SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE

PER-B41-21

JUDGMENT OF SHERIFF PRINCIPAL M LEWIS

in appeal by

[redacted]

Appellant

against

MENTAL HEALTH TRIBUNAL FOR SCOTLAND

Respondent

Appellant: [redacted] Advocate; [redacted]
Respondent: [redacted], Advocate; The Mental Health Tribunal for Scotland

[redacted], 27 July 2021

Introduction

[1] [redacted] has a diagnosis of schizo-affective disorder. He has been involved with mental health services since 1980. A Compulsory Treatment Order ("CTO") was granted on 5 December 2013. He resides at [redacted] Nursing Home where he receives in-patient care and assessment of his mental health and treatment requirements as well as treatment, support and supervision.

[redacted]

[2] The CTO has been extended on several occasions. It was scheduled to cease on 4 December 2020. Prior to the expiry date, the then Registered Medical Officer ("RMO"), [redacted] made a determination on 27 November 2020 under section 86 of the Mental Health (Care & Treatment) (Scotland) Act 2003 ("the 2003 Act") to extend the order for a further period of 12 months from 05 December 2020.

[3] On 09 December 2020 [redacted] submitted an application to the Mental Health Tribunal for Scotland ("the tribunal") in terms of section 99(1) for revocation of that determination because he believes that he does not require to be detained in hospital. The application was amended on 13 January 2021. The effect of the amendment was to include [redacted]. She is the sister of [redacted] and is his nominated named person in this process.

[4] At a hearing on 17 February 2021 the tribunal confirmed the determination in terms of section 103(2)(c). [redacted] decided to challenge that decision and has appealed to this court under section 320(2).

The hearing on 03 February 2021

[5] A hearing was scheduled to take place on 03 February 2021 by way of telephone conference call (due to the ongoing pandemic).

[6] [redacted] was present as was his trainee solicitor, [redacted]. However [redacted] did not attend. The tribunal was advised that [redacted] had vacated office and a replacement had not been appointed. The Mental Health Officer ("MHO"), [redacted], was not present but had arranged for a substitute to attend the hearing. The only medical assessment (form CTO3a) available to the tribunal was dated 27 November 2020.

[redacted]

[7] These unfortunate events led the tribunal to unanimously conclude that the interests of justice lay in adjourning the hearing to 17 February 2021 to enable the MHO to attend and also for a replacement RMO to be appointed. The tribunal issued a direction under Rule 49 of the Mental Health Tribunal for Scotland (Practice and Procedure) Rules 2005 ("the 2005 Rules"). The tribunal directed the Director of Medical Services at [redacted] Hospital [redacted] to (1) notify the tribunal within one week of the name of the RMO for [redacted] and (2) ensure the participation of the RMO or substitute to speak at the adjourned hearing. The tribunal is to be commended for taking such a prompt and practical approach to enable effective participation without further delay.

The hearing on 17 February 2021 and outcome

[8] On 17 February 2021 the hearing was conducted by telephone conference call. [redacted] attended the hearing and was accompanied by his solicitor and an advocacy worker.

[9] The tribunal had before it the following written material:–

- The application;
- The amendment to the application;
- Email from [redacted], solicitors, dated 01 February 2021;
- The tribunal decision of 10 December 2019;
- The determination of the RMO dated 26 November 2020;
- The advanced statement of [redacted] dated 01 November 2016;
- Interim decision of the tribunal dated 03 February 2021;
- The Rule 49 direction.

[redacted]

[10] The tribunal records at paragraph 12 of its decision "We heard oral evidence from all parties listed in paragraph 6." Those parties are:–

- [redacted];
- [redacted]
- [redacted]
- [redacted] (advocacy worker);
- [redacted] (trainee solicitor).

[11] [redacted] advised the tribunal that he had been appointed as RMO for [redacted] but had only taken up post on 08 February 2021. He had not had the opportunity to meet [redacted] although he did have access to the patient's medical case notes. The medical notes were not lodged.

[12] [redacted] did not attend. Her views were conveyed to the tribunal by the MHO, who "avised [redacted] believes that her brother requires to be subject to an order at this time for his care and treatment". Submissions and representations were made on behalf of the appellant by his solicitor and by his advocacy worker, [redacted].

