determination, for the avoidance of doubt, whether the relevant person has been represented by a lay representative (which would include a trainee who has not yet been admitted to the roll of solicitors and has not therefore been issued with a practicing certificate) or by a solicitor (which would include a person who has been admitted as a solicitor and has been issued with a practicing certificate).

8. In the event that a patient's representative withdraws from acting, the tribunal must consider whether or not a curator *ad litem* will be required to protect the patient's interests before proceeding. Curators *ad litem* are dealt with in **Chapter 23.**

RULE 46: DISTRIBUTION OF DOCUMENTS

1. This chapter deals with distribution and disclosure of documents in terms of rule 46 of the 2005 Rules. It should be read together with **Chapter 39** on rule 46A and rule 47 of the 2005 Rules.

2. Rule 46 requires that the Clerk shall send any document received in relation to the proceedings to parties as soon as reasonably practicable. It also includes the power to distribute any document to relevant persons. At the request of a relevant person, or on its own initiative, the Tribunal (or a Convener) may determine whether a document should also be sent to any other person. For example, a patient's welfare attorney or welfare guardian may ask for a copy of the tribunal papers in order to inform the representations they want to make to a hearing but may not wish to become a party in terms of rule 48 of the 2005 Rules.

In practice

3. Rule 46 does not set out the factors that require to be considered when such a request is made. The principles in section 1 of the 2003 Act will be of assistance. It is also necessary to consider the patient's right to privacy and confidentiality.

4. When a request for disclosure of papers is received it may be appropriate to seek the views of the parties. Where a patient lacks capacity the views of the Curator *ad litem* should be sought.

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RULE 48 REQUESTS

1. In terms of rule 48 of the 2005 Rules, any person who has an interest in a case can apply to the Tribunal for leave to enter the proceedings as either a party or a relevant person. The rights of parties and relevant persons are outlined in **Chapter 42.** In practice those who apply are likely to be a relative, welfare guardian or welfare attorney of a patient or someone else who has been involved in the patient's care.

2. An application under rule 48 must be made in writing and state the applicant's name, address, the nature of their interest and their reasons for the request.[1]

3. When the Tribunal receives such a request it must send a copy of the request to the parties and invite them to make written representations on the request, if any, by a certain time. In time critical cases a fairly short time period, for example 24 hours, may be given for such representations to be received.

4. Once any representations are received the usual practice is for an IHC to decide whether to grant the request taking account of any such representations. In terms of rule 48(5), the IHC or tribunal deciding the request must consider any representations made and if satisfied that the person who has applied has an interest in the case, and that it is reasonable to do so may grant the request. 'Interest' here means that the person has a legitimate interest in the hearing and in the outcome. Factors which are likely to be relevant include the views of the patient and the circumstances around nominating a named person. At the same time as granting the request the IHC or the tribunal will direct that the person shall be treated as a party or as a relevant person and that the request will be treated as their notice of response.

5. An application under rule 48 may be made by a person at a hearing. If all parties are present at the hearing, are able to state their positions about the request and consent to the tribunal considering it, it would be open to the tribunal to dispense with the need for obtaining written representations from the parties and to decide the request. If the person has applied to be a party (as opposed to a relevant person) then an adjournment may be required to allow them time to receive the papers.

In practice

6. When the Tribunal receives such a request it is sent over to an IHC to confirm that it meets the requirements of the 2005 Rules and that it should be actioned. If the IHC is satisfied with this, the IHC will ask the caseworker to intimate the request to the parties, including a Curator *ad litem* if one has been appointed to represent the patient's interests in the proceedings.

7. Rule 48(3) requires the Tribunal to send a copy of the request to the parties. So, when intimating a request and requesting written submissions, caseworkers should copy the wording of the request on to a word document (removing any email addresses), convert to PDF and send that document to the parties and to any Curator *ad litem,* together with an email stating:

TO PARTIES

"The Tribunal has received the enclosed written request from (enter name of person applying, relationship to patient and the patients name and CHI no) to enter proceedings as a party/relevant person [delete as appropriate] under Rule 48 of the Mental Health Tribunal for Scotland (Practice and Procedure) (No.2) Rules 2005 ("the Rules"). As you

[1] Rule 48(1) of the 2005 rules

are a party to these proceedings, in terms of Rule 48(3) of the Rules, the Tribunal invites you to make written representations about this request. These representations will be considered by the President's Office. If you wish to make written representations about this request, please email them to me by no later than (enter the date specified by the PO)."

TO CURATORS *AD LITEM*

"The Tribunal has received the enclosed written request from (enter name of person applying, relationship to patient and the patients name and CHI no) to enter proceedings as a party/relevant person [delete as appropriate] under Rule 48 of the Mental Health Tribunal for Scotland (Practice and Procedure) (No.2) Rules 2005 ("the Rules"). As you are curator ad litem for (enter name of patient), in terms of Rule 48(3) of the Rules, the Tribunal invites you to consider this request, including what the patient wants or would want - which could involve asking them - and then to make written representations on it. These representations will be considered by the President's Office. Please email written representations about this request to me by no later than (enter the date specified by the PO)."

8. No paperwork should be sent to the person until an application to be a party has been granted.

RULE 58: POWER TO DECIDE CASE WITHOUT ORAL HEARING

1. Rule 58 of the 2005 Rules gives the Tribunal the power to decide a case without an oral hearing where certain conditions are met. Essentially it means that such cases are decided by the three tribunal members considering the written evidence only.

Conditions to be satisfied before case is determined under Rule 58

2. The conditions for cases to be determined in this way are set out in rule 58(1), namely:

- the Tribunal considers that, having regard to the nature of the issues raised in the case, sufficient evidence is available to it to enable it to come to a decision without a hearing;
- to hold a hearing in this way will not be contrary to the interests of the patient;
- the Tribunal has given notice to those who require to be afforded the opportunity of making representations or of leading or producing evidence that it is proposing to dispense with an oral hearing;
- the patient has not applied for oral representations or oral evidence to be heard;
- no other person has, in the opinion of the Tribunal, shown cause why there should be an oral hearing;

Types of cases suitable for Rule 58 procedure

3. In practice, cases sometimes deemed suitable to be determined in this way are certain two year reviews (provided the previous review was not determined under rule 58), an application to extend and vary a hospital-based CTO or CO to a community-based one or an application to vary a CTO or CO in the same way. Some CORO cases, for example section 189 or 213 references, and some excessive security cases (though not under sections 265 or 269, which provide expressly for a hearing), may also be deemed suitable. Appropriate cases are identified either by the Tribunal Administration using parameters given by the PO or when a request is made by a party for the case to be determined under this rule.

Processing of rule 58 cases

4. When a case is identified as potentially suitable to be dealt with under rule 58 or this is requested, the Tribunal Administration sends the application or review papers over to an IHC or the President. They then scrutinise the application or review and assess if the conditions (a) and (b) above are met. They may decide that further information is required in which case they will ask the caseworker to request this.

5. Once the IHC or the President is satisfied that there is sufficient evidence available to enable the tribunal to reach a decision and that it would not be contrary to the interests of the patient, they will advise the Tribunal Administration to send out notice to the patient and to other notified persons of the Tribunal's proposal to dispense with oral representations and oral evidence. The Tribunal has pro-forma letters which are used for this.

