SHERIFFDOM OF NORTH STRATHCLYDE AT PAISLEY

PAI-B653-17

JUDGMENT

By

SHERIFF PRINCIPAL DUNCAN L MURRAY

In Appeal by

JH

Appellant

Against

THE MENTAL HEALTH TRIBUNAL FOR SCOTLAND

Respondent

Appellant: personally present
Respondent: Mays

PAISLEY, 24 April 2018

The Sheriff Principal, having resumed consideration of the cause, refuses the appeal.

[1] The appellant appeals against the decision of a Mental Health Tribunal (the Tribunal) on 8 August 2017 to make a hospital based care and treatment order (CTO). At the hearing

on 8 November 2017 leave was granted for the appellant to substitute the following grounds of appeal:

> "The appellant appeals against the decision of the Tribunal in terms of section 324(2)(c) of Mental Health (Care and Treatment) (Scotland) Act 2003 that the Tribunal has acted unreasonably in the exercise of its discretion.
>
> The Tribunal misused the evidence or material facts or took into account an irrelevant consideration in reaching their conclusion that the order should be made. In particular that the Tribunal should not have accepted the evidence of Dr D and the MHO."

The appellant withdrew the other grounds of appeal. Accordingly the appeal was narrowly focused on the evidential basis for the order to be made. The appellant wished to obtain a transcript of the evidence heard by the Tribunal at the hearing on 8 August 2017. The hearing was therefore continued until 14 February 2018 to allow the transcript to be obtained.

[2] When the case called on 14 February the transcript was not available. On the motion of the appellant, the hearing was continued until 14 March for receipt of the transcript. The appellant did not produce the transcript in advance of the hearing and at the hearing on 14 March 2018 and did not have complete copies of the transcript available for the court, himself and the respondent's agent. Both parties wished the appeal to proceed and to facilitate this the court arranged for additional photocopying to be undertaken to provide all parties with copies of the transcript.

The decision of the Tribunal

[3] In the "Reasons" section of the decision at page 4 the Tribunal stated:

"1. The tribunal accepted the written and oral evidence of the MHO, whom it found to be credible and reliable. The MHO had seen the medical reports by the RMO and Dr M and was in agreement with them that a hospital-based CTO was necessary.

2. The tribunal accepted as credible and reliable the evidence of Dr D, standing in for the RMO, who testified that the criteria for a hospital-based CTO were met. Dr D had been involved with the patient since the start of his admission when he had been transferred from the Royal Edinburgh Hospital. He had seen him again yesterday, he had read his notes and had discussed the case with the RMO.

3. The tribunal accepted as reliable the documentary evidence contained in the RMO's report and Dr M's report which supported the making of a hospital-based CTO."

[4] As is narrated in the Full Findings and Reasons of the tribunal, at the start of the proceedings on 8 August 2017 the appellant was represented, but the appellant's then solicitor's instructions were terminated and he withdrew from acting. The tribunal was satisfied after enquiry that the appellant was in a position to represent himself at the hearing. The appellant made clear that he wished the matter determined on the day of the hearing. The Tribunal concluded that the hearing should proceed. No challenge was made to that decision.

The statutory provisions

[5] Orders for Hospital Based Compulsory Treatment Orders are regulated by the Mental Health (Care and Treatment) (Scotland) Act 2003.

Section 63 provides:

"63 Application for compulsory treatment order
(1) An application to the Tribunal for a compulsory treatment order may be made by, and only by, a mental health officer.
(2) An application–

(a) shall specify–
(i) the measures that are sought in relation to the patient in respect of whom the application is made;
(ii) any medical treatment, community care services, relevant services or other treatment, care or service specified in the proposed care plan by virtue of section 62(5)(j) of this Act; and
(iii) where it is proposed that the order should authorise measures other than the detention of the patient in hospital, the name of the hospital the managers of which should have responsibility for appointing the patient's responsible medical officer; and
(b) shall be accompanied by the documents that are mentioned in subsection (3) below.
(3) Those documents are–
(a) the mental health reports;
(b) the report prepared under section 61 of this Act; and
(c) the proposed care plan,
relating to the patient."