[13] Based on the evidence, oral and written, the tribunal found that [redacted] has a mental disorder; his illness is characterised by persecutory and grandiose delusions with religious contents; he has mood congruent auditory hallucinations believing that he has been accused as a paedophile. The tribunal also found that without compulsory measures [redacted] would not reliable comply with medication and it would not be possible to treat him on a voluntary basis at this time. Accordingly the tribunal, having regard to the statutory principles set out in section 1 and to those matters set out in section 3, was satisfied that the statutory tests contained in section 64(5)(a)-(e) were met, and confirmed the determination in terms of section 103(2)(c) of the 2003 Act.

[redacted]

Grounds of appeal

[14] There are three grounds of appeal.

(i) The tribunal's decision was based on an error of law in that there was insufficient evidence before the tribunal to enable it to find as a matter of fact that the criteria for a CTO continued to be met.

(ii) The tribunal erred in law by failing to give adequate reasons to support its decision.

(iii) There has been a procedural impropriety in the conduct of the hearing involving a breach of Rule 45(1)(a) of the 2005 Rules in that the tribunal permitted the RMO to give evidence by reference to medical notes that were not lodged in process thus depriving the appellant of the opportunity to properly prepare for and participate in the hearing.

Submissions

The first ground of appeal

[15] For the appellant, [redacted] adopted his note of argument which he then supplemented considerably, at times appearing to introduce argument which had no foundation in the note of appeal.

[16] He submitted that when the liberty of an individual is at stake, there is a burden on the state to justify continued detention, and the state carries that burden throughout every stage of the process. The burden of proof lies with the RMO and the MHO to justify interference with [redacted] Article 5 right to liberty and security, even where an

[redacted]

application is brought by the patient (*Hutchison Reid v United Kingdom* 2003 37 EHRR 9 paras. 60-74), as here.

[17] Section 230(1) imposes a duty on the relevant managers to appoint an RMO as soon as possible after the occurrence of certain events. The effect of section 230(3)(a) and (b) is that there must always be an RMO and should a vacancy arise it must be filled as soon as reasonably practicable. The vacancy was not filled for 92 days. The role of the RMO is of considerable importance. The making of a CTO and any continuation thereof depends upon the RMO fulfilling his duties. Accordingly the tribunal must pay close attention to the evidence of the RMO.

[18] In the context of a review process, the RMO must carry out a medical examination of the patient. That examination is part of a process leading to revocation, extension, or variation. The new RMO did not assess [redacted] he relied upon prior medical records. He gave evidence to the tribunal, expressing opinion without having fulfilled his duties.

[19] The tribunal had no objective medical evidence of the patient's mental health as at or sufficiently close to the date of the hearing on whether the criteria in section 64(5) continue to be met, the only available medical evidence being contained in [redacted] determination to extend dated 26 November 2020. The nature and extent of any mental disorder may change over time. As there was no up to date medical evidence that the criteria continued to be met, it could not be reliably shown that [redacted] continues to suffer from persisting unsoundness of mind. Nor could it be reliably shown that his unsoundness of mind was sufficient to justify continued deprivation of liberty by way of a CTO.

[20] In response [redacted] adopted his note of argument. He accepted that the burden rests on the state (here in the form of the RMO, MHO and the tribunal) to justify continued detention. He also accepted that the role of the RMO is of importance throughout the

[redacted]

duration of the CTO. The RMO was under a duty to carry out a mandatory review of the CTO. [redacted] as RMO, carried out the review in compliance with the statutory scheme, and concluded that [redacted] continued to meet the criteria in section 64(5) for compulsory powers. On that basis he issued his determination. The appellant does not argue that [redacted] had failed in his duties in this process.

[21] The tribunal had before it that determination. As the RMO did not attend the hearing in January, the tribunal directed hospital managers to identify the new RMO and to ensure the participation of the RMO at the February hearing – it did not instruct the RMO to assess the patient.