6. If a patient requests an oral hearing, then an oral hearing will be scheduled. If another notified person applies for an oral hearing, the IHC or the President will decide if that person has shown cause why oral representations or oral evidence should be heard. If cause is shown an oral hearing will be fixed, otherwise the case will proceed under rule 58. A person may choose not to request oral representations or oral

evidence but may still wish to make representations. Any written representations received will form part of the Tribunal papers and will be circulated to members and parties in the usual manner.

In practice

7. The important point for members to note is that, when they receive papers for a case to be decided under rule 58, the above process has been followed and the decision has been made about the suitability for the case to be determined under this rule. Tribunal members are not required to assess whether the case is suitable for the rule 58 process when they receive papers for it. In the absence of a new factor coming to light which necessitates an oral hearing, to overturn the decision that the case should proceed in accordance with rule 58 may be contrary to the principle of finality in decision-making.

8. Rule 58 cases will usually be scheduled as a second case in a double hearing. Members should consider the case in the usual way and then complete the usual paperwork. The FFR should narrate that the case has been determined using the rule 58 procedure.

9. Advice is always available from the PO should any issue arise in relation to such cases.

SAME PANEL REQUESTS AND DIRECTIONS

Same panel to hear a matter previously considered or adjourned

1. There is no specific rule empowering the Tribunal to make a same-panel request or Direction. Consequently, there are no specific rules as to when this is appropriate and necessary. Practice Guidance issued by the Tribunal President in 2009 clarified the relevant rules which, read together, permit a same-panel Direction or request to be made.[1]

2. Rule 49 of 2005 Rules makes general provisions for a tribunal to make Directions. Rule 49(1) states:

> *Except as otherwise provided for in these Rules, the Tribunal may at any time, either on the request of a relevant person or on its own initiative, give such directions as the Tribunal considers necessary or desirable to further the overriding objective in the conduct of a case…*

3. The overriding objective is set out at Rule 4:

The overriding objective of these 2005 Rules is to secure that proceedings before the Tribunal are handled as fairly, expeditiously and efficiently as possible.

4. These two rules, when read together, permit the tribunal to make a Direction that the same tribunal members sit on any subsequent hearing of the relevant matter.

Making a Same Panel Direction

5. A Direction is an order of the tribunal and requires to be followed by the Tribunal Administration, unless the Direction is overturned on good grounds by another tribunal or by a convener sitting alone. Directions should therefore only be made where appropriate and in accordance with the overriding objective.

6. Although not specified in the 2005 rules, in general terms, the only circumstance where there is a proper legal requirement for the same decision maker(s) to hear a case is where evidence has been led before them and a hearing adjourned without a final decision having been made (i.e. the case is "part heard"). This does not generally include cases which had been concluded by, for example, the making of an interim order, or where the only issue determined by the tribunal prior to adjourning was one of procedure. Evidence in respect of the substantive application must have been heard in part.

7. Same panel Directions must be stated on a separate Directions sheet with full reasons for the direction being made.

Making a Same Panel Request

8. Where there is no proper requirement as set out above, but a panel believes that there are particular aspects of a case which would make it appropriate that it be heard by the same panel at a subsequent hearing, a same panel request may be made to the Tribunal Administration. Although the Tribunal is under no obligation to accommodate a same panel request (as opposed to a Direction) the Tribunal Administration will, in considering the request, have regard to the Principles in Section 1 of the 2003 Act and to the overriding objective set out in Rule 4.

[1] Practice Guidance 2009 – see appendix

In practice

9. Where evidence has been led but no decision has been made by the tribunal, then the same panel requires to continue to consider the case. If the same panel did not continue to consider the case then any evidence already heard by the tribunal would require to be reheard, as all members of the tribunal require to hear all the evidence led before a decision is made. In this situation, a same panel Direction is required.

10. Whilst it is clear when a same panel Direction is required, same panel requests are more subjective.

11. Same panel requests could appropriately be made in circumstances where it is considered that it would be beneficial to the patient, as having the same panel might limit the stress on the part of the patient where matters are unusually sensitive or complex, even in the context of mental health hearings. As such, these requests will arise infrequently.

12. Where an interim order has been made, in the event that the same panel was re-convened to consider making a further order that same panel would still require to be satisfied that the criteria in the 2003 Act were still met, and so would still require to hear evidence afresh.

13. Neither the 2003 Act nor the 2005 rules require the same panel to be re-convened in such circumstances. It was clearly envisaged that a different panel could sit and consider the case.

14. Members should also be mindful that patients may feel they are better served by a different panel looking at the evidence afresh and thus no perception arises that the issues have been pre-judged as a result of a decision made at an earlier hearing.

15. Where a patient requests the same panel, the tribunal should consider the reasons for the request. When granting a request, those reasons and the reasons for granting the request must be given. The tribunal should balance any perceived benefit to the patient in having the same panel against possible future perception of bias.

SHORT-TERM DETENTION CERTIFICATES

1. A short-term detention certificate ('STDC'), also known as a DET2 after the name of the mental health law form used, authorises a patient's detention in hospital for a period of up to 28 days.[1] Due to the safeguards attached to STDCs this is the preferred route for emergency detention in hospital. A person subject to a STDC may appeal against detention.

Granting of a STDC

2. In practice a STDC may be granted during the period of an emergency detention certificate (which authorises a patient's detention in hospital for 72 hours).[2] It can also be granted for someone who is living in the community, including someone subject to a community-based CTO, or who is in hospital as a voluntary patient.

3. A STDC should not be used for a patient who is subject to a community CTO but has failed to comply with the measures authorised by the order. In such circumstances a certificate under sections 113 and 114 of the 2003 Act should be used. A STDC is appropriate when the patient has become unwell and detention is required for the purpose of determining what medical treatment should be given or to give medical treatment. The MWC has produced guidance on this.[3]

4. A STDC cannot be granted if immediately before the granting of the STDC the patient is subject to a STDC, an extension certificate under section 47 (a certificate granted to extend detention under STDC for three days pending an application for a CTO being made), extension of the STDC under section 68 (extension of detention following an application to the tribunal for a CTO), the patient is detained under section 113(5) or a certificate has been granted under section 114(2) or 115(2).

5. In *R v Lothian Health Board (No. 2),*[4] Lord MacLean considered the meaning of "immediately after" in relation to a period of detention under section 26 of the Mental Health (Scotland) Act 1984. He stated that it *must…be a matter of impression in each case whether it can truly be said that the patient has been further detained immediately after the expiry of a period of detention under section 26.*[5] He held that as the patient knew the period of detention had expired; that the patient knew then that she could leave but preferred to remain voluntarily as an informal patient so her treatment could continue; that those responsible for her care in the hospital had reason to believe for some time before the period expired that they had her co-operation; and that nearly 24 hours elapsed between the expiry of the 28 day period and her further detention; the further detention was not effected immediately after the expiry of the detention. This case makes it clear that there is no absolute rule in relation to what "immediately after" may mean. Each case will depend on its own circumstances.