Section 64 provides:

"64 Powers of Tribunal on application under section 63: compulsory treatment order
(1) This section applies where an application is made under section 63 of this Act.
(2) Before determining the application, the Tribunal shall afford the persons mentioned in subsection (3) below the opportunity–
(a) of making representations (whether orally or in writing); and
(b) of leading, or producing, evidence.
(3) Those persons are–
(a) the patient;
(b) the patient's named person;
(c) any guardian of the patient;
(d) any welfare attorney of the patient;
(e) the mental health officer;
(f) the medical practitioners who submitted the mental health reports which accompany the application;
(g) if the patient has a responsible medical officer, that officer;
(h) the patient's primary carer;
(i) any curator *ad litem* appointed in respect of the patient by the Tribunal; and
(j) any other person appearing to the Tribunal to have an interest in the application.
(4) The Tribunal may–
(a) if satisfied that all of the conditions mentioned in subsection (5) below are met, make an order–
(i) authorising, for the period of 6 months beginning with the day on which the order is made, such of the measures mentioned in section 66(1) of this Act as may be specified in the order;
(ii) 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 service so specified being referred to in this Act as a *"recorded matter"*);
(iii) recording (by reference to the appropriate paragraph (or paragraphs) of the definition of *"mental disorder"* in section 328(1) of this Act) the type (or types) of mental disorder that the patient has; and
(iv) if the order does not authorise the detention of the patient in hospital, specifying the name of the hospital the managers of which are to have responsibility for appointing the patient's responsible medical officer; or
(b) refuse the application.
(5) The conditions referred to in subsection (4)(a) above are–
(a) that the patient has a mental disorder;
(b) that medical treatment which would be likely to–
(i) prevent the mental disorder worsening; or
(ii) alleviate any of the symptoms, or effects, of the disorder,
is available for the patient;
(c) that if the patient were not provided with such medical treatment there would be a significant risk–
(i) to the health, safety or welfare of the patient; or
(ii) to the safety of any other person;
(d) that because of the mental disorder the patient's ability to make decisions about the provision of such medical treatment is significantly impaired;
(e) that the making of a compulsory treatment order in respect of the patient is necessary; and
(f) where the Tribunal does not consider it necessary for the patient to be detained in hospital, such other conditions as may be specified in regulations.
(6) Subject to subsection (7) below, an order under subsection (4)(a) above may, in addition to, or instead of, specifying some or all of the measures sought in the application to which the order relates, specify measures other than those set out in that application.
(7) The Tribunal may specify in the order under subsection (4)(a) above measures other than those set out in the application only if, before making the order–
(a) subject to subsection (8) below, the Tribunal gives notice to the persons mentioned in subsection (3) above–
(i) stating what it is proposing to do; and
(ii) setting out what those measures are;
(b) the Tribunal affords those persons the opportunity–
(i) of making representations (whether orally or in writing) in relation to the proposal; and
(ii) of leading, or producing, evidence.
(8) Where the duty under subsection (7)(a) above arises during a hearing of the application, notice need not be given under that subsection to any person mentioned in subsection (3) above who is present at the hearing.
(9) Before making regulations under subsection (5)(f) above, the Scottish Ministers shall consult such persons as they consider appropriate."

The grounds for an appeal are set out in section 324(2):

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

(2) The grounds referred to in subsection (1) above are–
(a) that the Tribunal's decision was based on an error of law;
(b) that there has been a procedural impropriety in the conduct of any hearing by the Tribunal on the application;
(c) that the Tribunal has acted unreasonably in the exercise of its discretion;
(d) that the Tribunal's decision was not supported by the facts found to be established by the Tribunal.

Submissions for the appellant

[6] The appellant challenged that there was adequate evidence before the Tribunal for them to make a hospital based CTO. He referred to the distinction between Dr D's evidence at page 4 of the transcript where he stated that:

> "I believe that Professor H is certainly suffering from a manic episode, which may well be part of a bi-polar illness, although it is probably impossible to diagnose that at present."

with the mental health report completed by Dr S at page 3 where he makes a diagnosis of mental disorder characterised as 31.2 of ICD 10 which Dr D described as "a manic episode with psychotic symptoms" (page 51 of the transcript). He also referred to Dr D's evidence at page 11 of the transcript:

> "But despite feeling that he may have had a manic depressive illness, he doesn't feel that he is currently unwell at present, and has absolutely no insight into the fact that his mood is elated and that his behaviour is totally in keeping with the manic episode and out of character for him. I believe that this lack of insight – complete lack of insight – means that his ability to make decisions about medical treatment is significantly impaired."

The appellant challenged that Dr D could validly make the characterisation, which he did, because he had only seen him for 30 minutes on 7 July 2017 when others were also in also in attendance and again on the day prior to the tribunal 7 August.

[7] The appellant accepted he was suffering from a form of manic depression. A diagnosis he indicated he had been given by Dr K in America. He challenged that the doctors had however reached such a diagnosis. He also indicated he controlled his own manic episodes and self-medicated his way out of the problem. In particular this involved treating his hypoglycaemia which he believes is a symptom of his manic depression, but Dr D appeared unaware of this. He submitted this suggested a lack of knowledge on the part of Dr D. This was reinforced by Dr D's evidence (page 60 of the transcript) that he was unaware of any research that the use, of porridge, tea and biscuits and apple juice were beneficial for the treatment for bi-polar disorder, which was indicative of Dr D's lack of detailed knowledge of manic depression. The appellant further criticised Dr D for his view (page 14 of the transcript) that there was no medical reason for the breaks for food which the appellant was requesting in the course of the hearing and for not recognising the medical need for him to eat regularly to treat his condition and therefore to support his request for breaks for food in the course of the hearing. He also referred to a passage at page 26 of the transcript where he submitted that Dr D was insufficiently familiar with the term F-A-S-T as another indication of lack of medical expertise. As a result the Tribunal should not have relied on the medical opinion of Dr D.