[22] The tribunal accepted the evidence of the current RMO and the MHO, both of whom are professionals with specialist knowledge about mental illness. The views of the current RMO were put to the MHO who agreed with the RMO's assessment. Their respective opinions support the determination of [redacted]. The current RMO's opinion was based on facts within [redacted] medical notes and after discussions with members of staff responsible for [redacted] care in the care home. The medical notes do not reveal recent evidence of improvement or change in [redacted] condition nor do the discussions with members of staff in the care home [redacted] does not argue that his medical notes are inaccurate or incomplete or that the RMO misunderstood them.

[23] The tribunal is recognised as an expert tribunal with specialist knowledge which includes knowledge of what is needed to express an opinion on the diagnosis, effects and treatment of mental illness. The tribunal brought that expertise to the assessment of the evidence of the RMO and the MHO. The evidence of the RMO and MHO was tested in cross examination. The tribunal is entitled to accept unanimous medical opinion based on the facts and prefer it to the views of the patient. It is not for the appeal court to assess the

[redacted]

evidence and decide what weight to attach to it on an appeal based on an error of law. (*BG v Mental Health Tribunal for Scotland* 2015 18 CSIH 18).

[24] No error of law has been identified. There was ample evidence before the tribunal to justify the findings and the decision.

The second ground of appeal

[25] In the note of argument, the appellant identified the following deficiencies in relation to the decision:–

(i) The tribunal did not offer any explanation for preferring the evidence of the RMO and MHO to that of the patient.

(ii) The decision fails to address the submissions advanced by the appellant's solicitor in relation to the evidence of the RMO and MHO in so far as they could not speak to the presentation of the appellant at the date of the tribunal. That was a critical issue for determination by the tribunal and one which was not dealt with in the findings and reasoning.

[26] In expanding upon these points [redacted] relied upon *Laurie v HMTS* 2007 GWD32-555. He submitted that it is not for the tribunal to simply accept the historic evidence of the RMO; it requires to form its own view on whether the criteria is met. No evidence was presented to the tribunal about the presentation of the patient as at the date of the hearing and this was ignored by the tribunal in its written decision in its findings and in its narration of the submissions. The tribunal is not an umpire: it may adopt an inquisitorial role and order additional material or evidence if it considers it appropriate. It ought to have intervened when it became apparent during cross-examination of [redacted] that he had not

[redacted]

assessed [redacted] It is insufficient to blandly state that the evidence of the RMO and MHO is accepted in preference to that of the patient without giving any justification. The tribunal must give reasons for accepting or rejecting expert opinion, and failed to do so *(Kennedy v Cordia* 2016 SC (UKSC) 59).

[27] For the respondent it was submitted that the informed reader of the decision would be aware of the evidence and the submissions made to the tribunal and would be left in no doubt that the tribunal took into account the written evidence, the oral evidence, the submissions; accepted the oral evidence of the RMO and MHO; found on the basis of that evidence that the section 64(5) conditions were satisfied; and decided to confirm the determination for that reason. It is obvious from the terms of the decision that the tribunal preferred the evidence of the RMO and the MHO because their evidence was based on medical and special clinical expertise and the appellant did not lead contradictory medical evidence. An absence of an explanation does not make reasons inadequate (*Robbins v Mitchell, Airdrie Sheriff Court* 14 May 2007 and *BG v Mental Health Tribunal for Scotland*).

The third ground of appeal

[28] In the note of argument, the appellant contends that that the tribunal must have regard to the section 1 principles. Section 1(3)(d) requires that the tribunal have regard to the importance of providing such information and support to the patient as is necessary to enable the patient to participate as fully as possible in the process. The procedural impropriety is the failure of the RMO to lodge the medical notes on which he relied as the basis of his evidence to the tribunal that the criteria continued to be met. This is in breach of Rule 45(1)(a) of the 2005 Rules.