6. A STDC is granted by an AMP after the AMP has medically examined the patient.[6] It must be granted within three days of the medical examination. The *proforma* DET2, issued by the Scottish Government, is the form used by most detaining authorities. In the case of *LA v MHTS*[7] it was held that the completion of the DET2 was sufficient to satisfy the provisions of section 44(4) and (9) and does not require to be done with the same precision as a conveyancing document (page 2 of the DET2

[1] Section 44 of the 2003 Act
[2] Section 36 of the 2003 Act
[3] Non compliance with community compulsory treatment orders
[4] (OH) 1993 SLT 1021
[5] Ibid., at 1026F
[6] Please see Chapter 7 on AMPs.
[7] 2011 GWD 26-594

was missing and the RMO could not be sure it had been completed). In obiter remarks in the case of *Greater Glasgow Health Board v MHTS,*[8] Sheriff Principal Kerr stated that a clerical error of recording the time of medical examination did not invalidate the STDC.

7. There must be no conflict of interest in relation to the medical examination.

8. In order to grant the STDC the AMP must consider that it is likely that the following conditions are met: (a) the patient has a mental disorder; (b) as a result of the mental disorder, the patient's ability to make decisions about medical treatment is significantly impaired; (c) it is necessary to detain the patient in hospital for the purpose of determining what medical treatment should be given or giving that medical treatment; (d) if the patient were not detained in hospital there would be significant risk to the health, safety or welfare of the patient or to the safety of another person; and (e) the granting of the STDC is necessary.[9] A definitive diagnosis of the patient's mental disorder is not required. The AMP must also consult a MHO and the MHO should consent to the granting of the STDC.[10] Before deciding whether to consent to the STDC, unless it is impracticable to do so, the MHO should interview the patient and ascertain the name and address of the patient's named person.[11] The MHO should also inform the patient of the availability of independent advocacy services and take appropriate steps to ensure that the patient has the opportunity of making use of those services. The STDC cannot be granted without the consent of the MHO.

9. Unless it is impracticable to do so, the AMP should also consult the patient's named person about the proposed granting of the STDC and have regard to any views expressed by the named person.[12] Where it has not been practicable for the AMP to consult the named person in advance of granting the certificate, it would be best practice for the AMP to attempt to consult the named person as soon as practicably possible after the certificate has been granted.

Effect of STDC

10. The STDC authorises:

(i) the patient's removal to hospital, if not already in hospital at the time the STDC is granted, or to a different hospital. This removal must take place within three days after the granting of the STDC;

(ii) the detention of the patient in hospital for up to 28 days from the date of the certificate (if the patient was already in the hospital) or from the date of admission to hospital under the STDC;

(iii) the giving of medical treatment under Part 16.

11. The granting of a STDC has the effect of revoking any EDC which applied to the patient.[13]

[8] 27 February 2013 (unreported)
[9] Section 44(4) of the 2003 Act
[10] Section 44(3)(c) and (d) of the 2003 Act
[11] Section 45(1) and (2) of the 2003 Act
[12] Section 44(10) and (11) of the 2003 Act
[13] Section 55 of the 2003 Act

Notification and requirement to appoint RMO

12. The AMP has to give the hospital managers a copy of the STDC either before the patient is admitted to hospital or, if the patient is already in hospital, as soon as possible after they have signed it.[14] The hospital managers are obliged, as soon as practicable after the production to them of the STDC, to give notice of its granting to the patient, the named person, the guardian and welfare attorney of the patient. Within 7 days of the granting of the certificate, the hospital managers are required to give notice of its granting to the Tribunal and the MWC.[15]

13. The hospital managers are required to provide the patient with a range of information relating primarily to their rights and to provide them with assistance overcoming communication problems.[16]

14. The hospital managers should also appoint an AMP to act as the patient's RMO as soon as is practicable after the granting of the STDC.[17]

RMO's duty to review continuing need for detention and power to suspend detention

15. The patient's RMO is required to monitor and review the need for the STDC. Where the RMO is not satisfied that the conditions for the STDC continue to be met, the RMO should revoke the certificate.[18] Notice of the revocation should be given as stated in paragraph 11 above. The MWC also has the power to revoke a STDC but in practice this power is rarely used.[19]

16. The patient's RMO can grant a certificate suspending the detention authorised by the STDC for such period as he or she considers appropriate.[20]

Extension of STDC

17. A STDC can be extended for three days, by the granting of a certificate by an AMP under section 47 ('extension certificate'). This is to cover the situation when a patient's mental state deteriorates unexpectedly towards the end of the 28-day detention period of the STDC. The AMP has to be satisfied that the patient has a mental disorder; that the patient's ability to make decisions about medical treatment is significantly impaired; that it is necessary to detain the patient to give them medical treatment or to determine what medical treatment should be given; that there would a significant risk to the patient's health, safety or welfare or to the safety of another person, were the patient not detained; and that because of a change in mental health of the patient, an application should be made for a CTO.

18. If an application for a CTO is made during the period of a STDC or an extension period then, in terms of section 68, there will be an extension of the measures authorised by the STDC or extension certificate for a further period of five 'working days' which, in effect, means seven days.[21] Section 69 provides that, where section 68 applies, during the five working day period, the Tribunal must determine whether a CTO should made or determine the application. See **Chapter 2** on Adjournments in relation to the powers of the tribunal at a first hearing .The obligation to hold such a

[14] Section 44(6) and (7) of the 2003 Act
[15] Section 46 of the 2003 Act
[16] Sections 260 and 261 of the 2003 Act
[17] Section 230 of the 2003 Act
[18] Section 49 of the 2003 Act
[19] Section 51 of the 2003 Act
[20] Section 53 of the 2003 Act
[21] Section 68(2) of the 2003 Act. See **Chapter 24** on the calculation of days.

hearing within the five working day period is a mandatory one[22] though failure to comply with the obligation does not render a hearing held some days later incompetent, as the Tribunal is still required to deal with the application.[23]

Effect of STDC on EDC

19. The granting of a STDC has the effect of revoking any EDC in place at that time.[24]

Effect of STDC on compulsion orders, interim CTOs and CTOs

20. If a patient is subject to a CO, an interim CTO or CTO at the time a STDC or extension certificate is granted then the measures authorised by the CO, interim CTO or CTO will cease to have effect for the duration of the STDC or extension certificate.[25]

Effect of CTO or interim CTO on STDC

21. The making of an interim CTO or CTO has the effect of revoking any STDC in place and, by implication, any extension certificate.

Application to revoke STDC or extension certificate

22. Under section 50, a patient or their named person can apply to revoke a STDC or an extension certificate. Such an application can be made during any point of the STDC or the extension certificate period.