[8] As regards the conditions for granting the CTO, the appellant maintained that his relationship with a 32-year-old was not an indication of a mental disease, but rather, was a

miracle; that he was properly spending his own money buying a Porsche motor car, which he could afford. He submitted that what he was displaying was merely eccentric behaviour; he did not require to be locked up.

[9] Dr D was incorrect in saying his driving was dangerous (page 33 of the transcript) the appellant explained that he was a skilled driver, a trained racing driver and capable of driving at high speed.

[10] He had the funds to purchase the Porsche. As a consequence of his depression between October 2014 and June 2017 he had not spent money and had accumulated some 80,000 dollars in the bank. On this basis Dr D was in error in assuming the purchase of the Porsche was excessive as, absent an awareness of his financial position the doctor was unable to properly evaluate whether this was an excessive purchase or not.

[11] The appellant explained that at the Marriott Hotel he had undertaken a scientific experiment to explore how the hotel would respond if he had a stroke. He also undertook a further scientific experiment to explore how the police would respond if he was holding hostages. He submitted that these were genuine scientific tests and should not have been categorised as bizarre behaviours.

[12] The appellant also indicated that handing over his bank card with potential access to £2000 to his Romanian friend was perfectly normal behaviour, contrary to the position asserted by Dr D.

[13] Thus the evidential basis for Dr D's opinion was missing. He had been some three hours in the presence of the independent doctor who was to prepare the report on his behalf. The

time spent with Dr D and Dr M was insufficient to allow them to reach an informed view upon which the Tribunal could rely. Similar concerns applied as a result of the short duration of his contact with the mental health officer Mr C, as Mr C was at the time living in Spain. There had been a lack of a proper assessment when he was originally taken to the Royal Edinburgh Hospital. Accordingly, it was submitted that the evidence of Dr D and Mr C was unsatisfactory and should not have been relied on by the Tribunal.

[14] The appellant criticised the evidence of Dr D in relation to his co-operation with the investigation into his physical disorder (page 13 of the transcript). He explained that there was nothing voluntary about his receiving injections but these were given according to the timetable of the nursing staff. He reluctantly agreed to receive an injection on all occasions this was proposed so staff were not endangered by having to hold him down to administer injections. He also complained he had not received letters explaining why these injections were required. He maintained his position as identified by the chairman of the Tribunal at page 57- 58 of the transcript that Dr D was incorrect to say that he had refused treatment, and rejected Dr D's clarification that he had intermittently accepted treatment but had not done so inconsistently and that consistent acceptance of treatment was necessary to treat the condition which he believed the appellant was suffering from.

[15] The appellant challenged Dr D's assessment that he was a risk to himself and the public. The appellant pointed out that he had been released from the order on 18 September, prior to the expiry of the order on 22 December, the order itself being revoked on 29 November 2017. These dates were significant as his appeal had been accepted on 8

November and his release from the order was to avoid Dr S having to give evidence to justify the basis for his detention.

Submissions for the Mental Health Tribunal for Scotland

[16] The appellant in essence disagreed with the decision of the Tribunal and asserted that it acted unreasonably in accepting the evidence before it. Effectively his submission was that the statutory criteria were not met and the Tribunal should not have made the order. It had however to be noted that there was no evidence other than the documentary evidence: the short term order issued by Dr D, the mental health report of Dr M the GP, the report of Mr C the MHO, and the oral evidence from Dr D and Mr C the MHO before the Tribunal. Both the written evidence and the oral evidence presented to the Tribunal supported the making of the order.

[17] The thrust of appellant's complaints were that neither the MHO nor Dr D had seen him very much and Dr D was not competent and his evidence should not have been relied upon by the Tribunal. There was no substance to those complaints. Dr D was a specialist practitioner and properly qualified in the knowledge of mental and psychiatric conditions. Dr D had interviewed the appellant on the day prior to the hearing, had read the appellant's medical notes, and discussed these with Dr S the RMO and considered Dr S's report dated 28 July 2017. Dr D was perfectly able and competent to give a view and the Tribunal was entitled to find it credible and reliable. The Tribunal was also entitled to accept as reliable the written report provided by Dr S. The assertions made by the appellant did not amount to contradictory medical evidence which would have entitled the Tribunal to discount the

opinions expressed in the written reports before it and in the oral evidence from Dr D and the MHO.