[redacted]

[29] [redacted] submitted that ordinarily an RMO would not lodge medical records with the tribunal because the RMO would rely upon personal knowledge of the patient's illness, welfare, care and treatment through medical examination and discussion with the patient and others involved in the care programme. Here the appellant and the tribunal were deprived of the opportunity to consider and review the documents relied on by the RMO. In *Laurie v MHTS* when an RMO relied substantially on the report of a doctor who had not been called to give evidence to inform the RMO's opinion on the transfer of a patient, the court held that it was incumbent on the tribunal to satisfy itself that the evidence and the opinion of the RMO was soundly based. To determine whether it was soundly based the tribunal required to investigate the foundation on which it rested. In these proceedings, it was for the tribunal to satisfy itself as to the underlying foundation for [redacted]s opinion that the criteria continued to be met – and it did not do so.

[30] If a clinician examines medical notes and then at a hearing speaks to those notes, he is not giving expert opinion (*Kennedy v Cordia*). Further where an RMO relied substantially on the report of a doctor (not called to give evidence) to inform the RMO's opinion on the transfer of a patient, it is incumbent on the tribunal to satisfy itself that the evidence and opinion were soundly based (*Laurie v MHTS*). Proper disclosure was not made here, thus prejudicing the appellant.

[31] [redacted] contended that there was no breach of Rule 45(1)(a) of the 2005 Rules. The rule presupposes that the witness wishes to lead as evidence documents, files or other written material. The RMO did not want to put the medical notes before the tribunal. He wanted to give oral evidence about what he had read in the notes to explain the basis on which he was able to offer a clinical opinion.

[redacted]

[32] [redacted] did have the opportunity to consider the medical notes. He had legal representation since 09 December 2020. He could have asked for an order for production under Rule 49(1) or 59(1), or raised this as preliminary matter under Rule 43(1). The hearing was fair. The decision was made by an independent and impartial tribunal which took account only of the evidence that [redacted] heard, gave [redacted] the opportunity through his solicitor to cross examine witnesses, and gave [redacted] the opportunity to make representations (*MH v Mental Health Tribunal for Scotland* 2019 SC 527.) The tribunal could have ordered the RMO to produce the medical notes or ask him questions about them if it considered that was necessary. It did not do so. Nothing of substance has been lost here (*King v East Ayrshire Council* 1998 SC 182).

Decision

The first and second grounds of appeal

[33] These ground of appeal overlap, as both involve a dissection of the decision of the tribunal firstly to ascertain what evidence was led before it to permit it to make its findings in fact and secondly to ascertain whether the findings and reasoning are adequate. I have taken these grounds together to avoid repetition.

[34] Although it is easy to ascertain what written material was considered by the tribunal (see paragraph [12] above), it is more troublesome to identify the nature and extent of the oral evidence led. A list of witnesses is not sufficient. The tribunal does not need to narrate in its decision every word spoken by each witness (*Moray Council v Scottish Ministers* 2006 SC 691). Were that to be a requirement then decisions and judgment would run to hundreds of pages. What would be helpful, in my view, is a summary of the evidence of each witness, written with clarity and precision as this will assist the tribunal in determining whether there was any

[redacted]

evidence to justify the findings. That said, I accept that it is not for this court to assess the evidence and decide what weight to give to it (*BG v MHTS* at para. 40).

[35] However there is a dearth of any intelligible narration of the evidence of the RMO, the MHO, the named person and the patient. In the section headed "Preliminary Matters" the tribunal records:-

> "[redacted] ... attended and advised that he had been appointed as RMO ... but had only taken up that post on 08 February 2021 ... he had tried but been unable in that time frame to review the patient but was able to provide evidence for the patient's medical case notes. He advised [redacted] of this."

In the midst of finding in fact at paragraph 17 of the decision the tribunal records -

> "The RMO advised there was no recent evidence from medical notes and discussion with care home staff that this had improved. The tribunal accepted the evidence from the MHO, who has known the patient for three years, that although [redacted] is accepting depot injection at present ... he has at times been non-compliant with oral medication."