23. The Tribunal is required to send notice of the hearing (i.e. an invitation to the hearing) to the patient, the named person, any welfare guardian or welfare attorney of the patient, the AMP who granted the STDC, the MHO, the RMO (if there is one), any curator *ad litem* appointed by the Tribunal and any other person appearing to the Tribunal to have an interest in the application. The latter could include a primary carer or relative who is involved in the care of the patient. Before an application to revoke a STDC is determined, all these persons are entitled to make representations and to lead and produce evidence.[26]

24. In determining an application under section 50, the tribunal have to consider if they are satisfied that the patient has a mental disorder; that as a result of the mental disorder the patient's ability to make decisions about medical treatment is significantly impaired; that if the patient were not detained in hospital there would be a significant risk to the health, safety or welfare of the patient or the safety of another person; and that it remains necessary for the patient's detention in hospital to be authorised by the STDC i.e. could the patient be treated as an informal patient?[27]

25. If the tribunal is not satisfied that all the conditions mentioned in paragraph 24 are met then it must grant the application and revoke the STDC. The revocation by the tribunal of a STDC would have the effect of revoking any extension certificate granted.[28] Conversely, if the tribunal is satisfied that these conditions are met then the application falls to be refused. These are the only two options open to a tribunal in determining a section 50 application. In particular, the tribunal has no power to consider the validity of a STDC under section 50, for example whether there is a flaw in the STDC or if back-to-back STDCs have been granted. In these circumstances the

[22] *Smith v MHTS* 2006 SLT 347
[23] *Paterson v Kent* 2007 SLT (Sh Ct) 8
[24] Section 55 of the 2003 Act
[25] Section 56 of the 2003 Act
[26] Section 50(2) and (3) of the 2003 Act
[27] Section 50(4) of the 2003 Act
[28] Section 50(5) of the 2003 Act

appropriate remedy is for the patient to bring an application under section 291 in relation to unlawful detention.[29]

26. Very occasionally a solicitor may withdraw from acting for a patient due to the patient's inability to instruct after a section 50 application has been made. In these circumstances the Tribunal's normal course of action is to appoint a curator *ad litem* to report on, and only on, whether the section 50 application should be maintained. The wording of any interlocutor in these circumstances should be as follows:

> "The Tribunal, on intimation of the patient's solicitor having withdrawn from acting, appoints a curator *ex proprio motu* solely for the purpose of determining whether the application under section 50 of the Act should be maintained.
>
> The Tribunal appoints as curator *ad litem* ****** from the List of Curators held and maintained by the Mental Health Tribunal for Scotland."

[29] *M v MHTS* 2010 SLT (Sh Ct) 235

SPECIALIST KNOWLEDGE AND EXPERTISE

1. This chapter explores the use of knowledge and expertise of tribunal members in hearings and in making decisions.

Judicial Knowledge

2. In the law of evidence, judicial knowledge is information that it is assumed that the court is aware of and accordingly need not be proved. It is distinct from the judge's private knowledge, which cannot be used to fill a gap in the evidence. Judicial knowledge includes the content of Scots law, which includes legislation and case law.

3. It also includes facts which are so notorious no one would seriously dispute them or so obvious that it would be a pointless exercise to hear evidence on them. However caution requires to be applied and a medical or general member should not seek to fill in gaps in evidence with their knowledge.

4. Another example of where someone may argue something is within judicial knowledge is where a fact has been verified through the tribunal checking a reliable source, for example the definition of a word in the dictionary. However in an Inner House case in the Court of Session the court concluded that in the context of medical negligence the content of medical textbooks are not within judicial knowledge and would only have any value if put to a medical witness to comment upon.[1] This has application within tribunal proceedings.

Specialist Knowledge

5. The medical and general members can use their specialist knowledge to understand, interpret and assess evidence within their specialisms. They should not however use it to contradict specialist evidence from a witness unless they put this to the witness and give them an opportunity to comment.

6. The specialist knowledge of the medical and general members can also be used to assist the other members in understanding and focusing on the relevant issues before the tribunal which fall within their expertise. For example they can explain medical terminology or concepts.[2] Similarly, the legal member can explain any legal terminology to other members.

7. The use of specialist knowledge can also lead to the formulation of focused questions for the specialist witness.

A note of caution

8. There must be caution when relying on the specialist knowledge of the tribunal particularly where evidence is given which is contrary to the specialist knowledge and experience of the members. If this arises, the specialist knowledge should be tested with the witness.

9. In the case *Dugdale v Kraft Foods*, Phillips J made these comments on the use of specialist knowledge:

> *The members of industrial tribunals are appointed because of their special knowledge and experience, and we have no doubt that they are entitled to draw upon it in playing their part in assisting the tribunal as a whole to reach a decision. The main use which they will make of this knowledge and experience is for the purpose of explaining and understanding the evidence which they*

[1] *Gerrard v Royal Infirmary of Edinburgh NHS Trust* 2005 1 SC 192
[2] See *Taylor v Minister of Pensions* 1946 SLT 63 at 67

> *hear. Certainly, they are entitled to use their knowledge and experience to fill gaps in the evidence about matters which will be obvious to them but which might be obscure to a layman. More difficult is the case where evidence is given which is contrary to their knowledge and experience. If such an occasion arises, we think that they ought to draw to the attention of the witnesses the experience which seems to them to suggest that the evidence given is wrong, and ought not to prefer their own knowledge or experience without giving the witnesses an opportunity to deal with it. Provided that this opportunity is given there seems to us to be no reason why they should not draw on their own knowledge and experience in this way also. But it is highly desirable that in any case where particular use is made by an industrial tribunal of the knowledge or experience of one or more of its members in reaching their decision this fact should be stated, and that particulars of the matter taken into account should be fully disclosed.* [3]

In practice

10. It is always best to introduce any specialist knowledge held by the tribunal into the evidence, by the specialist member asking a relevant question of the right witness. Assuming the knowledge is confirmed by the witness, there is no need to rely on specialist knowledge, since the point will have been covered in oral evidence. Legal members should be alert to this when discussing specialist knowledge with tribunal colleagues.

11. It is good practice to state in the decision that a particular fact(s) are within specialist knowledge.

[3] [1977] ICR 48 (EAT)

SUSPENSION OF MEASURES

1. This chapter provides guidance on what suspension of measures is. The most common use of suspension is when the measure authorising detention in hospital is suspended to allow rehabilitation of a patient in the community. This chapter focuses mainly on this and how the periods are calculated. Unauthorised absence i.e. the effect of time not detained but not subject to a valid suspension certificate is dealt with Chapter 57.

What is Suspension of Detention?

2. Suspension of the measure authorising detention is dealt with under section 127 of the 2003 Act. The main purpose of suspension of detention is to support the patient's discharge from hospital by allowing time out of hospital.

3. The provisions in relation to suspension of hospital detention apply to EDCs (sections 41 and 42); STDCs (sections 53 and 54); CTOs, COs, ICTOs and other interim orders such as those relating to COs (sections 127 and 129). There are also provisions which relate to restricted patients including an assessment order (sections 221 to 223); a treatment order ('TO'), interim compulsion order, a temporary CO, a CORO, a HD and a TTD (sections 224 to 226). All of these latter types of orders would require the permission of the Scottish Ministers before suspension of detention.

4. To authorise or grant a suspension the RMO must complete a certificate of suspension which may specify either:

- a single period not exceeding 200 days, or
- a series of more than one individual period falling within a particular six month period.[1]

For orders involving restricted patients – TO, ICO, TCO, CORO, HD, TTD – a suspension certificate may specify either:

- a single period not exceeding 90 days; or
- a series of more than one individual period falling within a particular three month period.[2]

5. The maximum amount of suspension of detention that can be granted in a 12 month period is 200 days whenever counted from. Once the 200 day limit has been reached, no further suspension of detention can be granted.[3]

6. The RMO can revoke a suspension certificate if it is necessary to do so *in the interests of the patient or for the protection of any other person*.[4] There is no right of appeal against revocation.

Can conditions be attached to the suspension certificate?