[18] This was a discretionary decision of the Tribunal and under reference to *MacPhail Sheriff Court Practice 3rd Edition* paragraph 18.101 it was noted that an appellate court could only set aside the First Instance Tribunal's exercise of its discretion if satisfied that the Tribunal had not exercised its discretion at all; by exercising that discretion it had misdirected itself in law, misunderstood evidence or the material facts before it, taken into account an irrelevant consideration or failed to take into account a relevant consideration, or if its conclusion was such that no erroneous assumption of law or fact could be identified then its discretion must have been exercised wrongly.

[19] There were no such failures to be identified here for the Tribunal had taken account of all the evidence before it, had regard to the totality of that evidence, explained its findings-in-fact and reasons and was therefore entitled to make a compulsory treatment order in terms of Section 64(4)(a) of the 2002 Act where the purpose of the detention and compulsory treatment order were for the express purpose to authorise medical treatment where the patient was not content, or did not want to take that treatment. The Tribunal had given proper reasons for accepting the evidence which was presented to it and in the absence of contradictory evidence were entitled to do so.

[20] Dr D (page 4 of the transcript) stated that the appellant was suffering from depression and at page 36 gave some evidence of his beliefs at that time. The RLO was of the view section 4 of his report that medical treatment and medication was available and likely

to alleviate the symptoms of the appellant's mental disorder. The tribunal was entitled to find this to be acceptable evidence of mental illness which treatment was likely to alleviate.

[21] Findings-in-fact 3 and 4 on page 5 of the decision were unimpeachable. It is expressly narrated there that the appellant had cross-examined Dr D. Dr D had refuted any suggestion that he may have been unreasonable, repeated by the appellant in the course of this appeal. The Tribunal explained that they accepted the oral evidence of Dr D which echoed the evidence contained in the RLO's report and the report from Dr M that the appellant was suffering from inflated self-esteem and grandiose delusions. At page 41 of the transcript Dr D explained that he found the appellant's association with a "Romanian prostitute" concerning but he had greater concern about the experiment about how the hotel staff would respond if Professor H had a stroke or how the police would respond to a hostage situation. Dr D had specifically expressed an opinion that the patient believed he had magical powers, coupled with disinhibited actions and was behaving irresponsibly. It was perfectly reasonable for the tribunal to reach the view that the money which the appellant was prepared to give to the lady suggested that he was at risk of financial exploitation.

[22] Testing the response of the police to an alleged hostage situation or the management of the hotel's response to his having a stroke clearly demonstrated extremely unusual behaviour. In relation to the appellant's aggression at page 3.6 of Dr S's report, it was identified that there was a risk the appellant's own welfare and that of others. It can be seen why the tribunal preferred the evidence of the RMO and Dr M whose findings were

supported by Dr D in the transcript at page 11, citing a lack of insight and impaired decision-making by the appellant.

[23] The final statutory criteria for determining a CTO was necessary required that the Tribunal was satisfied that the appellant would not take medication on a voluntary basis and the Tribunal required to be satisfied there had to be compulsion. The evidence of the RMO and Dr M were of the view that it was necessary. The appellant had not indicated that he was happy to comply with treatment. Dr D's evidence was that the appellant's willingness to take medication was intermittent and he was not willing to stay in hospital to voluntarily accept treatment and had absconded on two occasions. Accordingly the Tribunal were entitled to be satisfied this ground for granting the order was also satisfied and the appeal should be refused.

Decision

[24] The grounds of appeal were that the Tribunal misused the evidence, or material facts or took into account an irrelevant consideration in reaching their conclusion that the order should be made. In particular the appellant focused on a submission that that the Tribunal should not have accepted the evidence of Dr D and to a lesser extent the evidence of the MHO. I have no doubt that it falls to be refused. There was adequate evidence before the Tribunal that the statutory basis for granting an order were satisfied. Indeed there was no contradictory evidence. The appellant accepted that he did not even know whether the independent psychiatrist who had examined him had reached a view that an order should not be made as the report had never been produced after he withdrew instructions from his solicitor.

[25] I accept that Dr D was qualified to give expert evidence and that the Tribunal was entitled to accept his evidence that the conditions for granting a CPO were established. That was also the view of the MHO and the views set out in the report by the RMO and Dr M. The Tribunal were entitled to prefer this evidence to the positon of the appellant that his behaviour was merely eccentric and that he was not a danger to himself or others. The Tribunal findings that the appellant suffered from a metal disorder that treatment was available to alleviate the effects of the disorder and of the risk to the appellant and others if treatment was not provided were clearly justified on the basis of the evidence as explained by the Tribunal on pages 5 - 7 of their decision. Nothing said by the appellant or referred to in the transcript establishes that those findings were unjustified or plainly wrong.

[26] There is no basis in which the decision can be said to be unreasonable or deficient in a manner which would entitle me to interfere with it. Accordingly the appeal falls to be refused.

D L MURRAY