[36] [redacted] was not called as a witness to speak to the terms of his determination. It is a matter of agreement that he vacated office. It appears that his replacement was appointed only after the section 49 direction was used by the tribunal on 03 February 2021. The tribunal sought to encourage the hospital managers rectify this omission; it did not cause it. The Mental Health (Care and Treatment) Act Code of Practice ("the Code") recommends that the appointment of an RMO should normally be the day of the Order or the next day, if the RMO is from a different hospital or service (Vol 1, para 9.03). Section 230(3) permits managers to replace an RMO and to authorise another RMO to act for a specific purpose or in particular circumstances, and that would include absence from work. The Code emphasises the importance of putting in place arrangements to cover periods of absence

[redacted]

(Vol 1, para 9.08), and of ensuring that another RMO is "appointed swiftly to act as the patient's RMO in any other circumstance where the patient's 'usual' RMO is absent…" (Vol 1, para 9.09). No explanation appears to have been given to the tribunal (or if it was it was not recorded) for the gap between the departure of [redacted] and the appointment of [redacted], nor does there appear to have been any explanation given to the tribunal for the lack of engagement with and assessment of [redacted] subsequent to [redacted]'s appointment. Neither party was able to provide any clarity on these issues during the appeal.

[37] The new RMO had access to the determination. [redacted] report was an important foundation of [redacted] opinion, but it was not the sole factor – he also explained, as I noted above, that he had regard to the medical notes and had discussions with the care home staff. To fail to meet with the patient in advance of the reconvened hearing is not satisfactory – and there may be good reason for that omission – for example the then restrictions imposed due to the pandemic. I would have expected to have seen an explanation for that in the decision.

[38] The RMO and MHO are key members of the patients multi-disciplinary care team. They have distinct duties and responsibilities. There is a duty on the RMO to keep under review the continuing need for compulsory powers as well as carrying out a mandatory review of the CTO. It is the latter which is relevant here. The process which the RMO must follow is set out in section 77(3)-(5). He must:-

- Carry out a medical examination of the patient or arrange for another RMO to do so;
- Consider whether the patient continues to meet the section 64(5) criteria;
- Consult with the patient's MHO;
- Consult with others who are providing treatment, community care services or other relevant services to the patient; and
- Consult with any other person the RMO considers appropriate.

[redacted]

It can be readily seen from the determination that [redacted] followed these steps and the MHO, having been appropriately consulted, supports the determination. There is a presumption in favour of revoking the CTO unless the RMO is satisfied the criteria are met. [redacted] was satisfied on 26 November 2020 and decided not to revoke the CTO. Section 83(3) placed a duty on him to review the objectives of the care plan and again it can be seen from his determination that he carried out such a review.

[39] The duties of the MHO include interviewing the patient, informing the patient of the proposed extension to the CTO, informing the patient of his/her rights and of the availability of advocacy services, and informing the RMO whether she disagrees with the determination. The appellant makes no criticism of the MHO or suggests that she failed in her duties.

[40] There is no difference of opinion between the members of then and the present care team. But for the lodging of an amendment to the application which caused a delay of four weeks and then the departure of [redacted] the application by [redacted] could have been considered and a decision made swiftly. I was not referred to any provision in the legislation requiring a further assessment by an RMO in the lead up to a hearing before the tribunal or for there to be continuous assessment where the hearing is continued to another date.

[41] The tribunal is a specialist tribunal. It includes specialist members. They are bound to have prior knowledge of the nature of particular mental disorders. There was no suggestion before this tribunal that the appellant wished to lead contradictory medical evidence, although he did not accept that he requires hospitalisation or the strictures of a CTO. There were no conflicts in the background facts or for that matter in relation to the current care package. There was no divergence between the RMO and the MHO. In *BG v MHTS* the tribunal accepted unanimous medical opinion based on the facts and prefer it to the opinion of a named person. The named person in these proceedings is supportive of the continuation

[redacted]

of the CTO. The outcome of the application at the end of the day is for the tribunal. The tribunal has a discretion on whether to grant or refuse the application depending on its assessment of the evidence and the criteria in section 64(5).

[42] Having considered the evidence and representations, the tribunal must be satisfied as to all of the 5 separate conditions for compulsory treatment in section 64(5)(a)-(e) before it can grant or refuse the application. The findings in fact are contained within paragraphs 14-19 inclusive, and appear in the main to be taken directly from [redacted] determination, which is in stark terms. The findings address each of the 5 conditions.