7. There can be conditions attached to a suspension of detention certificate. Possible conditions are:

- that the patient be kept in the charge of a person authorised in writing for that purpose by the patient's RMO; and

[1] Section 127(1A) of the 2003 Act
[2] Section 224(2A) of the 2003 Act
[3] Section 127(2) and section 224(4) of the 2003 Act
[4] Section 129 of the 2003 Act

- any other conditions as may be specified by the patient's RMO.[5]

However before making any such conditions the RMO must consider it necessary in the interests of the patient or for the protection of any other person to do so. Examples of conditions which could be attached to a suspension certificate include:

- that the patient live in a specified place under the care of a specified person;
- be kept in the charge of an escorting nurse; or
- that the patient accept visits from a medical practitioner or an MHO.

8. Both the Scottish Government and the MWC good practice guidance highlight that the patient's RMO, in consultation with the patient's multi-disciplinary team, will need to give careful consideration to whether the compulsory measures specified in a patient's CTO should in fact be varied under section 95 of the 2003 Act rather than temporarily suspended.[6] However there will be occasions when it is appropriate to grant a suspension certificate as a means of assessing the patient's likely recovery in a community environment rather than in a hospital.

How to calculate the period of detention?

9. The total period that a suspension of detention certificate can authorise the suspension of measures is 200 days in any 12 month period. This is a rolling 12 month period - there must be no day when, looking back from that day, the patient has had more than 200 days suspension of detention in the previous 12 months. The 2003 Act's original provisions for suspension of detention were complex and it was difficult to calculate the period of suspension. Changes made by the 2015 Act have simplified the calculation of a period or periods of suspension.

10. Any period of suspension of detention that lasts eight hours or less does not count as a day.

11. Periods of more than eight hours but less than 24 hours count as a day toward the 200 day total (whether that period occurs within one calendar day, or spans two days).

12. Where a suspension certificate authorises a continuous period of suspension of detention of more than 28 days form SUS1a should be used for this and the MWC notified. [7] Shorter periods of suspension do not require the use of this form or notification to MWC but do require certification.

13. The maximum period of 200 days relates to the actual time that detention is suspended, not that specified or suggested on the certificate.

14. The expiry date of any suspension certificate must not go beyond the last date on which the measures that the patient is subject to would currently authorise compulsion if not revoked. This should be particularly remembered for ICTOs.

Effect of being over-limit

15. The effect of suspension of detention has been considered by the Outer House of the Court of Session. The case of *DC Petitioner*[8] considered the originally enacted provisions in s127 of the 2003 Act. The case considered whether firstly a suspension

[5] Section 127(6) and section 224(7) of the 2003 Act
[6] Interim informal guidance on suspension of detention and other measures under sections of the Mental Health (Care and Treatment) (Scotland) Act 2003 as amended by the Mental Health (Scotland) Act 2015; Suspension of Detention Good Practice Guidance
[7] Mental Health law: forms - gov.scot (www.gov.scot)
[8] 2012 SLT 521

certificate granted by a RMO which extended beyond the statutory time limit imposed by the originally enacted section 127 was *ultra vires*, and if so whether the *'unauthorised absence absconder provisions'* applied in these circumstances.

16. Another question which was considered by the court was whether the part of the suspension certificate granted which extended beyond the time limit was severable from the remainder of the certificate. This would have an impact on the calculation of the three month period in s304(3) which provides: *Where in the case of a patient who is subject of a compulsory treatment order, the patient's unauthorised absence has continued for a period of 3 months the order shall cease to have effect.* Lord Stewart concluded that the *unauthorised absence absconder provisions* did apply where the statutory time limit for a suspension of a measure had been exceeded. This means that where the 'unauthorised absence' continues for more than three months the CTO ceases to have effect. Further, he concluded that any over-limit part of a suspension certificate which authorised leave beyond the statutory limit would not be severable.[9] Central to the conclusion that the over-limit part of the Suspension Certificate was not severable is the difficulty at that time in calculating the date when the '*intra vires absence became ultra vires'.* Arguably the amendments to section 127 remedy the difficulty with calculating the period of suspension by providing a clearer way in which to calculate suspension of detention therefore it may be argued that the *DC* case can be distinguished. This is yet to be tested.

In practice

17. Where a hearing considers that the 200 day limit may have been exceeded it will be prudent to obtain the suspension of detention certificates and calculate how many days the patient had been on suspension of detention. If the patient has been on unauthorised absence in excess of three months, then the CTO will cease to have effect in accordance with section 304.

18. It is not uncommon for an application to state that the 200 days ends on a particular date but for this to be incorrect. Members should check certificates to ensure that the end date stated is correct in an application.

[9] Ibid., paragraphs 60, 74 and 78

UNAUTHORISED ABSENCE OF PATIENT[1]

1. In relation to both compulsory treatment orders and compulsion orders, the legislation includes provisions to cater for non-compliance with the measures imposed on a patient. What follows is an explanation of the interpretation and application of these provisions.

Where a patient is subject to a hospital-based CTO and absconds

2. A patient who is subject to a hospital-based CTO and who absconds from:

- a place where he or she is being kept pending being taken to hospital under the order; or
- the hospital where he or she is being detained,

may be taken into custody and may be returned to (or taken to) hospital or to any other place the patient's RMO considers appropriate.[2]

3. A patient who falls within paragraph 2 above may be taken into custody/returned any time during the three-month period beginning with the day the patient absconded.[3]

4. A patient who has absconded in the circumstances set out in paragraph 2 above is said to be on 'unauthorised absence'.[4] If such a period persists for three months, the CTO ceases to have effect.[5]

Where a patient is subject to a hospital-based CTO with detention suspended

5. The rules explained here only apply where there is in place a valid and current suspension certificate under section 127 of the 2003 Act.[6]

6. It is important to note that in all such certificates, the detention measure will have been suspended. Certain (optional) conditions may be contained in the certificate. These can be seen in the proforma suspension certificate[7] at page 3.

[1] For a useful table of the main provisions in this area, see the 2003 Act Code of Practice, Vol 2, Chapter 8, pages 220-222. Note, however, that this table is based on the original provisions in the 2003 Act, and the subsequent amendments to those provisions are not reflected there. For the most part, the table remains accurate today. All references to statutory provisions are to those in the Mental Health (Care and Treatment) (Scotland) Act 2003.
[2] Sections 301(1) (a) and 303(1) (a) and (b) of the 2003 Act
[3] Section 303(4) (a) (i) of the 2003 Act
[4] Section 304(1) of the 2003 Act
[5] Section 304(3) of the 2003 Act. It is interesting to note that this period (3 months) is the same as the period during which a patient may be taken into custody following the absconsion: section 303(4) (a)(i). This suggests that Parliament envisaged that three months was a reasonable period within which to expect such a course of action to be taken.
[6] On the tests for granting such a certificate, see section 127(5) of the 2003 Act, and the commentary discussing the choice between suspension of detention and applying to vary the order in the 2003 Act Code of Practice, Vol 2, Chapter 4, paras 36-42 (pages 110-112).
[7] SUS1A Suspension Certificate CTO or CO Detention

7. Where a suspension certificate has been issued under section 127, in certain situations a patient may be taken into custody and returned to (or taken to) hospital or to any other place considered appropriate by the patient's RMO. This can happen if the certificate includes a condition, under section 127(6), which requires:

- that the patient be kept in the charge of an authorised person AND the patient absconds from the charge of that person;
- that the patient, on being recalled to hospital or, on the expiry of a specified period or the occurrence of a specified event, returns to the hospital in which he or she was detained or other specified place AND the patient fails to comply with that condition.[8]

8. A patient who falls within paragraph 7 above may be taken into custody/returned/taken to a place any time during the three-month period beginning with the day the patient absconded.[9]

9. A patient who falls within section 127(6) is said to be on 'unauthorised absence'.[10] If such a period persists for three months, the CTO ceases to have effect.[11]

10. Where none of the conditions on page 3 of the suspension certificate has been added (so that there is only a suspension of the detention measure), a question arises as to whether it is possible for the patient to be taken into custody under section 303. This situation arose in the case of *DC Petitioner*.[12] Lord Stewart concluded that such a person ('a leave overstayer') falls to be treated as having absconded from the hospital in which he is detained. He is therefore liable to be taken into custody under section 303 and, if not so taken, able to take advantage of the provisions of section 304[13].

Where a patient is subject to a hospital-based CTO with detention suspended: the 200-day limit

11. Under section 127, taking all suspension certificates within any 12-month period (whenever counted from) together, the total period authorised must not exceed 200 days. A 'day' for this purpose is a period of over eight hours (a suspension certificate which operates for eight hours or less does not, therefore, count for the purposes of the 200-day limit).[14]

12. If the total period does exceed 200 days, there is a question over whether the patient is, from the end of the 200th day, automatically in a period of 'unauthorised absence'. It would appear to follow from Lord Stewart's analysis in the *DC* case that the answer to this is yes. During that period, the patient is liable to be taken into custody under section 303. If that does not happen, and if the period of unauthorised absence lasts for three months then, by virtue of section 304, the CTO shall cease to have effect.

Where a patient is subject to a community based CTO

[8] Section 301(2) of the 2003 Act
[9] Section 303(4)(a)(i) of the 2003 Act
[10] Section 304(1) of the 2003 Act
[11] Section 304(3) of the 2003 Act. See footnote 2 above regarding the length of this period.
[12] 2012 SLT 521
[13] Ibid., at paras [69] to [73]
[14] Section 127(1)-(2A) of the 2003 Act

13. A patient who is subject to a community-based CTO which imposes a requirement that he or she resides at a specified place (the measure under section 66(1)(e)) and who fails to comply with that requirement may be taken into custody and may be returned to hospital, returned to the place from which they absconded or failed to reside or taken to any other place the RMO considers appropriate.[15]

14. A patient who is subject to a community-based CTO which imposes a requirement that he or she obtains the approval of the MHO to any proposed change of address (the measure under section 66(1)(g)) and who changes address without having obtained that approval, may be taken into custody and may be returned to hospital, returned to the place from which they absconded or failed to reside or taken to any other place the RMO considers appropriate.[16]

15. A patient who falls within para 13 and/or 14 above may be taken into custody and returned/taken to a relevant place any time during the three-month period beginning with the day when the patient absconded or their conduct or failure first gave rise to liability to be taken into custody.[17]

16. A patient who has failed to comply, as outlined under para 13 and/or 14 above, is said to be on a period of 'unauthorised absence'.[18] If such a period persists for 3 months, the CTO ceases to have effect.[19]

Where a patient is subject to a community-based CTO which has been suspended: the 90 day limit

17. The RMO may suspend any of the non-detention measures[20] in a CTO (section 128). In theory, this applies whether the CTO is a hospital-based or community-based one. However, in practice, this power is likely to apply only to community-based CTOs. This is since the only non-detention measure which applies to a hospital-based order is the measure authorising treatment.[21] It is very difficult to imagine circumstances in which the RMO would seek to suspend that measure, while the order itself remains in place, since the provision of medical treatment (as that phrase is very widely defined in section 329(1)) is a core part of any CTO.

18. Where the RMO suspends a non-detention measure, this must be specified in the suspension certificate, and the total period of suspension (for one or more than one certificate) must not exceed 90 days.[22] Part of a day is to count as a whole day.[23]

19. Unlike the 200-day limit for suspension of the detention measure, there is no 12-month (or any other) period within which the 90-day limit applies. This means that the limit applies to each CTO.

Where a patient is subject a measure other than a full CTO

20. Where a patient is subject to an interim CTO, STDC, EDC or is detained following alleged non-compliance with a CTO (under sections 113-115) or under section 299 (nurse's power to detain pending medical examination) and absconds/fails to comply

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[15] Sections 301(3) and 303(1)(a)-(c) of the 2003 Act.
[16] Sections 301(4) and 303(1)(a)-(c) of the 2003 Act.
[17] Section 303(4)(a)(ii) of the 2003 Act.
[18] Section 304(1) of the 2003 Act.
[19] Section 304(3). See footnote 2 above regarding the length of this period.
[20] Although 'non-detention measure' is not a phrase which appears in the Act, it refers to the measures in section 66(1)(b)-(h) inclusive.
[21] Section 66(1)(b) of the 2003 Act.
[22] Sections 128(1)(b) and 128(2) of the 2003 Act.
[23] Section 128(2C) of the 2003 Act.

in circumstances similar to those set out above, the patient will be liable to be taken into custody.[24]

21. Given the unlikelihood of a situation covered by section 302 coming before a tribunal, the relevant provisions will not be covered in detail and are referred to here for completeness.

Effect of the end of a period of unauthorised absence on the underlying CTO[25]

22. Where:

- a period of unauthorised absence has come to an end (for example by the patient being taken into custody under s.301); and
- the period of unauthorised absence lasted for longer than 28 consecutive days; and
- the period of unauthorised absence ended more than 14 days before the day on which the CTO would otherwise cease to have effect,

the CTO (unless renewed) expires 14 days after the day the unauthorised absence ceased.[26] The RMO must carry out a review of the CTO within that 14-day period.[27] It is important to note, then, that in these circumstances the CTO does not simply continue to its natural conclusion if no action is taken; it ceases to have effect following the 14-day period.

24. Where:

- the period of unauthorised absence has come to an end (for example by the patient being taken into custody under section 301); and
- the period of unauthorised absence lasted for longer than 28 consecutive days, and ended on the day the CTO would otherwise have ceased to have effect or within the period of 14 days ending with that day,

the CTO (unless renewed) continues in effect until 14 days after the day the unauthorised absence ceased.[28] The RMO must carry out a review of the CTO within that 14-day period.[29]

26. Where:

- the period of unauthorised absence ceases within 3 months; and
- The date of its cessation falls after the expiry of the CTO,

the CTO is treated as having continued in effect, and continues in effect for a period of 14 days after the period of unauthorised absence ceased.[30] The RMO must carry out a review of the CTO within that 14-day period.[31]

Miscellaneous points regarding CTOs

[24] Sections 302 and 303 of the 2003 Act
[25] For the equivalent position relating to a STDC or a section 114 or 115 certificate, see section 308 of the 2003 Act.
[26] Section 305(1) of the 2003 Act
[27] Section 305(2) of the 2003 Act
[28] Section 306(1) of the 2003 Act.
[29] Section 306(2) of the 2003 Act
[30] Section 307(1) of the 2003 Act
[31] Section 307(2) of the 2003 Act

28. Where a patient is taken into custody under sections 301-303, and absconds from that custody, the patient is liable to be taken (back) into custody.[32]

29 Where a patient absconds while being transferred to another hospital or hospital unit (under sections 124 or 124A), that is treated as absconding under section 301(1)(b).