[43] Firstly the tribunal found (para 14) that the patient has a mental disorder, namely schizo-affective disorder and that his illness is characterised by persecutory and grandiose delusions with religious contents; he has mood congruent auditory hallucinations believing that he has been accused as a paedophile. He has had extensive contact with psychiatric services since 1980. (This is recorded on page 4 of the determination, which is slightly more expansive about [redacted] s lack of insight into his illness)

[44] The second finding (para 15) is that medical treatment is available which would be likely to prevent the disorder worsening or to alleviate the symptoms, and that is in the form of depot and oral antipsychotic medication, mood stabilisers and anxiolytics, administered in a care home setting. [redacted] requires assistance for essential daily living needs and supervision of medication. (This is recorded on page 4 of the determination, includes reference to [redacted] s desire to live independently and to secure gainful employment).

[45] The third finding (para 16) covers the significant risk to the health, safety and welfare of the patient and of others were he not provided with such treatment. The tribunal found that [redacted] has a history of self-harming as well as acts of verbal and physical aggression towards others and socially inappropriate behaviours due to his persecutory beliefs and

[redacted]

religious delusions. He has variable compliance with medication and also disengages from treatment. He has a history of non-compliance with medication leading to relapses in his symptoms of illness. He has been hospitalised many times since diagnosis. He has displayed suicidal tendencies in response to auditory hallucinations. Without treatment he is prone to self-neglect. (This is set out on page 5 of the determination).

[46] The fourth finding (para 17) is that [redacted]'s ability to make decisions about medical treatment is significantly impaired because of the mental disorder. The finding records that [redacted] continues to lack insight into his disorder and has previously expressed the view that he does not have a mental illness, and that care and treatment is not necessary (this is reflected on page 45 of the determination).

[47] The fourth finding somewhat unusually contains what is more properly evidence and records the views of the current RMO and the MHO:–

> "The RMO advised that there was no recent evidence from medical notes and discussion with care home staff that this had improved. The tribunal accepted the evidence from the MHO, who has known the patient for three years, that although [redacted] is accepting the depot injection at present … he has at times been non complaint with oral medication. He has also refused depot mediation in October 2020."

[48] The fifth and final finding (para 19) relates to the matter of necessity. The tribunal found that the CTO continues to be necessary, and that without compulsory measures [redacted] is likely to be non-compliant with medication, risking relapsing in the symptoms of illness.

[49] Parties are agreed that the question for the court is whether the decision leaves the informed reader in no real and substantial doubt as to the reasons for the decision and the material considerations which were taken into account in reaching it (*Wordie Property*

[redacted]

Company Limited v Secretary of State for Scotland 1984 SLT 345 at 348). The lack of a summary of the evidence, as I have already observed, causes a difficulty. I cannot ascertain what oral evidence was given by the MHO, the RMO and any other party who addressed this tribunal. Although the tribunal states that it assessed the evidence carefully, I cannot ascertain whether the tribunal misconstrued the evidence or take into account irrelevant material or ignore material factors or err in the balancing exercise due to the limitations within the decision. There are of course fulsome findings in fact and detailed source material. However for this court or the informed reader to make sense of this decision it is necessary to revert to the supporting documentation, and then to make assumptions. Quite simply greater clarity of expression and a more bespoke approach could have been utilised in relation to the recording and evaluation of the evidence, and I encourage the tribunal to do so in the future.

[50] In relation to the balancing exercise, the tribunal records that it "accepted and preferred the written and oral evidence of the RMO and MHO". Although it did not explicitly state that it accepted that evidence over that of [redacted], it is clear from the language of the decision when read as a totality that it did reject the evidence of [redacted] and the submission made on his behalf in preference to that of the professionals. Section 13 of the decision notes briefly the submission made by the patient's solicitor and the views expressed by the advocacy worker. I am told by [redacted] that the submission was more fulsome in relation to the failure of the RMO to examine the patient immediately prior to the hearing. If such a submission was made, it ought to have been recorded. However, the issue (failure to examine the patient) is not, for reasons given elsewhere in this note, determinate of the outcome to the appeal.