30. Although there is a general power for the RMO to take a patient into custody where there has been non-compliance with a community-based CTO (sections 113-115), the RMO may, where the provisions of sections 301-303 apply, choose to take the patient into custody using those provisions instead. [33]

Compulsion orders

31. Where a patient is subject to a compulsion order, provision to similar effect regarding unauthorised absence is made by the Mental Health (Absconding by Mentally Disordered Offenders) regulations 2005.[34] In particular, patients who abscond or fail to comply with requirements imposed on them under the 2003 Act or the Criminal Procedure (Scotland) Act 1995, are liable to be taken into custody. The specific orders and specific situations generating a liability to be taken into custody are set out in a table in regulation 2. Regulation 2 does not appear to cover restricted patients on conditional discharge.

32. Regulation 9 makes provision for lapse of the compulsion order concerned. This includes expiry of the order if the patient has been liable to be taken into custody under regulation 2 for a period of three months but this action has not been taken.

[32] Section 301(5) of the 2003 Act.

[33] For a useful discussion of which provisions to apply in order to bring a patient back into hospital – the unauthorised leave provisions or the provisions on breach of the order – see the 2003 Act Code of Practice, Vol 2, Chapter 8, paras 06-09 (pages 223-224).

[34] Mental Health (Absconding by Mentally Disordered Offenders) regulations 2005 (SSI 2005/463)

VICTIMS

Background

1. The Victim Notification Scheme (VNS) was implemented in September 2017 when the legislation setting out the terms of the VNS came into force. Victim means victim or family member of victim as, when a victim is deceased, it will be the family members of that victim who have the rights in respect of Tribunal proceedings.

2. The legislation setting out the terms of the VNS formed part of the Mental Health (Scotland) Act 2015, namely 'Part 3 Victims' Rights'. The VNS is made up of two separate strands, the right to information and the right to make representations. The Tribunal deals only with the victim's right to make representations. This is outlined in section 56 of the 2015 Act. With regard to the right to information, the Scottish Government has a duty to facilitate this and indeed has oversight of the general management of the VNS, including the registration of victims.

Process

3. The earliest part of the process happens before a case is even before the Tribunal. The Tribunal is informed of new participants in the VNS by the Restricted Patient Team at the Scottish Government. These participants are added to the President's Office 'CORO Victim Register' spreadsheet to await the arrival of a live case for the relevant patient. The CORO Team will check the Register for every case they receive to identify if there is a VNS participant listed in connection with the patient. If there is a relevant participant, the CORO team will email the 'Representations' mailbox to note that we have a new case, and to advise what type of case it is. The CORO Team then follow up with a further email to advise of the hearing date when it is set.

4. The Tribunal will check on the type of case to make sure it is a relevant case to contact a victim about. Victims must be given the opportunity to make representations on cases that are outlined in the 2015 Act. In terms of section 56(2), victims must be afforded the opportunity to make representations when a decision has to be made by the Mental Health Tribunal under section 193 of the 2003 Act (including a decision under that section as applied by section 201(3) or 204(3) of that Act).

5. A decision under section 193 will include references under sections 185, 187 and 189, and applications made under section 191 or 192. No other case types, such as excessive security, are relevant here.

6. At this point the Tribunal Liaison Officer (TLO) will take the victim liaison part of the process forward. The first step is for the TLO to email the VNS Team within the Restricted Patient Team at SG to confirm the victim(s) details held are correct – this is mainly to check the Tribunal has an accurate record all of the victims who have registered for the VNS for that patient, and to confirm if they have registered to make representations and to receive information OR only to receive information. It also assists with confirming the address details are correct. Most will have registered to make representations and receive information. The Tribunal will only contact a victim if they have registered to make representations and receive information. If a victim has chosen to register to receive information only, the VNS team in SG will be responsible for liaising with them about the outcome of the case.

7. The VNS team are likely to confirm that the details they have match those on the Tribunal's Register; if not, records are corrected. Once the correct details are

confirmed, a letter will be sent to the victim. This letter will outline the type of application the Tribunal has before it, and what decisions can be made regarding this case and will ask the victim to get in touch by a particular date to advise the Tribunal if they wish to make representations. At that point, the victim will have to intimate whether they would like to make representations in writing or orally.

Representations

8. Most victims choose to make representations in writing. If this is the case, the Tribunal will identify a deadline for submission of the written representations, to allow enough time for the representations to be issued to the tribunal and the parties (including the patient) in advance of the hearing taking place. After the representations have been checked, they are sent to the CORO team who will then issue them to the parties and tribunal in the case. The tribunal should read the written representations and should take account of these representations before making a decision about what (if any) conditions to impose on the patient's conditional discharge under section 193(7).[1] How much weight can be given to the content of the representations will need to be decided by the tribunal. When writing their decision, the tribunal should reference that they received written representations from a victim and that these were taken into account in reaching their decision – they do not have to include any of the content from the written representations.

9. If oral representations are preferred by the victim, this will be facilitated via a teleconference hearing with only the tribunal and any legal representatives for the patient, named person or Scottish Ministers in attendance. By means of an interlocutor, the patient will be excluded from attending this particular hearing. The advice given to the tribunal is that the hearing is essentially to allow victims to make their representations and the only questions that should be asked are to clarify any information the victim has given. When the victim hearing has taken place, members will simply take notes of the hearing to the patient's hearing. When writing their decision, the tribunal should reference that they attended a hearing with a victim during which the victim made representations that were taken into account when reaching their decision – they do not have to include any of the content from the oral representations in the final written decision.

Decision

10. Once the decision has been made, the CORO team will advise the TLO what the decision was. Before contacting the victim about the decision, the TLO must check that the CORO team have sent the decision to the parties in the case, to avoid the victim hearing of the decision before it is received by the patient and other parties. Whether the victim made representations or not, the Tribunal will always write to the Restricted Patient team with the outcome, as prescribed by notice given to the Tribunal under section 17E of the Criminal Justice (Scotland) Act 2003.

[1] Section 193(9A) of the 2003 Act

WITHDRAWAL OF APPLICATIONS OR APPEALS

1. In terms of Rule 20 of the 2005 Rules, an applicant may withdraw an application made to the Tribunal under section 50, 63, 99, 100, 120, 163, 164, 164A, 192 or 214 of the 2003 Act either by sending a signed notice of withdrawal to the Tribunal or at the hearing of the application. Rule 26 of the 2005 Rules makes similar provision for withdrawal of an appeal under 125, 126, 178, 201, 204, 219, 220 or 290 of the 2003 Act. In practice, applicants in other types of cases (for example an RMO applying to extend and vary or vary a CTO or CO) may also withdraw that application. The same process will be followed.

2. Any notice of withdrawal of an application received before the hearing requires to be intimated to the relevant persons.[1] Notice of withdrawal of an appeal requires to be sent to the respondent.[2]

3. If the application or appeal is withdrawn at the hearing then the applicant, or solicitor on the applicant's behalf, should be asked to complete a Notice of Withdrawal of Application/Appeal form. The Clerks have a copy of this notice and will complete the appropriate case details before passing it to the applicant for signing. If an applicant withdraws an application at a telephone conference hearing then the tribunal should adjourn to allow the applicant to complete the written notice.

4. A withdrawal will bring the case to an end without a decision by the tribunal.

5. No one has any right to object to an application or appeal being withdrawn.

In practice

6. If the application or appeal is withdrawn at the hearing, written notice of withdrawal must be signed and with the Clerk before the parties leave the hearing.