[51] In relation to appellant's submission about the giving of evidence by skilled witnesses and limitations on the admissibility of expert evidence (*Kennedy v Cordia*), a skilled

[redacted]

witness may give evidence of fact as well as opinion evidence. The new RMO did both. If a skilled witness draws on the work of others there may be issues of admissibility. I cannot tell from the decision whether objection was made, on what basis and the outcome. Regardless, I agree with the submission of the respondent that the absence of an explanation does not make reasons inadequate (*Robbins v Mitchell, Airdrie Sheriff Court* 14 May 2007 and *BG v Mental Health Tribunal for Scotland*).

[52] It is not necessary for the tribunal to elaborate on every point made during the hearing. What is required is clarity of reasoning on the main issues which were in dispute and which were properly focused and examined during the hearing. The findings made by the tribunal are unequivocal. The outcome is sufficiently clear – that the tribunal was satisfied that the 5 conditions had been met based on the oral evidence of the RMO and the MHO supported by all of the written source material. Although this point was not argued, I am satisfied that the decision of the tribunal was supported by the findings in fact and is consistent with the applicable statutory regime.

[53] For the foregoing reasons I consider there is merit in ground of appeal one, but not in relation to ground of appeal two.

The third ground of appeal

[54] This particular ground of appeal is periled on a breach of Rule 45(1)(a). Rule 45(1)(a) of the 2005 Rules provides:

> "(1) Except as otherwise provided in these Rules or as specified by the Tribunal in a particular case, a relevant person shall send to the Tribunal seven days prior to any hearing–

[redacted]

(a) a list of documents and the documents that the relevant person wishes to lead as evidence; …

(2) Where a relevant person seeks to rely upon documents not produced in accordance with paragraph (1), the Tribunal may allow the documents to be lodged late where good reason is given.

(3) In determining whether to allow documents to be lodged late, the Tribunal shall have regard to whether to do so is fair in all the circumstances."

[55] As the court observed in the *Laurie* case:-

"I do not doubt that there will be many cases coming for decision before the Mental Health Tribunal for Scotland in which it will be entirely proper and satisfactory for them to proceed on the basis of a report or reports, in order for instance to inform themselves on ancillary matters or to make minor decisions on the way to reaching a major decision … without the need to call the author of the report to speak to it from the witness box. Indeed it is apparent from the procedural rules …. that the tribunal are given wide powers and discretions to decide what evidence they should take into account or call before them and in what form."

[56] It is clear that one source of information for [redacted] was the determination of [redacted] which was then supplemented by his direct engagement with those involved in [redacted] care and treatment at the care-home and his utilisation of the medical case notes. He had advised [redacted] of his intention to access the medical notes. It seems to me entirely reasonable for a newly appointed RMO to access medical notes to give him insight into the background circumstances, the diagnosis and treatment plan to enable him then to give evidence to the tribunal.

[57] Nowhere do I find in the decision by the tribunal a request by the RMO to lodge the medical reports nor a request by the appellant to have access to the medical reports. The tribunal did not order the RMO to produce the medical notes. It did not issue any direction as to issues on which it required evidence to be lead. It did not order [redacted] to speak to the

[redacted]

terms of his determination. It did not further adjourn the hearing for [redacted] to assess the patient. At the risk of repetition, this is a specialist tribunal with a degree of prior knowledge and an ability to fulfil an inquisitorial role. It chose not to do so.

[58] Accordingly I do not consider the rule has been breached in the manner contended by the appellant.

Outcome

[59] This appeal is allowed in relation to ground one and not in relation to grounds two and three. I wish to make it clear that my decision does not necessarily mean the tribunal came to the wrong result on account of any omission in the recording of the evidence or that they reached a correct decision despite the omission – my conclusion is that there was a flaw in failing to set out the evidence upon which their decision was based.

[60] In departing from plea in law 3 in the note of appeal, [redacted] accepted that in the circumstances, were I inclined to allow the appeal, I should not attempt to substitute a decision of my own for that of the tribunal and instead follow the usual course of remitting the case to the tribunal for reconsideration. That is what I shall do.

[redacted]