7. Where a RMO withdraws an application to vary a CTO after an interim order has been made varying the CTO, the interim order will continue in effect for its duration notwithstanding the withdrawal of the application. In this situation, the caseworker will seek the advice of an IHC on whether the hearing should be cancelled. In most cases, the hearing of the application to vary will be cancelled and the RMO will be advised that the interim order will fall after its expiry.

[1] Rule 20(2) of the 2005 Rules
[2] Rule 26(2) of the 2005 Rules

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WITNESSES

1. This chapter explores the rules relating to witnesses in tribunal proceedings.

Competency of a witness

2. There are rules relating to the competence and compellability of a person to give evidence. In some cases a person who has a mental disorder may not be a competent witness. However in MHTS proceedings the proper course of action is usually to allow the patient to give evidence while seeking to deal with matters by having regard to the overriding objective.

Attendance of a witness

3. Rule 60 of the 2005 Rules provides that evidence before the tribunal may be given orally or by signed statement however the tribunal can require the attendance of a witness in person. Citation of a witness is dealt with in Chapter 9.

4. Rule 49(1)(a) gives the tribunal the power to direct that a relevant person shall supply a list of witnesses whom they wish to call to give evidence at the hearing. In practice this power is rarely used.

5. Witnesses who are not a party do not require to be present throughout the proceedings and can be asked to leave after giving evidence. Rule 63 provides that the tribunal may exclude a witness until their time to give evidence if fair in all the circumstances. Although this does not tend to be the general practice in MHTS proceedings there can be very good reasons to adopt this approach and particularly so with child and adolescent hearings and those cases concerning a patient with a learning disability, where the number of people in a hearing should be kept to a minimum.

Compellability of a witness

6. A witness can be directed to attend a hearing or cited to attend but cannot be forced to actually give evidence. There may be cases where a patient, for example, does not wish to give evidence. Compelling a patient to do so would give rise to an issue of fairness.

Giving evidence under oath

7. Rule 63(6) provides that the tribunal may require a witness to give evidence on oath or affirmation. This rarely happens in tribunal proceedings due to the need to conduct the hearing as informally as the circumstances of the case permit.

Examination of a witness

8. Where a witness has lodged an application or a report they should be asked to confirm this and to formally adopt it into their evidence. This then reduces the matters which have to be covered in oral evidence.

Skilled Witness

9. A skilled witness is a professional providing evidence to the tribunal in that capacity. In MHTS proceedings this is likely to be a psychiatrist and a mental health officer but could also include a social worker, speech and language therapist, occupational therapist or nurse.

10. The term ‘expert witness’ is at times used interchangeably with the term ‘skilled witness’. The distinction tends to be where a specialist has been instructed as an independent specialist by a party in a case, the most common example being a

psychiatrist who is instructed to prepare an independent psychiatric report in respect of the patient. Regardless as to whether the witness is a professional working with the patient or an independent specialist the same rules of evidence apply to all skilled evidence.

11. The main distinction between a skilled witness and a non-skilled witness is that a skilled witness may state a professional opinion. The leading case in relation to skilled witnesses is a personal injury case, *Kennedy v Cordia (Services) LLP.*[1] In this case the Supreme Court examined a number of important aspects of the law on skilled evidence which apply equally to tribunal proceedings.

12. The court indicated that there are four tests which should be applied to all skilled evidence which is offered to a tribunal when deciding whether skilled evidence is admissible:

(i) whether the proposed skilled evidence will assist the [tribunal] in its task;

(ii) whether the witness has the necessary knowledge and experience;

(iii) whether the witness is impartial in his or her presentation and assessment of the evidence; and

(iv) whether there is a reliable body of knowledge or experience to underpin the expert's evidence.

13. These tests should be applied to all skilled evidence which is offered to a tribunal. These tests may be useful especially in cases where there is competing skilled evidence on a relevant point.

14. In the *Kennedy* case, the court also made a distinction between 'skilled evidence of fact' and 'opinion evidence'. Skilled evidence of fact is evidence from a skilled witness who gives an opinion and in doing so relies only on their expertise (as influenced by the work of other experts in the field) but where they have not been directly involved in the case in hand. Opinion evidence of fact is where a skilled witness gives an opinion based on both their expertise and on direct involvement in the case. The importance of the distinction between the two types of evidence is that in the case of 'opinion evidence' the admissibility test is stricter – the evidence must be necessary for the tribunal's consideration of the relevant issue – it is not enough that the evidence will be of assistance to the tribunal.

15. In giving their opinions, skilled witnesses are under special duties to the Tribunal. These are the same duties, defined by case law,[2] which apply in the public courts. The main duties of expert witnesses were outlined as follows:

(i) the expert must be independent and uninfluenced by the dispute;

(ii) they must offer independent and unbiased assistance to the tribunal;

(iii) any facts or assumptions on which their opinion is based must be stated;

(iv) any material facts detracting from their opinion must not be omitted from their evidence;

(v) if a matter falls outside the area of expertise of a witness, they must say so;

[1] [2016] UKSC 6
[2] *National Justice Compania Naviera SA v Prudential Assurance Co. Ltd.* ('The Ikarian Reefer') (No.1) [1995] 1 Lloyd's Rep 455 and *R v Lorraine Harris* [2005] EWCA Crim 1980 at 271

(vi) if insufficient data is available, the expert must indicate that their opinion is provisional;

(vii) the expert must, in their evidence, set out the full range of available expert opinion in the relevant area, even including opinion that is contrary to their own.

The tribunal is entitled, where necessary, to draw attention to these duties in appropriate cases.

The *'Ultimate Issue'* Rule

16. The 'ultimate issue' rule is an established rule in the Scots law of evidence and was affirmed in the *Kennedy* case. A skilled witness should not comment on the 'ultimate issue' – the legal test being considered by the tribunal. These are questions solely for the tribunal.

In practice:

17. It is not unusual for evidence to be interrupted during hearings due to the emotive nature of some of the subject matter. Hearings have to be carefully managed. Interruptions can be dealt with using various approaches but at all times issues of fairness have to be considered.

18. Where a witness other than a relevant person is not present the tribunal will require to hear representations on whether to adjourn the hearing to allow the evidence from that person to be heard. Factors to consider will include the reasons for non-attendance, how much bearing the evidence would have on the case and whether that evidence can be secured through other means for example by telephone, later in the day. The overriding objective in rule 4 of the 2005 Rules will be of relevance.

APPENDIX

Guidance

1. GUIDANCE TO TRIBUNAL MEMBERS No. 1/2009, revised 2024 - Same Panel Requests
2. GUIDANCE to TRIBUNAL MEMBERS No. 2/2009, revised January 2024 -Directions
3. PRACTICE DIRECTION No. 1/2010 - Citation of Witnesses
4. GUIDANCE TO TRIBUNAL MEMBERS No. 1/2013 - Guidance for Panel Members - Holding a Hearing without the aid of a clerk
5. GUIDANCE TO TRIBUNAL ADMINISTRATION No. 2/2014 – Notice and documents in Tribunal Proceedings concerning restricted patients
6. Members Newsletter January 2023
7. GUIDANCE TO TRIBUNAL MEMBERS No. 1/2023 - Foreign Language Interpreting and Translation
8. GUIDANCE TO TRIBUNAL MEMBERS No. 3/2023 - Guidance on sections 68 and 69
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